To be argued by: Justin A. Heller
Time requested: 20 minutes

Case No. APL-2020-00169

Court of Appeals of the State of New York

KIM E. SCHOCH, CNM, OB/GYN NP,

Plaintiff-Respondent,

- against -

LAKE CHAMPLAIN OB-GYN, P.C.,

Defendant-Appellant.

BRIEF FOR RESPONDENT KIM E. SCHOCH, CNM, OB/GYN

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Appellate Division, Third Department
Docket No. 529615;
Saratoga County Supreme Court
Index No.: 20184228

STATUS OF RELATED LITIGATION

There are currently seven (7) other appeals before this Court to resolve the same narrow question of law stemming from the conversion of Medical Liability Mutual Insurance Company ("MLMIC") to a stock insurance company, and the resulting extinguishment of the Policyholders' Membership Interests: Who is entitled to the cash consideration paid in exchange for the extinguishment of a MLMIC Policyholder's Membership Interest—(i) the *insured/practitioner* (here, Respondent) who became a MLMIC Policyholder, and thereby acquired a Membership Interest, as part of the bargained-for exchange of consideration under his/her employment agreement; or (ii) the *employer/Policy Administrator* (here, Appellant), which paid the MLMIC premiums on the insured's behalf and in exchange for his/her services under the employment agreement?

The status of these seven appeals are as follows:

- Columbia Memorial Hospital v. Hinds, 188 A.D.3d 1336 (3d Dep't 2020), *lv granted*, 36 N.Y.3d 904 (2021): Appellant's brief was filed March 8, 2021, respondent's brief was due May 7, 2021, and appellant's reply brief is due May 24, 2021.
- Maple Medical, LLP's six appeals: On February 26, 2021, the Appellate Division, Second Department granted Maple Medical, LLP leave to appeal the court's orders in six cases—*Maple Medical, LLP v.*

Arevalo, 189 A.D.3d 1018; *v. Goldenberg*, 189 A.D.3d 1018; *v. Mutic*, 189 A.D.3d 1019; *v. Scott*, 191 A.D.3d 81; *v. Sundaram*, 189 A.D.3d 1019; and *v. Youkeles*, 189 A.D.3d 1020. Appellant's joint brief was filed April 26, 2021, respondent's joint brief is due June 11, 2021, and appellant's reply brief is due June 28, 2021.

Appellant claims (in the "Related Appeals" section of its Brief) that various "institutional medical practices . . . have been granted *amicus curiae* relief." In the within case, however, the Court granted Samaritan Medical Center limited amicus curiae relief to submit papers in support of Appellant's request for leave to appeal. Respondent has not been served with any motions seeking to file an amicus brief on this appeal. The dockets for *Columbia Memorial Hospital* and *Maple Medical, LLP*[1] do not identify any amicus curiae parties.

[1] Respondent's counsel herein is also counsel for the respondents in the Maple Medical, LLP appeals, and has not been served with a motion for amicus curiae relief in any of those six appeals.

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COUNTERSTATEMENT OF QUESTIONS PRESENTED

1. Did the Appellate Division, Third Department correctly hold that Plaintiff-Respondent was legally entitled to her share of the Cash Consideration paid in exchange for the extinguishment of her Policyholder Membership Interest in Medical Liability Mutual Insurance Company ("MLMIC"), pursuant to New York Insurance Law (§7307[e][3]), the MLMIC Plan of Conversion, and the Decision of the New York State Department of Financial Services ("DFS") approving the MLMIC Plan?

   Answer: The court below correctly held that Plaintiff-Respondent was legally entitled to her share of the MLMIC Cash Consideration pursuant to Insurance Law §7307(e)(3), the MLMIC Plan of Conversion and the DFS Decision approving the Plan.

2. Did the Appellate Division, Third Department correctly hold that Plaintiff-Respondent would not be unjustly enriched by receiving her share of the Cash Consideration paid in exchange for the extinguishment of her MLMIC Policyholder Membership Interest?

   Answer: The court below correctly held that Plaintiff-Respondent would not be unjustly enriched by receiving her share of the MLMIC Cash Consideration.

NATURE OF THE CASE

Plaintiff-Respondent Kim E. Schoch, CNM, OB/GYN NP ("Ms. Schoch") respectfully submits this Brief in response to the appeal of Defendant-Appellant Lake Champlain OB-GYN, P.C. ("Appellant" or "Lake Champlain") from the Opinion and Order of the Appellate Division, Third Department ("*Schoch* Order"), which (i) reversed the Judgment of the Saratoga County Supreme Court, (ii) denied Appellant's cross-motion for summary judgment, (iii) granted Ms. Schoch's motion for summary judgment, and (iv) declared that Ms. Schoch was solely entitled to her $74,747.03 share of the MLMIC Cash Consideration (defined *infra*) (R.360-69).

The question before the court below was straightforward. After MLMIC demutualized (thereby extinguishing its Policyholders' Membership Interests), who was entitled to the consideration paid in exchange for Ms. Schoch's Policyholder Membership Interest: (i) *Ms. Schoch*, who became a Policyholder—and thereby acquired a Membership Interest—as part of the bargained-for exchange of consideration under her Employment Agreement; or (ii) *Appellant*, which paid Ms. Schoch's premiums on her behalf pursuant to the Employment Agreement and in its capacity as her Policy Administrator? The answer to that question was manifest, compelled by the clear framework of the Insurance Law and Plan of Conversion, the DFS Superintendent's unequivocal Decision approving the Plan, the plain terms of the parties' Employment Agreement, and established unjust enrichment precedent.

Simply put, Insurance Law §7307(e)(3) and the Plan of Conversion mandated that as the Policyholder/Insured, Ms. Schoch was entitled to the Consideration paid for her extinguished Membership Interest. The DFS decisively confirmed the Policyholders' legal right to the Consideration—with the limited exceptions being where their employer/Policy Administrator was expressly designated to receive or assigned the Consideration. Neither of those exceptions occurred here.

Faced with Ms. Schoch's clear legal entitlement to the Consideration, Appellant coopted the *same* argument that another employer[2] unsuccessfully made to the DFS and in its ensuing Article 78 proceeding: The persons entitled to the Consideration under §7307 are those who made the premium payments, and not the insureds/employees on whose behalf the payments were made. Recognizing that Appellant's argument had no basis in the controlling statutory and documentary authorities, the Third Department correctly held that "pursuant to the language of the statute, the conversion plan and DFS's decision, MLMIC should pay the cash consideration to [Ms. Schoch]."[3] *Schoch* Order, R.365.

In an unavailing attempt to revive this oft-rejected argument under the guise of statutory interpretation, Appellant, among other things, improperly dismisses the

[2] That employer, Maple Medical, LLP, has six related appeals before this Court (*see, supra*).

[3] The Second and Fourth Departments similarly denied employers' claims to the Cash Consideration paid on account of their employees' Policyholder Membership Interests. *See Maple Med., LLP v. Scott*, 191 A.D.3d 81, 93 (2d Dep't 2020) and *Maple-Gate Anesthesiologists, P.C. v Nasrin*, 182 A.D.3d 984, 985 (4th Dep't 2020).

Plan as "extrinsic," mischaracterizes the DFS Decision as inconclusive regarding "statutory rights" to the Cash Consideration, and mistakenly relies on Insurance Law §501's inapposite definition of "policyholder" (App. Brief,[4] 2, 23-24). Appellant's efforts are unavailing for a host of reasons—most notably:

- §7307 and the Plan of Conversion are inextricably linked: The statute defers to the plan to set forth the "manner and basis" of extinguishing policyholders' membership interests and distributing the resulting consideration to "each person who had a policy of insurance in effect." MLMIC's Plan unequivocally states that the Policyholder/Insured (here, Ms. Schoch) is the "person who had a policy of insurance in effect" and is therefore entitled to the Consideration under §7307(e)(3).

- The Plan and DFS Decision rejected Appellant's misreading of §7307: The Plan and DFS affirmed that, contrary to Appellant's claim, §7307(e)(3)'s formula for calculating policyholders' shares of Consideration does not (i) distinguish between policyholders who paid the premiums themselves and those whose employer/Policy Administrator paid the premiums on their behalf (like Appellant did pursuant to the Employment Agreement and in its capacity as Ms. Schoch's Policy Administrator/agent), and (ii) has no relevance to a policyholder's entitlement to the Consideration under §7307(e)(3).

[4] "App. Brief" hereinafter refers to Appellant's Brief.

- The DFS found that the Plan did not violate §7307: By issuing her Decision, the DFS Superintendent confirmed that the Plan, including its definition of Policyholders and their entitlement to the Consideration, did not violate §7307.

- The DFS Decision foreclosed statutory challenges to the Consideration: In confirming Policyholders' legal right to the Consideration under §7307(e)(3) and the Plan, the DFS Superintendent underscored that MLMIC's objection/escrow procedure is a mechanism for courts to determine whether the Consideration should be paid to an employer/Policy Administrator pursuant to an assignment or other contractual obligation (neither of which existed herein). It is not, as Appellant contends, an invitation to challenge the DFS Superintendent's findings in her Decision and argue whether the Plan comports with §7307.

- Insurance Law §501 is expressly limited to Article 5: Appellant's contention that §501's definition of "policyholder" should be imported into §7307 was not raised below. Even if the argument were properly before this Court, §501's definitions are expressly noted as being for "the purposes of this article [5]" only. Moreover, even under §501's definition, Ms. Schoch would still be the policyholder.

In short, Ms. Schoch's clear legal right to the Consideration under the framework of §7307, the Plan and the DFS Decision cannot be circumvented by Appellant's disregard of the interdependence of §7307 and the Plan, its improper

collateral attack of the DFS Decision, and its reliance on §501's inapposite definition of policyholder.

Having no legal right to Ms. Schoch's share of the Cash Consideration, Appellant posits that its service as Ms. Schoch's Policy Administrator and payment of her premiums entitled it to the Consideration on a theory of unjust enrichment. Appellant's argument entirely ignores that (a) Appellant was merely Ms. Schoch's agent, conferred with only limited rights established by MLMIC (none of which entitled it to the Consideration), (b) Appellant paid the premiums as an express term of the parties' Employment Agreement, and (c) Ms. Schoch provided the contractually agreed-upon consideration for those premium payments. Quite simply, Appellant was compensated for, and cannot base an unjust enrichment claim on, its payment of premiums. Moreover, as correctly held by the Third Department below, none of the circumstances that courts should consider when evaluating a claim of unjust enrichment militated in Appellant's favor. *See Schoch* Order, R.368.

Accordingly, for those and the other reasons herein, Ms. Schoch respectfully requests that this Court affirm the Third Department's Order in its entirety.

COUNTERSTATEMENT OF FACTS, AND BACKGROUND OF MUTUAL INSURANCE COMPANY STRUCTURE

A. MLMIC was owned by its Members, the Policyholders.

Prior to its October 1, 2018 conversion to a stock insurance company, MLMIC was a mutual insurance company (R.75, para. 1). A mutual insurance company is owned by, and operated for the benefit of, its members, who are the policyholders of the company. *See* Insurance Law §1211(a).[5] Under MLMIC, the Policyholder was the person listed as the "insured" on the Declarations Page of the policy (R.79).

B. Ms. Schoch was the sole insured under her MLMIC policy.

Ms. Schoch was employed as a certified nurse midwife with Appellant from June 18, 2007 until February 27, 2015 (R.5; R.11, ¶2; R.225, ¶22). During her employment with Appellant, Ms. Schoch was covered by a MLMIC malpractice policy. (R.233-34, R.245; *see also* R.11 ¶4). As evidenced by the Declarations Page of her MLMIC policy, Ms. Schoch was the sole insured—and thus the sole Policyholder—under her malpractice policy (R.245).

C. MLMIC Policyholders had both contractual rights and membership rights.

Policyholders in a mutual insurance company have two distinct types of rights: (1) contractual rights; and (2) membership rights. *See Schoch* Order, R.362

[5] *See also Methodist Hosp. of Brooklyn v. State Ins. Fund*, 64 N.Y.2d 365, 374 (1985) ("A mutual insurance company is organized and operated for the benefit of its policyholders who are by virtue of their policies members of the company.").

(Policyholders have "a dual relationship with a mutual insurance company, in that they have both a membership interest (e.g., the right to vote and receive dividends) and contractual rights (i.e., the obligations of the insurance company under the policy).") (citing Insurance Law §1211[a]; *Dorrance v. U.S.*, 809 F.3d 479, 482 [9th Cir. 2015]; *Bank of N.Y. v. Janowick*, 470 F.3d 264, 267 [6th Cir. 2006]; 17 Steven Plitt *et al.*, Couch on Insurance 3d §39:37 [1995]). Contractual rights are paid for by policy premiums and encompass the insurance coverage/benefits under the policy. *See Dorrance*, 809 F.3d at 485.

Membership rights, on the other hand, are <u>not</u> paid for by policy premiums, but rather are acquired "'as an incident of the structure of mutual insurance policies,' through operation of law and the company's charter and bylaws." *Schoch* Order, R.367 (quoting *Dorrance*, 809 F.3d at 485; citing *Columbia Mem. Hosp. v. Hinds*, 65 Misc. 3d 1205(A), 2019 NY Slip Op 51508, ¶5 [Sup. Ct. Columbia Cty. 2019]). Membership rights include the right to participate in meetings of the members, to vote on company affairs, to receive excess annual premiums in the form of dividends,[6] and to receive consideration for the extinguishment of membership interests as part of a demutualization. *See* Insurance Law §1211, §7307(e)(3).

[6] As discussed *infra* (at Point V[B]), a mutual insurance company "dividend" is not like a stock dividend of annual profits; it is an "adjustment" between the annual premium "estimated at the year's beginning . . . and the amount found actually to have been necessary in retrospect." *Kern v. John Hancock Mut. Life Ins. Co.*, 8 A.D.2d 256, 259 (1st Dep't 1959), *aff'd*, 8 N.Y.2d 833 (1960).

MLMIC's membership interests were called "Policyholder Membership Interests" and, consistent with the foregoing, did not "include insurance coverages provided under the Policies" (R.79).

D. Ms. Schoch designated Appellant to be her Policy Administrator with limited contractual and membership rights.

Under her Employment Agreement (R.17-27), one of the benefits that Appellant agreed to provide in exchange for Ms. Schoch's services was the payment of her malpractice premiums (R.11 ¶3; R.24, ¶16). To effectuate payment of her MLMIC premiums, Ms. Schoch signed a Policy Administrator - Designation and/or Change form ("PA Designation Form") designating Appellant as the "Policy Administrator" of her MLMIC policy (R.12 ¶5, R.29). The PA Designation Form (R.29) provided that the Policy Administrator would act as the "agent" of the insured and would be conferred only the following limited rights:

- Contractual Rights – "paying of Premium[s], requesting changes in the policy," "terminat[ing] coverage," and receiving "all legal notices"; and
- Membership Rights – "receiving dividends and any return Premiums when due."

E. Appellant acted as Ms. Schoch's Policy Administrator and exercised the limited Administrator rights it had been granted.

During Ms. Schoch's employment, Appellant acted as her Policy Administrator and exercised the limited rights which it had been conferred:

- Paying Ms. Schoch's premiums -- in accordance with its obligation under the Employment Agreement (R.12, ¶5);

- Requesting changes to Ms. Schoch's policy (including its cancellation/non-renewal) -- as evidenced by the policy Endorsements (R.230-31, R.237-38, R.240-44);

- Receiving the Endorsements issued by MLMIC to Appellant[7] (*id.*); and

- Receiving the "dividends" (i.e., refunds of excess annual premiums) and the return premiums upon the cancellation of Ms. Schoch's policy (R.230-31; R.284, ¶15).

F. MLMIC sought DFS' permission to demutualize and submitted a proposed Plan of Conversion.

Insurance Law §7307 ("§7307") sets forth a procedure for a mutual insurance company to convert to a stock insurance company—to wit, applying for the DFS Superintendent's permission to submit a proposed plan of conversion, and then submitting the plan to DFS. *See* §7307(b)-(e). MLMIC followed that procedure by applying for permission to submit a proposed plan (on July 16, 2016), receiving DFS' permission to submit a proposed plan (on May 22, 2018), and submitting the Plan of Conversion (the "Plan") (on June 15, 2018) (R.72, R.136, R.180).

G. After holding a public hearing, DFS reviewed the Plan to ensure that it did not violate the Insurance Law, and approved it.

On August 23, 2018, in accordance with her obligations under §7307(g), the DFS Superintendent held a public hearing on the proposed Plan ("DFS Hearing"). Following the Hearing, the DFS Superintendent was required to review the Plan to ensure it "does not violate [the Insurance Law], is not inconsistent with law, is fair

[7] The PA Designation Form stated that the Policy Administrator's name would be displayed on any issued Endorsements (R.29).

and equitable and is in the best interests of the policyholders and the public." §7307(h)(1). The Superintendent completed her review and issued a Decision dated September 6, 2018 (the "DFS Decision") approving the Plan (R.127-54).

H. MLMIC's Policyholders approved the Plan of Conversion.

The DFS Superintendent conditioned her approval on the Plan being submitted to a vote of MLMIC Policyholders (R.128, ¶2 & n.1). On September 14, 2018, the proposed Plan was submitted to a vote of all eligible Policyholders, and two-thirds of those Policyholders approved the Plan (R.107-08, R.128, R.175).[8]

I. The Plan provided that Policyholder Membership Interests would be exchanged for Cash Consideration, which would be distributed to Eligible Policyholders or their Designees.

Insurance Law § 7307(e) provides that a plan of conversion shall include:

> "(3) The manner and basis of exchanging the equitable share of each eligible mutual policyholder for securities or other consideration, or both, of the stock corporation into which the mutual insurer is to be converted and the disposition of any unclaimed shares. The plan shall also provide that each person who had a policy of insurance in effect at any time during the three year period immediately preceding the date of adoption of the resolution described in subsection (b) hereof shall be entitled to receive in exchange for such equitable share, without additional payment, consideration payable in voting common shares of the insurer or other consideration, or both."

Rather than give Policyholders stock in the new company, the Plan provided that the "Eligible Policyholders" (or their "Designees") would receive $2.502 billion

[8] The conversion transaction closed on October 1, 2018 (R.216).

in cash consideration ("Cash Consideration" or "Consideration") for the extinguishment of their Membership Interests (R.75, para. 3, R.86 ¶8.1). The Plan defined "Eligible Policyholders" as Policyholders during the period July 15, 2013 through July 14, 2016; "Policyholder" as the person identified on the policy's Declarations Page as the "insured"; and "Designees" as Policy Administrators (or EPLIP Employers)[9] specifically designated by the Eligible Policyholders to receive the Cash Consideration (R.77, R.79).

J. Ms. Schoch was an Eligible Policyholder.

Ms. Schoch had a MLMIC policy in effect during the above three-year period, and she was the only person identified as the "insured" on the Declarations Page of her policy (R.245). Thus, she was an Eligible Policyholder entitled to receive the Consideration under the Plan (R.79).

K. Ms. Schoch did not designate Appellant to receive the Cash Consideration.

The Plan stated that, "The amount distributable to each Eligible Policyholder shall be paid directly to such Eligible Policyholder unless such Eligible Policyholder has affirmatively designated a Policy Administrator . . . to receive such amount on its behalf, in which case such amount shall be distributed to such Designee" (R.85 ¶6.3[f]). In its June 22, 2018 Policyholder Information Statement, MLMIC

[9] Ms. Schoch's policy was not an Employee Professional Liability Insurance Policy (EPLIP); thus, any reference in the Plan or DFS Decision to EPLIP Employers has been omitted in this Brief.

explained that such designation of a Policy Administrator must be made "in writing (using a designation form to be provided by MLMIC)" (R.169 ¶A.5). MLMIC subsequently clarified that prior Policy Administrator designations "do not extend to the distribution of the cash amounts allocated to eligible policyholders," and that the Policyholder would need to sign a specific Consent Form to designate its Administrator to receive the Consideration (R.31-32 [emphasis added]).[10]

Ms. Schoch did not sign the Consent Form required by MLMIC to make Appellant a "Designee" for receipt of the Cash Consideration (R.13 ¶9; R.56 ¶ 81). Appellant filed an objection with MLMIC to the distribution of the Consideration to Ms. Schoch (R.227, ¶34), and the underlying dispute ensued (R.37).

[10] *See also* "MLMIC Provides Clarification of Ability to Make Assignments of Cash Consideration"; MLMIC Blog, August 7, 2018, accessible at https://www.mlmic.com/blog/dentists/clarification-of-ability-to-make-assignments-of-cash-consideration (noting that in addition to signed Consent Forms, MLMIC would honor "signed assignments" of Eligible Policyholders' "right to receive their allocable share of the cash consideration). Ms. Schoch did not execute an assignment of her right to receive the Cash Consideration (R.13, ¶10; R.40, ¶19).

ARGUMENT

I. THE COURT BELOW CORRECTLY RELIED ON THE PLAN OF CONVERSION IN HOLDING THAT MS. SCHOCH WAS LEGALLY ENTITLED TO THE CASH CONSIDERATION UNDER §7307

In an unavailing attempt to manufacture an error in the *Schoch* Order, Appellant argues that the Third Department improperly relied on the Plan in holding that Ms. Schoch was legally entitled to the Consideration under §7307. Appellant's argument is fatally flawed inasmuch as it ignores the interdependence of §7307 and the Plan. As described below, §7307(e) defers to the plan of conversion to set forth "[t]he manner and basis" of effectuating the extinguishment of policyholders' membership interests and distribution of the consideration to "each person who had a policy of insurance in effect." As such, contrary to Appellant's spurious claim, the Third Department's reliance on MLMIC's Plan was not in derogation of §7307; it was essential to determine legal entitlement to the Cash Consideration.

A. Under Insurance Law §7307(e)(3), the plan of conversion governs the distribution of demutualization consideration.

Section 7307(e)(3) provides that a plan of conversion shall include:

> "The manner and basis of exchanging the equitable share of each eligible mutual policyholder for securities or other consideration, or both . . . . The plan shall also provide that each person who had a policy of insurance in effect at any time during the three year period immediately preceding the date of adoption of the [mutual insurer's] resolution described in subsection (b) hereof shall be entitled to receive in exchange for such equitable share, without additional payment, consideration payable in voting common shares of the insurer or other consideration, or both."

It is clear that the statute defers to the plan of conversion to set forth "[t]he manner and basis" of effectuating the extinguishment of policyholders' membership interests and distribution of the resulting consideration to "each person who had a policy of insurance in effect" during the relevant three-year eligibility period. *See Bank of N.Y.*, 470 F.3d at 274 ("[T]he mutual company's demutualization plan defines . . . rights [to proceeds]."). Simply put, the Plan is not a "non-statutory, non-legislative, extrinsic document," as Appellant suggests (App. Brief, 21), but rather a critical component of the framework of §7307.

B. MLMIC's Plan of Conversion provided that the Policyholders-Insureds were entitled to the Cash Consideration.

MLMIC's Plan of Conversion provided that the "Eligible Policyholder" was the "person who had a policy of insurance in effect," and was therefore entitled to receive the Cash Consideration, under §7307(e)(3):

- "Eligible Policyholders, or their Designees, will receive Cash Consideration in consideration of the extinguishment of their Policyholder Membership Interest" (R.75, para. 3).
- "The amount distributable to each Eligible Policyholder shall be paid directly to such Eligible Policyholder unless such Eligible Policyholder has affirmatively designated a Policy Administrator . . . to receive such amount on its behalf, in which case such amount shall be distributed to such Designee"[11] (R.85, ¶6.3[f]).
- "Each Eligible Policyholder (or its Designee) shall receive a cash payment equal to the applicable Conversion Payment" (R.86, ¶8.2).

[11] Ms. Schoch did not designate Appellant to receive the Consideration (R.13 ¶9; R.56 ¶ 81).

See Schoch Order, R.363 ("Consideration is owed to anyone who had a policy of insurance in effect during the relevant time period. Under MLMIC's conversion plan, the consideration is payable to eligible policyholders or their designees."); *see also Maple Med., LLP v. Scott*, 191 A.D.3d 81, 93 (2d Dep't 2020) ("Scott") ("In conformity with the statute, the MLMIC plan of conversion also makes clear that the policyholders are the ones entitled to the cash consideration unless there has been a specific designation to an identified policy administrator.").

The Plan defines "Eligible Policyholder" as the "Policyholder" under any policy in effect during the period July 15, 2013 to July 14, 2016 (R.77); and "Policyholder" as "the Person(s) identified on the declarations page of such Policy as the insured" (R.79).[12] As Appellant concedes,[13] Ms. Schoch was listed as the sole "insured" on the Declarations Page of her MLMIC Policy (R.245). As such, Ms. Schoch was the "Policyholder" under the Plan. *See Schoch* Order, R.363 ("The conversion plan defines member of the corporation as a policyholder, which is further defined as the person identified on the policy's declarations page as the insured. [Ms. Schoch] was the named insured on the relevant MLMIC policy.").

[12] The Plan's definition of Policyholder as the "insured" is consistent with New York case law, which routinely identifies the policyholder as the insured. *See, e.g.*, *Allstate Ins. Co. v. Sullivan*, 230 A.D.2d 732, 732 (2d Dep't 1996); *Utica Fire Ins. Co. of Oneida County v. Gozdziak*, 198 A.D.2d 775, 775 (4th Dep't 1993); *Rhine v. N.Y. Life Ins. Co.*, 248 A.D. 120, 123 (1st Dep't 1936).

[13] *See* App. Brief, at 6 ("the named insured on each policy is the individual practitioner").

C. Appellant ignores that as Policy Administrator, it paid Ms. Schoch's premiums on her behalf.

Section §7307(e)(3) contains a formula for calculating a policyholder's share of the demutualization consideration:

> "The equitable share of the policyholder in the mutual insurer shall be determined by the ratio which the net premiums (gross premiums less return premiums and dividend paid) such policyholder has properly and timely paid to the insurer on insurance policies in effect during the three years immediately preceding the adoption of the resolution by the board of directors under subsection (b) hereof bears to the total net premiums received by the mutual insurer from such eligible policyholders . . . ."

In a specious attempt to distort §7307 in its favor, Appellant posits that if a policyholder "did not pay *any* premiums, she or he is not entitled to an equitable share" (App. Brief, 19). Appellant's contention is not only belied by the Plan and DFS Decision (*see, infra,* at Points I[D] and II[B], respectively), but it also ignores that (a) Appellant's payment of her premiums "was not a gratuitous act; it was part of the bargained-for consideration for the employment services" that Ms. Schoch provided under the Employment Agreement (*Scott*, 191 A.D.3d at 103-04); and (b) Appellant paid Ms. Schoch's premiums as her "agent," in its capacity as Policy Administrator (R.29).

It is beyond cavil that an agent acts for and on behalf of its principal. *See E. River Sav. Bank v. Samuels*, 284 N.Y. 470, 480 (1940) ("'An agent represents and acts for his principal . . . .'" [quoting *Taylor v. Davis*, 110 U.S. 330, 335 (1884)]);

Ryan v. New York, 177 N.Y. 271, 283 (1904) ("the agent . . . speaks and acts for his principal and so binds him"); *Faith Assembly v. Titledge of N.Y. Abstract, LLC*, 106 A.D.3d 47, 58 (2d Dep't 2013) ("'The agent is a party who acts on behalf of the principal . . . .'" [citations omitted]).[14] Accordingly, the premium payments that Appellant made as agent for Ms. Schoch were effectively made *by her*. *See Banditree, Inc. v. Calpo, Inc.*, 146 A.D.2d 74, 76 (1st Dep't 1989) ("[A]n act done by an agent on behalf of the principal within the scope of the agency is not the act of the agent, but of the principal . . . ."). In short, even under Appellant's contrived reading of the statute, Ms. Schoch's equitable share of the Consideration would still be calculated based on the premium payments made on her behalf.

D. The Plan confirmed that an Eligible Policyholder's share of the Consideration is based in part on the premiums paid *on the policy*.

Further refuting Appellant's misreading of §7307(e)(3), the Plan stated that each "Eligible Policyholder shall be entitled to an allocation of the Cash Consideration based on the Eligible Premium with respect to such Eligible Policyholder" (R.77), and defined "Eligible Premium" as the net premiums "properly and timely paid on each Eligible Policy"[15] (R.87 [emphasis added]). In

[14] *See also U.S. Underwriters Ins. Co. v. Landau*, No. 05-cv-2049, 2010 U.S. Dist. LEXIS 57462, *14 (E.D.N.Y. June 8, 2010) (applying N.Y. law) ("The agent stands in its principal's shoes . . . .").

[15] *See also* MLMIC's Policyholder Information Statement, R.168, A1; R.169, A6 & A8 (repeating the Plan's reliance on the "Eligible Premium" [defined at R.165] to calculate the amount of Consideration payable to each Eligible Policyholder).

other words, MLMIC confirmed that a Policyholder's share of the Consideration does not turn on the amount of premiums they *personally paid*, but rather on the premiums paid on their policy.[16] As such, an employer/Policy Administrator's payment of its employee/Policyholder's premiums on their behalf has no bearing on the Policyholder's entitlement to the Consideration under §7307 or the Plan.

E. The court below correctly upheld the framework of §7307 and the Plan in holding that Ms. Schoch was entitled to the Consideration.

Section 7307(e)(3) is "precise," "clear and unambiguous" that the person "'entitled to receive the consideration' . . . is 'anyone who had a policy of insurance in effect during the relevant time period.'" *Scott*, 191 A.D.3d at 92-93 (quoting *Schoch* Order, R.363). Recognizing the interdependence of §7307 and the plan of conversion, the Third Department correctly relied on MLMIC's Plan in holding that Ms. Schoch was the person "who had a policy of insurance in effect" during the relevant period and was therefore entitled to the Cash Consideration:

> "Under MLMIC's conversion plan, the consideration is payable to eligible policyholders or their designees.[17] . . . The conversion plan defines member of the corporation as a policyholder, which is further defined as the person identified on the policy's declarations page as the insured. [Ms. Schoch] was the named insured on the relevant MLMIC policy. Hence, per the relevant statute and the conversion plan's definitions, [she] was entitled to the cash consideration" (R.363 [citing *Maple-Gate*

[16] *See also* Plan, R.76 ("The amounts allocated to Eligible Policyholders shall vary according to the premiums properly and timely paid under their Eligible Policies . . . ." [Emphasis added]).

[17] *See, supra*, n.11 (Appellant was not a designee for receipt of the Consideration).

Anesthesiologists, P.C. v Nasrin, 182 A.D.3d 984, 985 (2020)]).

Ms. Schoch respectfully submits that, like the Third Department, this Court should eschew Appellant's attempt to disregard the clear framework of §7307 and the Plan, and reject its request to engraft onto §7307 a condition that only a policyholder who personally paid the premiums is entitled to the consideration.

II. APPELLANT IMPERMISSIBLY ATTEMPTS TO COLLATERALLY ATTACK THE DFS DECISION APPROVING THE PLAN

Having mischaracterized the Plan as an "extrinsic document" (App. Brief, 21), Appellant seeks to bolster its statutory interpretation argument by recasting the DFS Decision as inconclusive regarding "any person's statutory rights with respect to the Cash Consideration" (*id.*, 2). The DFS Superintendent could not have been clearer, however, as to who is entitled to receive the Consideration under §7307 (*the Eligible Policyholders*) and how that Consideration is to be determined (based on the net premiums paid *on the Eligible Policyholder's policy*) (DFS Decision, R.130, para. 2). Appellant's efforts to circumvent those unequivocal findings amount to an impermissible collateral attack on the DFS Decision and should be rejected.

A. <u>The DFS Superintendent plays a critical role in the conversion process under §7307.</u>

By way of background, §7307's predecessor, §487-b, was enacted to "set forth statutory procedures and guidelines" for a mutual insurer to convert to a stock company. *See* Mem of N.Y. Exec. Chamber, Bill Jacket, S-3822, L 1981, ch 657 at 1. The Superintendent of Insurance's role in §487-b's procedures was critical:

> "The bill authorizes the Superintendent to approve, refuse to approve or request modification of the plan before granting approval. Approval by the Superintendent is predicated upon his finding that the plan does not violate the Insurance Law, is not inconsistent with law, is fair and equitable and in the best interests of the policyholders and the public" (*id.*).

As part of the consolidation of the departments of insurance and banking, the DFS was created, and the DFS Superintendent was tasked with determining whether the plan violates the Insurance Law, is consistent with law, is fair and equitable, and is in the best interests of the policyholders and the public. *See* §7307(h)(1).

B. The DFS Superintendent correctly rejected that only the payor of premiums is entitled to the Cash Consideration under §7307(e)(3).

Having reviewed MLMIC's proposed Plan and held a public hearing thereon, the DFS Superintendent issued her Decision approving the Plan (R.127-54). In her Decision, the DFS Superintendent documented several medical groups and hospitals' contention that the Cash Consideration should be paid to them "where they paid the premiums on behalf of policyholders and/or acted as policy administrators" (R.149). In particular, she highlighted—and rejected—the position of one medical group (Maple Medical, LLP ["Maple Medical"]) that §7307(e)(3)'s formula for calculating policyholders' shares of consideration foreclosed anyone but the actual payor of the premiums from receiving the consideration:

> "One commenter referred to the provision in Insurance Law § 7307(e) stating that in calculating each such person's equitable share one must factor in the amount 'such policyholder has properly and timely *paid* to the insurer on insurance policies in

> effect during the three years immediately preceding . . .' (emphasis added). The commenter suggested that this means that the person that paid the premium is automatically entitled to the proceeds of the sale. The Superintendent finds that this is not determinative because the same provision refers to the 'policyholder,' which might or might not be the person who paid the premiums" (R.149).[18]

In other words, the DFS Superintendent correctly recognized that whether the premiums were paid by the Policyholders themselves, in the one instance, or on their behalf by their employers/Policy Administrators, in the other, has no relevance to whether the Policyholder is entitled to the Consideration under §7307(e)(3). As the DFS Superintendent unequivocally confirmed in her Decision:

- "Insurance Law § 7307(e)(3) expressly defines those persons who are entitled to receive the proceeds of the Demutualization as each person who had a policy 'in effect' during the three-year period preceding the MLMIC Board's adoption of the resolution (the 'Eligible Policyholders')"; and

- The operative component in calculating the Consideration is the "net premiums timely paid on that Eligible Policyholder's eligible policy"

(R.130 [emphasis added]). *See also Schoch* Order:

> "Instead, [Lake Champlain] relies on its payment of premiums, as well as language in the conversion plan, DFS's decision approving the plan, and the statute stating that the amount of the cash consideration is based partly on the amount of premiums that 'such policyholder has properly and timely paid to the insurer' (Insurance Law § 7307 [e] [3]. However, as noted above, this language pertains to how the considerations are

[18] *See Scott*, 191 A.D.3d at 96 ("DFS considered, and rejected, [Maple Medical's] precise argument in its decision, finding that the matter of who paid the premium 'is not determinative . . . .'"); *Schoch* Order, R.364 (discussing DFS' rejection of Maple Medical's above position).

calculated, rather than to whom they must be paid."

(R.364 [footnote omitted] [citing *Columbia Mem. Hosp.*, 2019 NY Slip Op 51508(U), ¶4 ("The statute repeatedly refers to those eligible for cash consideration as the 'policyholder.'")]).[19]

C. Maple Medical commenced, *and lost*, an Article 78 proceeding challenging the DFS' approval of the Plan.

Following issuance of the DFS Decision, Maple Medical commenced an Article 78 proceeding (*Maple Med., LLP, et al. v. New York State Dept. of Fin. Servs.*, Index No. 65929/2018, Sup. Ct. Westchester County) to challenge the Plan of Conversion's definition of "Policyholder" by way of the DFS Decision. Maple Medical argued that §7307(e)(3) requires that "policyholders be defined under the conversion plan as the parties who actually paid the premiums and not the doctors who are insured under the policies" (R.216, para. 2). The Westchester County Supreme Court refused to disturb the DFS Decision, holding that the DFS Superintendent had a rational basis for approving the Plan, including its definition of Policyholders (and their entitlement to the Cash Consideration) (R.217, para. 4).

[19] *See also Scott*, 191 A.D.3d at 98 ("We agree with the Third and Fourth Departments that Insurance Law § 7307 makes clear that the policyholder is entitled to the consideration, and that the references to the amount of premiums paid applies only to calculation of the *amount* of consideration.").

D. Appellant's statutory interpretation argument is a veiled attempt to collaterally attack the DFS Decision.

Appellant argues that the Plan's definition of Policyholder (i.e., "the Person(s) identified on the declarations page of such Policy as the insured") is contrary to §7307(e)(3), which it contends should be interpreted such that "the persons who qualify as 'policyholder' entitled to cash consideration" are the payors of the premiums (App. Brief, 3-5). At bottom, that is the same argument--albeit under the guise of statutory interpretation--that Maple Medical raised at the DFS Hearing (and in its Article 78 proceeding). As the court aptly explained in *Grossman v. Akker*:

> "Under the collateral attack doctrine, a party is precluded from indirectly challenging the Superintendent's approval of a demutualization plan through a plenary action. In other words, because the Superintendent has exclusive jurisdiction to determine whether a plan complies with the statute, litigants may not use a plenary action as a means to achieve a different result, but rather, must avail themselves of CPLR Article 78."

2016 NY Slip Op 31551(U), ¶10 (Sup. Ct. N.Y. Cty. Aug. 8, 2016) (citing *Fiala v. Metropolitan Life Ins. Co.*, 6 A.D.3d 320 [1st Dep't 2004]; *Chatlos v. MONY Life Ins. Co.*, 298 A.D.2d 316 [1st Dep't 2002]). *See also ABN AMRO Bank, N.V. v. MBIA Inc.*, 17 N.Y.3d 208, 227 (2011) (recognizing the applicability of the collateral attack doctrine to the plenary lawsuit in *Fiala* [*supra*], where plaintiff challenged the "Superintendent's decision to approve a demutualization of an insurance company," "public hearings were held and plaintiff had notice and opportunity to be heard").

Here, Appellant is attempting to challenge the DFS Superintendent's determination that the Plan (including its definition of Policyholder) "does not violate the Insurance Law" (R.138 [emphasis added]), and her unequivocal rejection of the claim that §7307(e)(3) conditions a person's entitlement to the Consideration on their out-of-pocket payment of the premiums. Simply put, Appellant should not be permitted to litigate on this appeal issues that were resolved by the DFS Decision. *See Grossman*, 2016 NY Slip Op 31551(U), ¶9 (dismissing amended complaint as an impermissible collateral attack because "[t]o sustain these causes of action would permit plaintiffs to relitigate, through a plenary action, issues that were previously decided by the Superintendent" in approving the demutualization plan); *Fiala*, 6 A.D.3d at 321 (affirming dismissal of claims respecting mutual life insurance company's demutualization as "impermissible collateral attacks on the Superintendent's determination" approving the plan of conversion]).[20]

E. DFS' acknowledgement of the Plan's objection procedure did not leave the question of statutory entitlement to the courts.

While addressing the Plan's procedure for a Policy Administrator to object to the Policyholder's receipt of the Cash Consideration, the DFS Superintendent stated that "[t]he determination of who is entitled to the cash consideration depends on the facts and circumstances of the parties' relationship and applicable law, to be decided

[20] *See also Brawer v. Johnson*, 231 A.D.2d 664, 664 (2d Dep't 1996) (affirming dismissal of all causes of action as "a collateral attack on the bank's conversion plan which was approved by the New York State Superintendent of Banks").

either by agreement of the parties or by an arbitrator or court" (R.151). Through tortuous and erroneous reasoning, Appellant claims that the DFS' acknowledgement of the Plan's objection procedure, together with the above language, left the question of statutory entitlement to the Consideration to the courts (App. Brief, 2-3 & 10-11).

Appellant's claim is belied, however, by the DFS Superintendent's discussion of Policyholders' rights under §7307(e)(3) and the limited availability of the MLMIC objection procedure:

> "Insurance Law § 7307(e)(3) defines the policyholders eligible to be paid their proportional shares of the purchase price, but also recognizes that such policyholders *may have assigned* such legal right to other persons. Therefore, the plan appropriately includes an objection and escrow procedure for the resolution of disputes for those persons who dispute whether the policyholder is entitled to the payment in a given case" (R.149, ¶4 [emphasis added]).

In short, the DFS Superintendent affirmed the Plan's inclusion of an objection procedure for an employer/Policy Administrator that was not designated to receive the Consideration (by way of MLMIC's Consent Form) but nevertheless claims to have been assigned a Policyholder's legal right to the Consideration. It was not, as Appellant advocates, carte blanche for courts to disregard the Insurance Law or Plan. *See Bank of N.Y.*, 470 F.3d at 274 (demutualization plan defines rights to proceeds).

Consistent with the foregoing, the Third Department explained in *Schoch*:

> "Although the conversion plan gives a policy administrator the right to object if it believes that it has a legal right to the cash consideration, the right to object carries no rights, in and of itself,

> to the consideration, and the objector must prove its claimed legal right thereto. [Lake Champlain] has failed to provide any proof in that regard, as it has not demonstrated that [Ms. Schoch] assigned it that right through a designation form or contractual arrangement." (R.363-64 [emphasis added]).
>
> * * *
>
> "According to DFS, the determination of who is entitled to the cash in these situations depends on the facts and circumstances of the parties' relationship and the applicable law. [Lake Champlain] attempts to take this last portion of DFS's decision out of context, as if all determinations of the proper payee are based on the parties' relationship. However, that only applies if an objector raises a legitimate assertion that it is entitled to the consideration based on an assignment from the policyholder (*see id.*), which does not exist here. Accordingly, pursuant to the language of the statute, the conversion plan and DFS's decision, MLMIC should pay the cash consideration to [Ms. Schoch]." (R.365 [emphasis added]).

See also Scott, 191 A.D.3d at 95 & 97-98 (citing *Schoch* with approval); *Maple-Gate*, 182 A.D.3d at 985 ("although [employees] had assigned some of their rights as policyholders to [employer] as Policy Administrator, they had not designated [employer] to receive demutualization payments."); *Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 63 Misc. 3d 703, 709 (Sup. Ct. Erie Cty. 2019) (Where there is no signed consent or assignment, "this alone is fatal to the [employer's] claim that it is entitled to the cash consideration." [Emphasis added]).

In sum, DFS recognized that MLMIC's objection procedure is a mechanism for courts to determine whether the Consideration should be paid to an employer/policy administrator pursuant to an assignment or other contractual

obligation. Its acknowledgement of this mechanism did not negate the approval of the Plan (and its definition of the Policyholders entitled to the Consideration under §7307), nor did it invite employers/Policy Administrators to challenge the DFS Decision or Plan under the guise of statutory interpretation.

III. APPELLANT'S ARGUMENT RESPECTING INSURANCE LAW §501 WAS NOT RAISED BELOW AND, IN ANY EVENT, FAILS AS A MATTER OF LAW AND FACT

Faced with Ms. Schoch's clear entitlement to the Consideration in accordance with §7307, the Plan and the DFS Decision, Appellant strains to find some other provision of the Insurance Law to support its baseless claim that it is the "Policyholder." Contrary to its contention, Section 501 provides no such support.

A. Appellant's argument respecting Insurance Law §501 was not raised below and could have been refuted.

It is axiomatic that "this Court with rare exception does not review questions raised for the first time on appeal." *Bingham v. N.Y.C. Transit Auth.*, 99 N.Y.2d 355, 359 (2003). An issue of statutory interpretation may constitute such a "rare exception" if it "could not have been avoided by factual showings or legal countersteps had it been raised below." *Id.* (citing *Telaro v. Telaro*, 25 N.Y.2d 433, 439 [1969] ["Of course, where new contentions could have been obviated or cured by factual showings or legal countersteps, they may not be raised on appeal."]).

Appellant argues that the definition of "policyholder" in Insurance Law §501 ("a person who has contracted with an insurer for property/casualty insurance

coverage") should be applied to §7307, and that it should be considered the policyholder under that definition (*see* App. Brief, 23-27). Appellant did not assert any statutory claim to the Cash Consideration below—let alone raise §501.[21] While Appellant's argument entirely lacks merit (*see infra*), it bears emphasis that had it been timely raised below, Ms. Schoch could have established that she (and not Appellant) "contracted for" insurance coverage (for example, by submission of her MLMIC insurance application).[22] Accordingly, Ms. Schoch respectfully submits that the Court should decline to reach Appellant's argument respecting §501. *See Bingham*, 99 N.Y.2d at 359 ("Had defendants' new argument been presented below, plaintiff would have had the opportunity to make a factual showing or legal argument that might have undermined defendants' position.").

Even assuming *arguendo* that Appellant's §501 argument was properly before this Court, it fails as a matter of law and fact for the reasons below.

B. Appellant's claim that §501 is the only Insurance Law provision defining "policyholder" in relation to a property/casualty policy is false.

Appellant's claim that "in the entirety of the Insurance Law, there is only one section in which the term 'Policyholder' is specifically defined in the context of a

[21] Instead, Appellant asserted equitable claims to the Consideration (*see, e.g.*, R.47-58).

[22] *See* MLMIC's application for midwives (a copy of which is available at www.mlmic.com/wp-content/uploads/2014/04/EHCPRev01-15-2015inclLegalDefandPA.pdf), noting that (a) the applicant is the midwife, (b) the employer must have its own MLMIC policy, and (c) the insurance would be issued to the applicant. In the *Schaffer* case, the employee (Dr. Title) completed and submitted a similar application (for physicians/surgeons) to MLMIC (R.292, ¶6; R.293, ¶9).

contract for property/casualty insurance" (App. Brief, 23) is false. Insurance Law §3420(j)(2)—found within Article 34 (entitled "Insurance Contracts-Property/Casualty")—defines "policyholder" as "an individual or individuals as defined by the terms of the policy."[23]

C. Insurance Law §501 expressly limits the definitions therein to Article 5, which was enacted decades after §7307 and has nothing to do with demutualization.

Appellant's §501 argument rests on the presumption that a word used in one part of a statute is used in the same sense throughout the statute. As Appellant concedes, however, that presumption is rebuttable by an "'indication of a contrary intent'" (App. Brief, 25 [quoting *Matter of Mental Hygiene Legal Serv. v Sullivan*, 32 N.Y.3d 652 (2019)]). Here, §501 clearly indicates "a contrary intent" by reciting that the definitions contained therein are "[f]or the purposes of this article." Courts have held that a statutory definition circumscribed by similar language as in §501 is applicable only to the specific article or section in which it is defined. *See, e.g.*, *Matter of Keane*, 2 A.D.2d 148, 153 (3d Dep't 1956) ("It seems clear that the definition prescribed by a statute for words used in that particular statute does not necessarily govern the construction of those same words . . . as they may appear in other acts . . . ."), *aff'd*, 6 N.Y.2d 910 (1959); *Michaels v. Chem. Bank*, 110 Misc.

[23] That definition of policyholder is consistent with Insurance Law §7312, which defines policyholder for the purposes of a reorganization of a domestic mutual life insurer into a stock life insurer as the person "determined by the records of a mutual life insurer."

2d 74, 76 n.* (Sup. Ct. N.Y. Cty. 1981) (Debtor and Creditor Law §270's definition of "debt" "is applicable only to the section where it is defined" and therefore is inapplicable to the instant case that does not implicate §270.); *People v. Muhleman*, 183 Misc. 979, 979 (Sup. Ct. Bronx Cty. 1944) (declining to extend General Business Law §359-e's definition of "sale or offer of sale to the public" beyond the specific "subject matter covered by that section").[24] As such, by its express terms, §501's definition of "policyholder" should not be extended beyond Article 5.

Appellant's argument is further undermined by Article 5's markedly different subject matter and purpose as compared to those of §7307. The provisions of Article 5 (entitled Certificates of Insurance) were enacted to address the issuance of certificates that do not accurately reflect the terms of, and improperly attempt to expand coverage or skirt liability under, the subject insurance policy. *See* Senate Introducer's Mem in Support, Bill Jacket, S-6545-A, L 2014, ch 552 at 9. Section 7307, on the other hand, was enacted to permit a mutual insurer's conversion to a stock company, to "set forth statutory procedures and guidelines for the conversion," and to authorize the Superintendent to determine whether the plan of conversion violates the Insurance Law. Mem of N.Y. Exec. Chamber, Bill Jacket, S-3822, L

[24] *See also Steinfeld v. Richard A. Eisner & Co., LLC* (*In re Gen. Vision Servs.*), 423 B.R. 790, 794 (S.D.N.Y. 2010) (applying N.Y. law) ("By its express terms, that statutory definition of 'director' is only to be applied in the context of that chapter of the BCL. In light of this explicit restriction, the Bankruptcy Court did not err in not defining the term 'director,' as used in CPLR 213(7), as broadly as the BCL's definitional section.").

1981, ch 657 at 1.[25]

Quite simply, it strains the bounds of credulity to suggest, as Appellant does, that the term "policyholder" in §7307--which was enacted over 30 years prior to §501 and concerned an entirely different subject matter--was intended to have the same meaning as §501's limited definition thereof.

D. Even if §501's definitions were applicable herein, Ms. Schoch would still be the policyholder.

Even if it were appropriate to extend §501's definitions to §7307 (it is not), Ms. Schoch would still be the "policyholder" as defined under §501(g). Under the Insurance Law, an "insurance contract" is an agreement between the insurer and the insured. *See* Insurance Law §107(27) and §1101(1) ("'Insurance contract' means any agreement or other transaction whereby one party, the 'insurer', is obligated to confer benefit of pecuniary value upon another party, the 'insured' or 'beneficiary' . . . ."). Consistent with that definition of "insurance contract", the bill jacket respecting §501 confirms that a contract of insurance is between the insurer and the insured:

> "A certificate of insurance . . . is a simple document that merely summarizes the essential terms, conditions, and duration of the contract of insurance that is in effect between the insured and the insurer." Senate Introducer's Mem in Support, Bill Jacket, S-6545-A, L 2014, ch 552 at 9 (emphasis added).

[25] The cited bill jacket relates to the enactment of §487-b, which was §7307's predecessor statute.

Based on the foregoing, Ms. Schoch, as the insured (*see, supra*, Point I[B]), was necessarily the person who contracted with MLMIC for insurance coverage. Appellant's claim to the contrary is pure contrivance, based on its patent disregard of the fact that it was acting as Ms. Schoch's agent in its capacity as her Policy Administrator (R.29; R.245). As this Court has recognized, when an agent (such as Appellant) "contracts in the name of [its] principal [here, Ms. Schoch], the principal contracts and is bound, but the agent is not." *E. River Sav. Bank*, 284 N.Y. at 480 (emphasis added) (quoting *Taylor*, 110 U.S. at 335]). Accordingly, if §501 were applicable here (which it is not), Ms. Schoch would be considered the "policyholder" thereunder.

IV. APPELLANT IS IMPROPERLY ATTEMPTING TO RE-WRITE THE INSURANCE LAW TO PERMIT GROUP MALPRACTICE POLICIES

Appellant admits (App. Brief, at 6) that New York does not permit group malpractice insurance policies, and policies must therefore be issued to the individual practitioners. *See* Insurance Law §3435; Regulation 135 (11 NYCRR §153.0) (permitting issuance of group property/casualty insurance only with respect to public and not-for-profit insureds). Yet, by arguing that it is the policyholder for employees such as Ms. Schoch—whether by its strained interpretation of §7307 or its inapt reliance on §501—Appellant is improperly attempting to re-write the Insurance Law's prohibition of group malpractice insurance policies. The Court should not countenance Appellant's efforts to effect judicial legislation.

V. AS MS. SCHOCH'S POLICY ADMINISTRATOR, APPELLANT HAD LIMITED RIGHTS RESPECTING HER POLICY—NONE OF WHICH ENTITLED IT TO THE CASH CONSIDERATION

In a last-ditch attempt to find some support for its statutory interpretation argument, Appellant turns to revisionist history by positing that the parties had a "shared belief that Lake Champlain, rather than Ms. Schoch, possessed all of the legal rights of membership" (App. Brief, 28). To the contrary, Ms. Schoch was at all times the Policyholder (and therefore owner of the related Membership Interest) of her MLMIC policy. Appellant simply agreed to pay her premiums pursuant to their Employment Agreement and, to effectuate such payments, was designated as Policy Administrator of her MLMIC policy. As Policy Administrator, Appellant was Ms. Schoch's "agent," conferred with only limited rights respecting the policy—"for the paying of premiums, requesting changes in the policy, including cancellation thereof, and for receiving dividends and any return Premiums when due" (R.29). None of those limited rights entitled Appellant to the Consideration.

A. Appellant's payment of premiums did not confer a right to the Cash Consideration.

A Policy Administrator, by definition, pays the policy's premiums; and despite payment, the Plan of Conversion does not permit Policy Administrators to receive the Consideration unless designated by the Policyholder. In short, if mere payment of premiums on behalf of a Policyholder conferred a right to the Consideration, the Plan would have said so. It did not. *See Bank of N.Y.*, 470 F.3d

at 274 (Mutual insurer's demutualization plan defines rights to proceeds.).

Moreover, Appellant's contention that payment of premiums entitles it to the Consideration misunderstands the basic structure and operation of a mutual insurance company, which the Third Department described below:

> "[P]olicyholders have a dual relationship with a mutual insurance company, in that they have both a membership interest (e.g., the right to vote and receive dividends) and contractual rights (i.e., the obligations of the insurance company under the policy) (*see Dorrance v United States*, 809 F3d 479, 482 [9th Cir 2015]; *Bank of New York v Janowick*, 470 F3d 264, 267 [6th Cir 2006], *cert denied* 552 US 825 [2007]; 17 Steven Plitt et al., Couch on Insurance 3d § 39:37 [1995]; *see also* Insurance Law § 1211 [a])." *Schoch* Order, R.362.

As the Third Department further explained, "membership interests in a mutual insurance company are <u>not</u> paid for by policy premiums; such rights are 'acquired . . . at no cost, but rather as an incident of the structure of mutual insurance policies,' through operation of law and the company's charter and bylaws (*Dorrance v United States*, 809 F3d at 485; *see Columbia Mem. Hosp. v Hinds*, 65 Misc 3d 1205[A], 2019 NY Slip Op 51508 at *5)." *Schoch* Order, R.367 (emphasis added).

Simply put, the MLMIC premiums paid by Appellant were not paid for or allocated to Ms. Schoch's Policyholder Membership Interest. Thus, as confirmed by the court below, Appellant's payment of Ms. Schoch's premiums on her behalf did not entitle it to the Consideration. *See Schoch* Order, R.363-65. *See also Scott*, 191 A.D.3d at 94-98 (discussing *Schoch* with approval); *Maple-Gate*, 182 A.D.3d at

986 ("The mere fact that [the employer] paid the annual premiums on the policies on [its employees'] behalf does not entitle it to the demutualization payments.").

B. Appellant's receipt of dividends and return premiums is entirely unrelated to Ms. Schoch's entitlement to the Cash Consideration.

While Appellant attempts to manufacture some significance to Ms. Schoch having never received or claimed an interest in dividends or return premiums (App. Brief, 28), its efforts fall flat. Ms. Schoch did not receive or claim an interest in the dividends or return premiums for the simple reason that she had conferred the right to those dividends/premiums on Appellant under the PA Designation Form.

Further, Appellant's suggestion that it is entitled to the Consideration because it received dividends[26] in its capacity as Policy Administrator is plainly without merit. A mutual insurer's dividend bears "no relation to a dividend upon stock . . . ." *Menin v. N.Y. Life Ins. Co.*, 188 Misc. 870, 871 (Sup. Ct. N.Y. Cty. 1941). Rather, a dividend in a mutual insurance company is a refund of the surplus annual premium. *Kern*, 8 A.D.2d at 259 (A mutual insurance company "dividend" is an "adjustment" between the annual premium "estimated at the year's beginning . . . and the amount found actually to have been necessary in retrospect.").[27] Similarly, the return premium is a refund paid upon the cancellation of a policy, based on a pro-rata share of the annual premium paid by the Policy Administrator (*see* R.230).

[26] MLMIC dividends were not cash payments; they were "credited to the policy" (R.29, ¶4).

[27] *See also Dorrance*, 809 F.3d at 481 (Surplus annual premiums are returned as dividends.).

The MLMIC demutualization payout, on the other hand, represents cash consideration payable to Policyholders in exchange for the extinguishment of their Policyholder Membership Interests. *See Schoch* Order, R.361 (Cash Consideration was to be paid "in exchange for the extinguishment of his or her policyholder membership interest."). Accordingly, the Consideration is clearly not a dividend or return premium to which Appellant would have been entitled under the terms of the PA Designation Form. *See Columbia Mem. Hosp.*, 2019 NY Slip Op 51508(U), ¶5 ("This cash contribution, by law, is not a return to the hospital of any insurance premiums it paid on behalf of the defendant, it represents the policyholder's share in MLMIC."); *Maple-Gate*, 96 N.Y.S.3d at 841 ("Unlike a [premium] refund, the cash consideration was clearly intended to be in exchange for the extinguishment of the defendants' membership interest in MLMIC.").[28] As such, Appellant's receipt of dividends and the return premium is entirely irrelevant to Ms. Schoch's entitlement to the Consideration.

C. Appellant mischaracterizes MLMIC's Coverage Confirmation and Endorsements.

In a final, hollow attempt to transmute its limited Policy Administrator rights to policy ownership, Appellant relies on (a) MLMIC's Coverage Confirmation, which states that "[t]he insurance policy referenced above has been issued to the

[28] *See also Dorrance*, 809 F.3d at 486 (Consideration "received in exchange for the membership rights cannot be understood as a partial return on their past premium payments . . . .").

Policy Administrator named herein" (R.233), and (b) MLMIC's issuance of Ms. Schoch's policy Endorsements to Appellant (R.231-32, R.241-44). It bears emphasis that the PA Designation Form provided that all Endorsements would display the name of, and all legal notices would be provided to, the Policy Administrator (R.29). In other words, MLMIC issued policy documents to Appellant in its capacity as Ms. Schoch's agent. Moreover, both documents make clear that Ms. Schoch is the "insured" under the policy (R.232; R.234; R.244). The fact that MLMIC issued Ms. Schoch's policy and Endorsements to her Policy Administrator/agent has no bearing on whether she was the "insured"--and thus the Policyholder--under the policy.

D. Appellant was not conferred "all of the legal rights of membership."

One of the significant membership rights in a mutual insurer is the right to vote on company affairs. *See* Insurance Law §1211; Plan, R.79 ("Policyholder Membership Interests" means, with respect to MLMIC, the interests of Members arising under the New York Insurance Law and under the charter, bylaws and Policies of MLMIC prior to the Conversion, including the right to vote . . . ."). With respect to MLMIC's demutualization, Eligible Policyholders were "entitled to vote" on the Plan at a special meeting (R.81 at §5.1[a]). As recognized at the DFS hearing, however, employers/Policy Administrators were not entitled to vote on the proposed

Plan.[29] Therefore, contrary to Appellant's contention, it was not conferred "all of the legal rights of membership." (App. Brief, 28). Instead, it was conferred only those limited rights specifically set forth in the PA Designation Form (*see, supra*).

E. MLMIC declared that a Policy Administrator's limited rights as the Policyholder's agent did not entitle it to the Consideration.

MLMIC repeatedly declared that a Policy Administrator may receive Cash Consideration only if the Policyholder expressly designates as such:

- Plan of Conversion: "The amount distributable to each Eligible Policyholder shall be paid directly to such Eligible Policyholder unless such Eligible Policyholder has affirmatively designated a Policy Administrator . . . to receive such amount on its behalf, in which case such amount shall be distributed to such Designee" (R.85, ¶6.3[f]);

- Policyholder Information Statement: "The amount distributable to Eligible Policyholders shall be paid directly to each Eligible Policyholder unless such Eligible Policyholder has affirmatively designated in writing (using a designation form to be provided by MLMIC) a Policy Administrator . . . to receive such amount on its behalf . . ." (R.169, ¶A.5; *see also* R.170-71, ¶A.12); and

- June 29, 2018 Notice: "In connection with the Conversion, it has been determined that the current policy administrator designations on file with MLMIC do not extend to the distribution of the cash amounts allocated to eligible policyholders." (R.31).

[29] *See* the DFS Hearing transcript, at 129:4–130:12 (a copy of which is available on the DFS website at www.dfs.ny.gov/system/files/documents/2019/01/mlmic_transcript_20180823.pdf), of which the Court may take judicial notice. *See Urgent Med. Care, PLLC v. Amedure*, 64 Misc. 3d 1216(A), 2019 NY Slip Op 51188(U), ¶¶ 4-5 (Sup. Ct. Greene Cty. July 12, 2019) (taking judicial notice of "the entire record of the [DFS demutualization] process" as a "'matter[] of public record'" [quoting 10A Carmody-Wait 2d §56:33]).

Consistent with MLMIC's declaration to its constituents that prior Policy Administrator designations did not entitle those Administrators to receive the Consideration, the Third Department noted that "an ordinary designation as policy administrator does not convey the right to receive the cash consideration." *Schoch* Order, R.363. Instead, a Policy Administrator may receive the Consideration only if the Policyholder "assigned it that right through a designation form or contractual arrangement"—neither of which occurred here. *Id.*, R.364.

In short, there is nothing about a Policy Administrator/agent's exercise of its limited rights that entitled it to receive the proceeds of the Policyholder/principal's Membership Interest. If a Policy Administrator were entitled to the Cash Consideration by reason of its prior appointment, the Plan of Conversion would have provided so. It did not. Accordingly, the Third Department correctly held that the employer's "designation as policy administrator gave it no greater right to the cash consideration." *Id.*, R.363. *See also Maple-Gate*, 182 A.D.3d at 985 ("[A]lthough [the employees] had assigned some of their rights as policyholders to [their employer] as Policy Administrator, they had not designated [their employer] to receive demutualization payments."); *Scott*, 191 A.D.3d at 95-96 (discussing *Schoch* and *Maple-Gate* with approval).

VI. THE THIRD DEPARTMENT CORRECTLY HELD THAT MS. SCHOCH WOULD NOT BE UNJUSTLY ENRICHED BY RECEIVING THE CASH CONSIDERATION

As the Third Department stated below, given Ms. Schoch's legal entitlement to the Cash Consideration, the next issue was whether she "would be unjustly enriched if she received the cash consideration as required by the statute and MLMIC's conversion plan" (R.365). It is well-settled that the unjust enrichment "doctrine is a narrow one; it is 'not a catchall cause of action to be used when others fail.'" *E.J. Brooks Co. v. Cambridge Sec. Seals*, 31 N.Y.3d 441, 455 (2018). An allegation that a party "'received benefits, standing alone, is insufficient to establish a cause of action to recover damages for unjust enrichment.' 'Critical is that under the circumstances and as between the two parties to the transaction the enrichment be unjust.'" *Goel v. Ramachandran*, 111 A.D.3d 783, 791 (2d Dep't 2013) (citations omitted). *See also Clark v. Daby*, 300 A.D.2d 732, 732 (3d Dep't 2002) ("the mere fact that the plaintiff's activities bestowed a benefit on the defendant is insufficient to establish . . . unjust enrichment"), *appeal denied*, 100 N.Y.2d 503 (2003).

The typical unjust enrichment cases are those "in which the defendant, though guilty of no wrongdoing, has received money to which he or she is not entitled" (*E.J. Brooks Co.*, 31 N.Y.3d at 455)[30]; or those where a defendant enjoys a benefit

[30] *See also Schoch* Order, R.365-66 ("'The essence of such a cause of action is that one party is in possession of money or property that rightly belongs to another.'" [quoting *Clifford R. Gray, Inc. v. LeChase Constr. Servs., LLC*, 31 A.D.3d 983, 988 (3d Dep't 2006)]).

bestowed by the plaintiff "'without adequately compensating plaintiff therefor.'" *Smith v. Chase Manhattan Bank, USA, N.A.*, 293 A.D.2d 598, 600 (2d Dep't 2002). Neither of the above situations applied to the case below.

A. Pursuant to the Insurance Law, Plan of Conversion and DFS Decision, Ms. Schoch is legally entitled to the Cash Consideration.

As the court below held, Ms. Schoch is "legally entitled" to the Consideration "pursuant to the language of [§7307(e)(3)], the conversion plan and DFS's decision." *Schoch* Order, R.365. *See also Scott*, 191 A.D.3d at 92 ("The plain language of Insurance Law § 7307, the plan of conversion, and the DFS decision make clear that the policyholder is entitled to the consideration paid in connection with the MLMIC demutualization"); *Maple-Gate*, 182 A.D.3d at 985 (Under the Insurance Law and Plan, payment of the Cash Consideration was "required to be made to those policyholders who had coverage during the relevant period . . . .").

Appellant fails to explain--nor can it--how Ms. Schoch's receipt of money rightfully belonging to her under the Insurance Law, Plan and DFS Decision is unjust, improper or inequitable.[31] *See A & A Assocs. v. Olympic Plumbing & Heating Corp.*, 306 A.D.2d 296, 297 (2d Dep't 2003) ("[N]o issue of fact was raised

[31] Appellant's reliance on *Simonds v. Simonds* (45 N.Y.2d 233 [1978]) to support a purported equitable interest in the Consideration is misplaced. In *Simonds*, a husband breached his separation agreement with his first wife, causing his second wife to receive life insurance benefits that had been contractually promised to his first wife. The court held that the first wife had a vested equitable interest in the life insurance policy that arose from the separation agreement and was superior to the second wife's legal right to the proceeds as beneficiary. Here, by contrast, there was no contract from which Appellant obtained *any* interest in the Cash Consideration.

as to whether the respondents derived a benefit that belonged to plaintiff, which is necessary to sustain a cause of action based on unjust enrichment."), *appeal denied*, 1 N.Y.3d 503 (2003); *GHVHS Med. Group, P.C. v. Arthurs*, 2019 NY Slip Op 33988(U), 2019 N.Y. Misc. LEXIS 7166, *6 (Sup. Ct. Orange Cty. Oct. 7, 2019) ("[Employee's] enrichment is not at [her employer's] expense, but rather an unforeseen benefit of the bargain . . . ").[32]

Indeed, as the Third Department held below, "[t]he fact that one party will receive these benefits does not mean that such party has unjustly enriched itself at the other's expense, i.e., that it 'is in possession of money or property that rightly belongs to another' (*Clifford R. Gray, Inc. v LeChase Constr. Servs., LLC*, 31 AD3d at 988)." *Schoch* Order, R.368 (emphasis added; citation omitted). Quite simply, Ms. Schoch's receipt of Cash Consideration rightly belonging to her cannot sustain a cause of action for unjust enrichment.

B. Appellant paid Ms. Schoch's premiums as part of the bargained-for exchange of consideration under their Employment Agreement.

Appellant's unjust enrichment counterclaim admittedly stems from its payment of her MLMIC policy premiums.[33] However, under the Employment

[32] *See also CDR Creances S.A. v. Euro-Am. Lodging Corp.*, 40 A.D.3d 421, 422 (1st Dep't 2007) ("unjust enrichment cause of action was properly dismissed for failure to identify any improper benefit"); *Clifford R. Gray, Inc.*, 31 A.D.3d at 988 ("[P]laintiff asserts no facts suggesting that defendant is in possession of money or property belonging to plaintiff.").

[33] *See* App. Brief, 35-36 (stating that the basis for its unjust enrichment claim to the Consideration is "its payment of all the policy premiums"); *see also* Appellant's Answer, R.55, ¶70.

Agreement, Ms. Schoch agreed to devote her professional services to generating revenue for Appellant, in exchange for which Appellant agreed to, among other things, pay for Ms. Schoch's malpractice insurance policy. Appellant was therefore compensated for, and cannot base an unjust enrichment claim on, its payment of premiums. *See Scott*, 191 A.D.3d at 103-04 ("Since the physicians provided their services to [employer] in exchange for the benefits paid to them, or for them, under the employment agreements, it simply cannot be said that the employees have not already adequately compensated [their employer] for the benefits paid. The payment of the medical malpractice insurance premiums was not a gratuitous act; it was part of the bargained-for consideration for the employment services that the physicians provided to the medical group."); *Smith*, 293 A.D.2d at 600 (dismissal of unjust enrichment claim where there was "no allegation that the benefits received were less than what these purchasers bargained for"); *Fruchthandler v. Green*, 233 A.D.2d 214, 215 (1st Dep't 1996) (dismissing plaintiff's unjust enrichment claim because defendant provided consideration for the benefit plaintiff provided).[34]

Moreover, as the Third Department observed below, "both parties benefitted from [Lake Champlain's] fulfillment of its contractual obligation to provide

[34] *See also GHVHS Med. Group, P.C. v. Sidorski-Nutt*, Index No. EF001620-2019, at 3 (Sup. Ct. Orange Cty. Jan. 6, 2020) (As a result of the Policyholder's services under the employment agreement, the employer had "already received the benefit of the bargain" and therefore could not sustain an unjust enrichment claim.).

malpractice insurance and pay for the premiums, inasmuch as the insurance provided coverage to protect the liability interests of [Ms. Schoch] both individually and as an employee of [Lake Champlain]" (R.368 [emphasis added]). Thus, Appellant "received protection from the policy because, as [Ms. Schoch's] employer, [Lake Champlain] may also be named in a malpractice complaint based on [Ms. Schoch's] actions" (*id.*, n.4). The Third Department's analysis as to the parties' exchange of consideration was correct and supported summary judgment in Ms. Schoch's favor.

C. None of the additional factors that courts consider when evaluating an unjust enrichment claim warranted denial of Ms. Schoch's summary judgment motion.

Relying on *Paramount Film Distrib. Corp. v. State* (30 N.Y.2d 415 [1972]), the court below stated that when evaluating an unjust enrichment claim, "'courts will look to see if a benefit has been conferred on the [plaintiff] under mistake of fact or law, if the benefit still remains with the [plaintiff], if there has been otherwise a change of position by the [plaintiff], and whether the [plaintiff's] conduct was tortious or fraudulent'" (R.366). The Third Department reviewed the above circumstances and found as follows:

- "No factual mistake exists, other than the parties' mutual failure to consider the potential for demutualization when negotiating their employment agreement";
- "[T]he benefit of the cash consideration would be paid to [Ms. Schoch] based on the statute and the conversion plan — a correct reading of the law, rather than a mistake";

- "[B]oth parties benefitted from [Lake Champlain's] fulfillment of its contractual obligation to provide malpractice insurance and pay for the premiums, inasmuch as the insurance provided coverage to protect the liability interests of [Ms. Schoch] both individually and as an employee of [employer]";
- "Neither party changed its position based on demutualization . . ."; and
- "[Ms. Schoch's] conduct was neither tortious nor fraudulent" (R.368).

Based on its above analysis, the Third Department rightly held that Ms. Schoch "was entitled to a declaratory judgment entitling her to receive the cash consideration from MLMIC's demutualization" (R.369). *See also Scott*, 191 A.D.3d at 105 (Employer has "no cognizable unjust enrichment cause of action" against any of the physicians.); *Columbia Mem. Hosp. v. Hinds*, 188 A.D.3d 1336, 1339 (3d Dep't 2020) ("[F]or the reasons stated in *Schoch* . . . , we find that [employer] failed to establish any legal or equitable right to distribution of the MLMIC funds . . . ."); *Maple-Gate*, 182 A.D.3d at 985 ("as a matter of law . . . [employer] had no legal or equitable right of ownership to the [Consideration]."); *GHVHS Med. Group, P.C. v. Cornell*, 2020 NY Slip Op 20104, ¶4 (Sup. Ct. Orange Cty. Jan. 16, 2020) (Employee would not be unjustly enriched because "there are no allegations of fraud or tortuous conduct. Moreover, there was no mistake of fact or law as neither party was even aware of this benefit at the time the employment contract was signed").[35]

[35] The facts alleged in support of the *Schoch* employer's unjust enrichment claim are materially identical to those alleged by the employers in *Scott* (191 A.D.3d at 84), *Columbia Mem. Hosp.* (188 A.D.3d at 1337), *Maple-Gate* (182 A.D.3d at 984), and *Cornell* (2020 NY Slip Op 20104).

Ms. Schoch respectfully submits that the Third Department's reasoning was sound, comports with established unjust enrichment precedent and should be affirmed in its entirety.

D. The First Department's decision in *Schaffer* has been rejected by the Second, Third and Fourth Departments, and should not be followed by this Court.

As the court recognized below, the First Department—hearing *Matter of Schaffer, Schonholz & Drossman, LLP v. Title* (171 A.D.3d 465 [1st Dep't 2019] ["*Schaffer*"]) in the first instance, on submitted facts, pursuant to CPLR 3222—"summarily held, without any analysis, that awarding an employee a cash consideration related to MLMIC's demutualization would constitute unjust enrichment where the employer had paid the policy premiums." *Schoch* Order, R.368. Indeed, the First Department reached its determination without discussing or citing the Insurance Law, the Plan, the DFS Decision, the parties' employment agreement, or New York unjust enrichment law—all of which, for the reasons explained above and in the *Schoch* Order, require that the Consideration be paid to the Policyholders.

Having engaged in a substantive analysis of the controlling statutory and documentary authority, together with the basic structure and operation of mutual insurance companies and controlling unjust enrichment law, the Second, Third and Fourth Departments correctly determined to decline to follow the First Department's

holding in *Schaffer*. *See Scott*, 191 A.D.3d at 100-02; *Columbia Mem. Hosp.*, 188 A.D.3d at 1339; *Schoch* Order, R.368; *Maple-Gate*, 182 A.D.3d at 986. Ms. Schoch respectfully submits that this Court should follow the reasoning of the Second, Third and Fourth Departments, and not that of the First Department.

E. Each of the cases relied on by Appellant is distinguishable or inapposite.

In support of its erroneous arguments, Appellant relies on several cases, each of which fails to establish its purported right to the Cash Consideration.

Castellotti v. Free (138 A.D.3d 198 [1st Dep't 2016]), a motion to dismiss case that did not reach the merits of the unjust enrichment claim,[36] involved an alleged oral agreement whereby a sister agreed that if her brother paid their mother's estate taxes, the sister would give half of her inheritance to her brother. The brother paid the estates taxes, but the sister kept all of the inheritance, thereby resulting in her enrichment at her brother's expense. Here, by contrast, Appellant paid Ms. Schoch's premiums in exchange for her services pursuant to the written Employment Agreement and in accordance with the PA Designation Form, neither of which concerned the Cash Consideration.

[36] Appellant's reliance on another motion to dismiss case, *Urgent Med. Care, PLLC v. Amedure* (64 Misc. 3d 1216(A) [Sup. Ct. Greene Cty. 2019]), is misplaced, as the court did not reach the merits.

Ruocco v. Bateman, Eichler, Hill, Richards, Inc. (903 F.2d 1232 [9th Cir. 1990]) ("Ruocco") and *Chi. Truck Drivers, Helpers & Warehouse Workers Union (Indep.) Health & Welfare Fund v. Local 710, Int'l Brotherhood. of Teamsters* (Case No. 02-cv-3115, 2005 U.S. Dist. LEXIS 42877 [N.D. Ill. Mar. 4, 2005]) ("*Chi. Truck*")—two ERISA cases on which the First Department relied in *Schaffer*—are plainly inapposite because neither involved a state law unjust enrichment claim. *See Scott*, 191 A.D.3d at 102 (comparing the ERISA claims at issue in *Ruocco* and *Chi. Truck* with the state law unjust enrichment claim at bar, and holding that "[t]he federal ERISA authorities are of no assistance in this regard).

Instead, both *Ruocco* and *Chi. Truck* concerned whether demutualization proceeds were ERISA "plan assets"—a question clearly not involved here. Whether the proceeds were "plan assets" was material because ERISA plan assets generally cannot "inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable [plan] expenses . . . ." 29 U.S.C. § 1103(c)(1). Ultimately, the *Ruocco* and *Chi. Truck* courts determined whether the demutualization proceeds were plan assets (and if so, to whom they were entitled) by looking to the applicable Department of Labor ("DOL") ERISA advisory opinions, ERISA statutes, and any contracts or legal instrument related to the ERISA plans.

Ruocco pre-dated the applicable ERISA advisory opinions (cited in *Chi. Truck*), and it appears that neither the ERISA statutes, nor any plan-related contracts or documents, provided any direction as to the distribution of the demutualization funds. As such, the court resorted to balancing the equities, concluding that the employees should receive the funds because (a) they paid the premiums (and the funds themselves were surplus premiums), and (b) ERISA plans are intended to inure to the benefit of plan participants and beneficiaries (not employers). In *Chi. Truck*, the court was guided by the DOL ERISA advisory opinions and ERISA statutes.

Significantly, neither *Ruocco* nor *Chi. Truck* references any plan-related contracts or documentation that provided guidance as to the distribution of the demutualization proceeds. By contrast, in the instant case, the Plan of Conversion and the DFS Decision, as well as Insurance Law §1211(a) and §7307(e)(3), expressly provide that (a) the Policyholders are the owners of their Membership Interests, and (b) absent a designation or assignment to the Policy Administrator (neither of which occurred here), the Policyholders are entitled to the Consideration paid on account of the extinguishment of their Membership Interests. *See RLJCS Enters. v. Prof'l Benefit Trust, Inc.*, 438 F. Supp. 2d 903, 912 (Dist. Ct. N.D. Ill. 2006) (declining to "balance the equities" as in *Ruocco* because "in the instant case, there was a contract that governed the administration of the Trust, and that contract

stated that the Trust, not the Defendants, owned the policies.").

Appellant's reliance on *Mell v. Anthem, Inc.* (2010 U.S. Dist. LEXIS 19056 [S.D. Ohio Mar. 3, 2010], *aff'd*, 688 F.3d 280 [6th Cir. 2012]) is similarly misplaced. *Mell* involved a dispute between the City of Cincinnati, the holder of a group health insurance policy (rather than the individual polices at issue herein) and its employees, the holders of certificates of benefits under the policy (rather than policyholders/members/owners of the MLMIC policies at issue herein) over the proceeds of the demutualization of Anthem Insurance. The Ohio statute that governed "Rights of mutual policyholders" in a demutualization stated that "[s]hares shall be issued to the owner or owners of a mutual policy…as such owners appear on the face of the policy." While the Ohio statute used the terms "policyholder" and "owner," the latter was undefined.

Even though the record contained no evidence that the group policy named plaintiffs as policyholders, the District Court assumed as true the employees' claim that they were the statutory "policyholders." Nevertheless, the District Court sought to determine who the owner was, and thus the party entitled to the demutualization proceeds. To determine the meaning of the word "owner," the District Court applied the standard maxim of statutory construction that the undefined term should be given its plain meaning. The District Court ultimately held that the employees could not be the "owners" of the policy, because the employees "had nothing to do with the

choice of insurance carrier, nor with its governance, and they received what they bargained with the City to get: insurance coverage." 2010 U.S. Dist. LEXIS at *32-33.

The Sixth Circuit affirmed, holding that the pre-merger bylaws for Anthem's predecessor-in-interest, CMIC, "which adopted the policyholder definition found under Ohio insurance law," provided additional support for the City's claim to the proceeds. Specifically, the Court noted that CMIC's bylaws established that the City, as the member, would be the holder of the group master policy. 688 F.3d at 286. Accordingly, the employees' attempts to transmute themselves from mere beneficiaries of the insurance policy to "policyholders" was unavailing. *Id.* at 287.

Greathouse v. City of E. Liverpool (159 Ohio App.3d 251 [Ohio Ct. App. 2004]) is similar to *Mell,* and also involved a dispute over the Anthem demutualization. *Greathouse* involved a claim by a municipal employee to the Anthem demutualization proceeds resulting from a health insurance policy provided to him as an employment benefit. The court determined that the municipality was the owner of the policy, and therefore entitled to the proceeds. Although not discussed in *Greathouse*, as explained in *Mell*, the Ohio statute did not define "owner." It was therefore appropriate for the court to consider indicia of ownership.

In the instant case, unlike the Ohio statute, §7307(e)(3) does not use the undefined term "owner." Rather, Insurance Law §§ 1211 and 7307(e)(3) establish

that a mutual company is owned by its "members," that the "members" are the "policyholders," and that upon demutualization, the "policyholders" are entitled to consideration in exchange for the extinguishment of their membership interest. Pursuant to those provisions, the Plan and DFS Decision require that the Consideration be paid to the Policyholders (such as Ms. Schoch). *Mell* and *Greathouse*, as well as *Ruocco* and *Chi. Truck*, therefore are entirely inapposite.

Finally, *Town of N. Haven v. N. Haven Educ. Ass'n* (2004 Conn. Super. LEXIS 15 [Conn. Super. Ct. Jan. 5, 2004]) involved the limited issue of arbitrability of the dispute as to demutualization proceeds under the contract between the North Haven Education Association (the teachers/employees) and the North Haven Board of Education (the employer). The court's passing comment as to the "fairness" of permitting demutualization proceeds to be issued to the Town, the policyholder under whose policy the Board provided coverage to its employees, is pure dicta and should be afforded no weight.

F. <u>Appellant's request for relief not sought below is improper.</u>

In the alternative, Appellant requests "$39,340.54 as reimbursement for the premiums that it paid during the applicable policy period" (App. Brief, 36). That request necessarily fails inasmuch as Appellant has no cognizable unjust enrichment claim (*see, supra*). Moreover, Appellant's request for such partial relief was not raised in any of its papers before the Saratoga County Supreme Court or the Third

Department and, therefore, is not properly before this Court. *See generally Gayz v. Kirby*, 41 A.D.3d 782, 783 (2d Dep't 2007) (Defendants' "request for this relief is made for the first time on appeal, and thus, it is not properly before us."); *Conn. Mut. Life Ins. Co. v. Srogi*, 101 A.D.2d 698, 698 (4th Dep't 1984) ("Such relief was not sought from the referee or the trial court and should not be requested for the first time on appeal.").

CONCLUSION

Based upon the foregoing, Ms. Schoch respectfully requests that this Court affirm the *Schoch* Order in its entirety.

Dated: May 10, 2021
Albany, New York

NOLAN HELLER KAUFFMAN LLP

By: _____

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CERTIFICATION PURSUANT TO RULE 500.13(c) OF THE RULES OF PRACTICE OF THE COURT OF APPEALS

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ADDENDUM OF NOT-READILY-AVAILABLE CITED MATERIALS

Cases:

Legislative Materials:

Chi. Truck Drivers, Helpers & Warehouse Workers Union (Indep.) Health & Welfare Fund v. Local 710, Int'l Bhd. of Teamsters

United States District Court for the Northern District of Illinois, Eastern Division

March 4, 2005, Decided ; March 4, 2005, Filed

02 C 3115

Reporter
2005 U.S. Dist. LEXIS 42877 *

CHICAGO TRUCK DRIVERS, HELPERS AND WAREHOUSE WORKERS UNION (INDEPENDENT) HEALTH AND WELFARE FUND, Plaintiff, v. LOCAL 710, INTERNATIONAL BROTHERHOOD OF TEAMSTERS, CHICAGO TRUCK DRIVERS, HELPER AND WAREHOUSE WORKERS UNION (INDEPENDENT) PENSION FUND, Defendants.

Prior History: *Chi. Truck Drivers, Helpers & Warehouse Union (Indep.) Health & Welfare Fund v. Local 710, Int'l Bhd. of Teamsters, 2004 U.S. Dist. LEXIS 4657 (N.D. Ill., Mar. 19, 2004)*

Counsel: [*1] For Chicago Truck Drivers, Helpers and Warehouse Workers Union (Independent) Health and Welfare Fund, Plaintiff: Michael Joseph Kralovec, Joseph R. Lemersal, Sara R. McClain, Nash, Lalich & Kralovec, Chicago, IL.

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For Chicago Truck Drivers, Helpers and Warehouse Workers Union (Independent) Pension Fund, Defendant: David George Huffman-Gottschling, Joseph M. Burns, Sherrie E. Voyles, Jacobs, Burns, Orlove, Stanton & Hernandez, Chicago, IL.

Judges: HONORABLE RONALD A. GUZMAN, United States Judge.

Opinion by: RONALD A. GUZMAN

Opinion

MEMORANDUM OPINION AND ORDER

Judge Ronald A. Guzman

Chicago Truck Drivers, Helpers and Warehouse Workers Union (Independent) Health and Welfare Fund ("Health and Welfare Fund") seeks a declaratory judgment against Local 710, International Brotherhood of Teamsters ("Local 710") and Chicago Truck Drivers, Helpers and Warehouse Workers Union (Independent) Pension Fund ("Pension Fund") that the demutualization compensation [*2] for four employee-benefit plans of Principal Financial Group ("Principal") is a plan asset and should revert to the participants of the plans. Before the Court is the Health and Welfare Fund's motion for summary judgment and Local 710's motion for partial

summary judgment. For the reasons provided in this Memorandum Opinion and Order, the Court grants in part and denies in part both motions.

FACTS

This controversy stems from Principal's conversion from a mutual insurance company into a public stock company, a process known as a "demutualization." Principal adopted its plan for demutualization on March 31, 2001. (Pl.'s LR 56.1(a)(3) P 27.) When a mutual insurance company undergoes a demutualization, eligible policyholders receive compensation. (*See* Local 710's LR 56.1(a)(3) P 2; Local 710's Ex. 1, Letter from Principal to Policyholders of 10/26/01.) This compensation is given because policyholders lose ownership interests in the mutual insurance company when it becomes a stock company. (Local 710's Ex. 1, Letter from Principal to Policyholders of 10/26/01.) In the instant case, the Health and Welfare Fund received compensation from Principal for four different employee [*3] benefit plans: an in-house pension plan, a severance plan, a life insurance plan, and a 401(k) plan. The Health and Welfare Fund now seeks a declaratory judgment as to whom is entitled to the demutualization compensation. The issues in this case are whether the demutualization compensation is an asset of the plans, and, if so, whether the compensation reverts to the participants of the plan or to the employers.

Local 710 is a local union affiliated with the International Brotherhood of Teamsters. (Pl.'s LR 56.1(a)(3) P 5.) The Chicago Truck Drivers, Helpers and Workers Union Independent (the "CTDU") merged into Local 710 on February 1, 2001. (*Id.* P 7.) The CTDU was an independent labor union representing employees in the trucking, warehousing, and related industries in and around the Chicago area. (*Id.* P 6.) After the merger, the CTDU ceased operation as a labor organization, and Local 710 is a successor to the rights and liabilities of the CTDU. (*Id.* PP 12-13.) The Health and Welfare Fund and Pension Fund were established by the CTDU for the benefit of CTDU members covered by collective bargaining agreements with participating employers. (*Id.*)

The first of the benefit [*4] plans at issue in this case, a retirement plan for their office employees (the "in-house pension plan"), was established by the Health and Welfare Fund, the Pension Fund, and the CTDU in 1961. (*Id.* P 14.) This plan was funded through a group annuity contract with Bankers Life and Casualty and later Principal. (*Id.*) It was funded by contributions from the Health and Welfare Fund, the Pension Fund, and the CTDU on behalf of their employees. (*Id.* P 15.) The plan was terminated in 1987. (*Id.* P 16.) When the plan was terminated, all active employees who would have been eligible for a benefit received a lump sum payment, while former employees who had retired and were receiving benefits continued to receive a defined monthly benefit through a group annuity contract with Principal. (*Id.* PP 17-18.) This contract was fully funded at the time of the discontinuation of the plan. (Pl.'s Ex. 3, Boudreau Aff. P 20.) The Health and Welfare Fund received a check from Principal in the amount of $ 1,200,280.00 as demutualization compensation in connection with the in-house pension plan. (Pl.'s LR 56.1(a)(3) P 31.)

The supplemental retirement and security plan ("severance plan") [*5] was established in 1969. (*Id.* P 22.) Like the in-house pension plan, the severance plan is funded by an annuity contract with Principal. (*Id.* P 23.) The severance plan is currently in effect for employees of the Health and Welfare Fund and the Pension Fund, but employees of the CTDU left the severance plan and received their benefit payments on or before the CTDU and Local 710 merged. (Pl.'s Ex. 3, Boudreau Aff. PP 26-27.) The Health and Welfare Fund received a check from Principal in the amount of $ 78,329.00 as demutualization compensation in connection with the severance plan. (Pl.'s LR 56.1(a)(3) P 30.)

The employees' savings plan ("401(k) plan") was established in July, 1983. (*Id.* P 20.) This plan is a voluntary program for employees and is funded by contributions by the employees. (*Id.* P 21.) The 401(k) plan is in effect for the employees of all three parties in this case - the Health and Welfare Fund, Pension Fund, and Local 710. (Pl.'s Ex. 3, Boudreau Aff. P 32.) The Health and Welfare Fund received a check from Principal in the amount of $ 85,766.00 as demutualization compensation in connection with the 401 (k) plan. (Pl.'s LR56.1(a)(3) P 31.)

Finally, the [*6] member life, accidental death, and dismemberment policy (the "life insurance plan") was established in February 1992. (*Id.* P 24; Pension Fund's Ex. F, U.S. Dep't of Labor's Pension & Welfare Benefits Admin. Office of Regs. & Interpretations Advisory Op. 94-31 A.) This plan was funded by contributions from the Health and Welfare Fund, the Pension Fund, and the CTDU on behalf of their respective employees. The benefits of this plan are paid through a group policy with Principal. (Pl.'s LR 56.1(a)(3) P 26.) Employees of the Health and Welfare Fund and the Pension Fund currently participate in the plan, but the CTDU ceased participation in the life insurance plan upon its merger with Local 710. (Pl.'s Ex. 3, Boudreau Aff. P 35.) The Health and Welfare Fund received 541 shares of Principal common stock as demutualization compensation in connection with the life insurance plan. (Pl.'s LR 56.1(a)(3) P 32.)

Local 710 argues that the compensation from the demutualization reverts to the employers -- the Health and Welfare Fund, the Pension Fund, and Local 710 as successor to the CTDU, with the exception of the 401(k) plan. (*Id.* P 34.) The Health and Welfare Fund, on the other hand, [*7] argues that the demutualization compensation should be used for the benefit of the participants of the various plans. (*Id.* P 35.) The Health and Welfare Fund brought suit, seeking a declaratory judgment of the rights of the parties to the demutualization compensation. (Compl. P 32.) Before the Court is the Health and Welfare Fund's motion for summary judgment seeking a declaratory judgment that the demutualization compensation is a plan asset to be used for the benefit of the participants of the plans and Local 710's motion for partial summary judgment, seeking a declaration that the demutualization compensation reverts to the employers.

DISCUSSION

Pursuant to *Federal Rule of Civil Procedure 56(c)*, the court may grant summary judgment "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." *FED. R. CIV. P. 56(c)*. When considering the evidence submitted by the parties, the court does not weigh [*8] it or determine the truth of asserted matters. *Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 249, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986)*. All facts must be viewed and all reasonable inferences drawn in the light most favorable to the non-moving party. *NLFC, Inc. v. Devcom Mid-America, Inc., 45 F.3d 231, 234 (7th Cir. 1995)*. "If no reasonable jury could find for the party opposing the motion, it must be granted." *Hedberg v. Ind. Bell Tel. Co., Inc., 47 F.3d 928, 931 (7th Cir. 1995)*.

Summary judgment is appropriate in this case because there are no material facts in dispute. Therefore, the movants are entitled to a judgment as a matter of law.

The first issue is whether the demutualization compensation is a plan asset of the various plans. ERISA does not define plan assets. *See Bannistor v. Ullman, 287 F.3d 394, 402 (5th Cir. 2002)*. The U.S. Department of Labor has issued advisory opinions that address the issue of whether the demutualization compensation is a plan asset. (Pension Fund's Ex. A, U.S. Dep't of Labor's Pension & Welfare Benefits Admin. Office of Regulations & Interpretations Advisory Op. 92-02A (2002); Pl.'s Ex. 5, EBSA Advisory Op. [*9] 2001-02A n.1 (2001).) "[I]f the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Mead Corp. v. B.E. Tilley, 490 U.S. 714, 722, 109 S. Ct. 2156, 104 L. Ed. 2d 796 (1989)*. An agency's advisory opinions are not binding authority, but they are "entitled to deference, such that the interpretation will be upheld so long as it is reasonable." *Reich v. McManus, 883 F. Supp. 1144, 1153 (N.D. Ill. 1995)*. "[A] court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency." *Chevron U.S.A. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 844, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984)*.

According to the Department of Labor:

> The proceeds of the demutualization will belong to the plan if they would be deemed to be owned by the plan under ordinary notions of property rights. . . . In the case of an employee pension benefit plan, or where any type of plan or trust is the policyholder, or where the policy is paid for out of

> trust assets, it is the view of the department that all of the proceeds [*10] received by the policyholder in connection with a demutualization would constitute plan assets.

(Pl.'s Ex. 5, EBSA Advisory Op. 2001-02A n.l (2001).) Determining whether the demutualization compensation consists of a plan asset under ordinary notions of property rights requires "consideration of any contract or other legal instrument involving the plan documents. It also requires the consideration of the actions and representations of the parties involved." (Pension Fund's Ex. A, U.S. Dep't of Labor's Pension & Welfare Benefits Admin. Office of Regulations & Interpretations Advisory Op. 92-02A (2002).)

In *Ruocco v. Bateman, Eichler, Hill, Richards, Inc., 903 F.2d 1232 (9th Cir. 1990)*, the Ninth Circuit Court of Appeals considered the issue of whether stock issued as demutualization compensation for a long-term disability insurance plan could revert to an employer. This plan was wholly funded by contributions from the participants of the plan. *Id. at 1238*. The court held that allowing the compensation to revert to the employers would give the employers an undeserved windfall. *Id.* As a result, the "balancing of equities" weighed in favor [*11] of allowing the demutualization compensation to revert to the employees. *Id.*

Like the disability plan in *Ruocco*, the contributions to the 401(k) plan in this case were made entirely by the employees, outside of minor administrative costs. Therefore, the demutualization compensation should revert to the employees. This conclusion was undisputed and is now stipulated by the parties. (*See* Pension Fund's Resp. Pl.'s Mot. Summ. J. at 11-12; Local 710 Mem. Opp'n Pl.'s Mot. Summ. J. at 14; Joint Mot. Partial Dismissal & Release of Funds P 4.) Moreover, like the plan in *Ruocco*, the 401(k) plan in this case is an employee pension benefit plan wholly funded by the participants of the plan. Because the plan was fully funded by the employees, they are entitled to the compensation as a result of their loss of ownership in Principal. As in *Ruocco*, awarding this compensation to the employers would give them an undeserved windfall -- they would be receiving money as a result of the investment of the participants of the plans, not their own efforts. Accordingly, the demutualization compensation attributable to the 401(k) plan reverts to the employees.

Determining whether the demutualization [*12] compensation is a plan asset for the remaining plans is a closer issue. Following the guidelines of the EBSA, this Court will follow ordinary notions of property rights and look to the plan documents and representations by the parties to determine whether the demutualization compensation is a plan asset. There is no evidence that the parties made any representations other than in the plan documents as to whether or not the demutualization compensation is a plan asset. Therefore, this Court will focus on the language of the plans to determine this issue.

After examining the plan documents, this Court holds that the demutualization compensation is a plan asset for the in-house pension plan and the severance plan, but not for the insurance plan. At first blush, the compensation would appear not to be a plan asset for any of the remaining plans because it is undisputed that these plans were funded by the employers. Determining that the compensation reverts to the plans and not the employers could therefore result in an undeserved windfall to the plans. However, both the in-house pension plan and severance plan are "employee pension benefit plans." As a result, the compensation would be [*13] presumed to be a plan asset under the EBSA Advisory Opinion unless language in the plan documentation suggests otherwise.

In interpreting the language of a contract, a court's primary purpose is to discern the intent of the parties. *See Volt Information Sciences v. Board of Trustees, 489 U.S. 468, 488, 109 S. Ct. 1248, 103 L. Ed. 2d 488 (1989)*. In this case, however, neither the in-house pension plan nor the severance plan specifically addresses the issue of demutualization compensation. The demutualization compensation would therefore be presumed to be a plan asset under the EBSA Advisory Opinion 2001-02A quoted above. The plans do address the issue of whether any dividends awarded under the plans would revert to the employers or become plan assets. Both plans declare that "[d]ividends declared under the Group Contract and forfeitures shall be applied to reduce future Employer Contributions." (Pl.'s Ex. B, Health & Welfare Fund & Pension Fund Employees Retirement Plan at 21, Pl.'s Ex. D, Health & Welfare Fund & Pension Fund Employees Restated Supplemental Retirement & Security Plan at 22.) This language suggests that the dividends would become plan

assets used to pay for the [*14] plans, rather than simply reverting to the employers to be used however they wish. Like dividends, the demutualization compensation at issue in this case comes from Principal. The language in the plans regarding dividends shows that the parties intended future compensation from Principal to become a plan asset. Although the language of the plans with regard to the disposition of dividends alone is not determinative, coupled with the EBSA's view that demutualization compensation ordinarily becomes a plan asset for an employee pension plan, it is sufficient to convince the Court that the demutualization compensation is a plan asset for the in-house pension plan and the severance plan.

Local 710 argues that the language in the plans regarding dividends should not affect the outcome of this case because demutualization compensation is not a dividend. (Local 710's Mem. Opp'n Pl.'s Mot. Summ. J. at 10.) It is true that the demutualization compensation is not a dividend, but it is awarded to policyholders in exchange for loss of ownership interests in the company. Dividends are payments by a company to its stockholders. RICHARD A. BREALEY & STEWART C. MYERS, PRINCIPALS OF CORPORATE FINANCE [*15] 64 (5th ed. 1996). When a mutual insurance company demutualizes, it compensates policyholders for the loss of their ownership interests, which therefore includes their ability to receive dividends. *See id.* at 417-38.

Local 710 points out that Principal "will continue to pay policy dividends as declared." (Pl.'s Ex. K, Plan of Conversion of Principal Mut. Holding Co. at A-3.) However, this language only means that Principal will continue to pay *declared* dividends. It does not mean that Principal can award new dividends in the future. In addition, there is no evidence that Principal has awarded dividends for any of the plans at issue in this case. Therefore, the fact that demutualization compensation is not a dividend is insufficient to overcome the strong presumption that it is a plan asset given the specific facts of this case.

Although the demutualization compensation is a plan asset for the in-house pension plan and severance plan, this does not necessarily mean that it reverts to the participants of the plans. The plans state: "No part of the plan assets shall be paid to the Employer at any time, except that, after the satisfaction of all liabilities under the Plan, any [*16] assets remaining will be paid to the Employer. The payment may not be made if it would contravene any provision of law." (Pl.'s Ex. B, Health & Welfare Fund & Pension Fund Employees Retirement Plan at 47; Pl.'s Ex. D, Health *&* Welfare Fund & Pension Fund Employees Restated Supplemental Retirement & Security Plan at 56.) Under the terms of the plans, therefore, the demutualization compensation, as a plan asset, may be distributed to the employers if the plan has satisfied all of its liabilities.

Because the in-house pension plan has been terminated, it has satisfied all of its liabilities to the participants and their beneficiaries. The Pension Fund argues that since former employees are continuing to receive benefits under this plan, the plan has not satisfied all of its liabilities. (Pension Fund's Resp. Mot. Summ. J. at 13;) However, it is undisputed that these participants are receiving their benefits under a plan that was fully funded at the time of the termination of the in-house pension plan. Therefore, the in-house pension plan has no "liabilities" and the demutualization compensation reverts to the contributing employers -- the Health and Welfare Fund, the Pension Fund, [*17] and Local 710 as successor to the CTDU.

The plan provides that residual assets may be distributed to an employer so long as no provision of law is violated. ERISA addresses the issue of whether residual assets may be distributed to an employer:

> (d) Distribution of residual assets. . . .
>
> (1) Subject to paragraph (3), any residual assets of a single-employer plan may be distributed to the employer if-
>
> (A) all liabilities of the plan to participants and their beneficiaries have been satisfied,
>
> (B) the distribution does not contravene any provision of law, and
>
> (C) the plan provides for such a distribution in these circumstances.
>
> (3)(A) Before any distribution from a plan pursuant to paragraph (1), if any assets of the plan attributable to employee contributions remain after satisfaction of all liabilities . . . such remaining assets shall be equitably distributed to the participants who made such contributions or their beneficiaries.

29 U.S.C. § 1344 (2003). The in-house pension plan satisfies all of these requirements. As noted above, all liabilities of the plan have been satisfied and the plan provides for a distribution of [*18] the assets to the employers. In addition, no provision of law has been violated, and the Health and Welfare Fund does not cite to any law that would be violated by distributing the compensation to the employers. Finally, it is undisputed that the employers were responsible for the contributions to the plans, not the employees. Therefore, no equitable distribution to the participants need be made.

The Health and Welfare Fund argues that the compensation cannot be distributed to three employers, *i.e.*, the Health and Welfare Fund, the Pension Fund, and Local 710, because the language of the statute is in the singular. The statute provides "any residual assets of a single-plan may be distributed to *the* employer. . . ." 29 U.S.C. § 1344(d) (emphasis added). The Court is not persuaded that this language prevents the compensation from being distributed to three employers when all three employers have made contributions to the plan. This is especially true because, as the Health and Welfare Fund points out, the plans at issue in this case are single-employer plans despite the fact that multiple employers fund the plans. (*See* Mem. Supp. Mot. Summ. J. at [*19] 7.) The Court therefore holds that the demutualization compensation for the in-house pension plan reverts to the three employers that are parties in this case -- the Health and Welfare Fund, the Pension Fund, and Local 710.

Unlike the in-house pension plan, the severance plan has not been terminated and is currently in full force and effect for employees of the Health and Welfare Fund and the Pension Fund. Because the plan provides that the assets of the plan shall not be distributed to the employers until after satisfaction of all liabilities of the plan, the demutualization compensation does not revert to the employers. The compensation should be used to reduce future contributions by the two remaining employers in the case - the Health and Welfare Fund and the Pension Fund. If at some point the Health and Welfare Fund and the Pension Fund satisfy all of their liabilities under the plan, Local 710 would then be entitled to a share of the demutualization compensation, using the same reasoning as applied to the in-house pension plan.

Unlike the in-house pension plan and the severance plan, the life insurance plan is not an employee pension plan. A "pension plan" is defined by ERISA [*20] as:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program --
> (i) provides retirement income to employees, or
> (ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond. . . .

29 U.S.C. § 1002(2)(A). Unlike a pension plan, the life insurance plan fits under the ERISA definition of "an employee welfare benefit plan" because it provides "benefits in the event of . . . death. . . ." 29 U.S.C. § 1002(1)(A). The EBSA discussed the disposition of demutualization compensation for an employee welfare benefit plan in the Advisory Opinion 2001-02A, which states:

> [I]n the case of an employee welfare benefit plan . . . the appropriate plan fiduciary must treat as plan assets the portion of the demutualization proceeds attributable to participant contributions. . . . [and] the plan fiduciary should give appropriate consideration to those facts and circumstances [*21] that the fiduciary knows or should know are relevant to the determination, including the documents and instruments governing the plan. . . .

(Pl.'s Ex. 5, EBSA Advisory Op. 2001-02A at n.2.)

In this case, it is undisputed that the employers made all of the contributions to the plans. Therefore, there is no reason to treat any portion of the demutualization compensation as a plan asset. In addition, there is nothing in the language of the plan to suggest that the parties intended demutualization compensation to become a plan asset. Unlike the in-house pension plan and the severance plan, there is no language in the life insurance plan regarding dividends. The plan is silent with respect to possible assets such as dividends or demutualization compensation. *As* a result, the employers have made no representations suggesting that demutualization compensation would be a plan asset in the language of the plans. Therefore, the Court holds

that the demutualization compensation is not a plan asset for the life insurance plan and that it reverts to the Health and Welfare Fund, the Pension Fund, and Local 710.

The Pension Fund argues that Local 710 is not entitled to any of the demutualization [*22] compensation for the life insurance plan because Local 710 has not contributed to the plan. (Pension Fund's Resp. Pl.'s Mot Summ. J. at 11.) It is undisputed that the CTDU made contributions to the life insurance plan, however, and it is also undisputed that Local 710 is a successor to all the rights and liabilities of the CTDU. Therefore, Local 710 is entitled to a share of the demutualization compensation attributable to the contributions made by the CTDU.

CONCLUSION

For the reasons provided in this Memorandum, the Court grants in part and denies in part the Health and Welfare Fund's Motion for Summary Judgment [doc. no. 12-1] and Local 710's Motion for Partial Summary Judgment [doc. no. 19-1]. The Court enters a declaratory judgment that: (1) the demutualization compensation attributable to the 401(k) plan reverts to the participants of the plan as stipulated in the Joint Motion for Partial Dismissal and Release of Funds; (2) the demutualization compensation attributable to the severance plan must be used to offset future employer contributions; and (3) the demutualization compensation attributable to the in-house pension plan and life insurance plan reverts to the [*23] employers. This case is hereby terminated.

SO ORDERED

ENTERED: March 4, 2005

HON. RONALD A. GUZMAN

United States Judge

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GHVHS Med. Grp., P.C. v. Arthurs

Supreme Court of New York, Orange County

October 7, 2019, Decided

EF001609-2019

Reporter
2019 N.Y. Misc. LEXIS 7166 *; 2019 NY Slip Op 33988(U)

GHVHS MEDICAL GROUP, P.C., PLAINTIFF, - AGAINST- GILLY ARTHURS, MEDICAL LIABILITY MUTUAL INSURANCE COMPANY and COMPUTERSHARE TRUST COMPANY, N.A., DEFENDANTS. Index No. EF001609-2019

Subsequent History: Summary judgment denied by, Dismissed by, in part, As moot, Judgment entered by *GHVHS Med. Group, P.C. v. Cornell, 2020 N.Y. Misc. LEXIS 1883 (N.Y. Sup. Ct., Jan. 16, 2020)*

Judges: [*1] Hon. Maria S. Vazquez-Doles, J.S.C.

Opinion by: Maria S. Vazquez-Doles

Opinion

DECISION AND ORDER

VAZQUEZ-DOLES, J.S.C.

Plaintiff commenced this action to determine its right to receive monies from the sale and demutualization of Defendant Medical Liability Mutual Insurance Company, (hereinafter MLMIC). MLMIC demutualized the insurance company with the approval of the NYS Department of Insurance, and sold their company to Berkshire, Hathaway. As part of the plan which was approved by the NYS Department of Insurance, each "Eligible Policyholder" or its "Designee" were to receive a payment reflecting its pro rata share of the cash consideration, allocated according to the amount of the premium paid on the policy. In this case, Gilly Arthurs was the "eligible policy holder" entitled to receive approximately $4,744.00. The money is currently being held in escrow by Computershare. Plaintiff alleges that they are entitled to the money as they have paid all the premiums on behalf of Arthurs, have been the administrator of the medical malpractice insurance policy and the sole recipient of any dividends.[1] Plaintiff further alleges that many other doctors and nurse practitioners agreed to assign their rights to Plaintiff, [*2] but Arthurs refused because of a dispute about money owed on her final paycheck. Plaintiff seeks relief of a declaratory judgment which finds Plaintiff is the rightful recipient of the funds as they have paid all the premiums for the insurance policy, without contributions from Arthurs. Plaintiff argues in the alternative that Arthurs will be unjustly enriched if she is declared to be the recipient.

Defendant, Gilly Arthurs, has not filed a response to this motion sequence number 2, but in her pro-se response to

[1] Although Plaintiff makes this claim regarding dividends, there is no evidence submitted to support that dividends were actually distributed by MLMIC prior to the sale and demutualiztion.

motion sequence number 1, she states that Plaintiff owes her money for accrued time and has refused to pay because she breached the employment contract. The letter also indicates that she would assign her rights if Plaintiff paid her the $9,887.50 which she alleges is owed from leave accrual.

Defendant, MLMIC and Computershare have not filed any opposition papers to this motion either.

DISCUSSION:

The pertinent undisputed facts in the case show that an employment contract was signed between Plaintiff and Arthurs in May of 2016. The employment contract specifically stated that Plaintiff "...will maintain professional liability insurance on behalf of each party at its sole cost and [*3] expense." (Employment Contract Pg 5). The contract is silent as to demutualization and acquisition with future profits. The plan for demutualization and acquisition was approved by the NYS Department of Insurance on September 6, 2018, thus the parties were unaware that this future event would occur when they signed the employment contract.

Since the written contract between the parties does not specifically address the issue of who should receive the profits of the sale, the Court is faced with the question of who is the proper recipient of those funds. Plaintiff argues that they should receive the profits as they were the 'administrators" of the policy and that it would be inequitable to allow Defendant Arthurs to be unjustly enriched when she did not pay for or administer the malpractice insurance.

Under a plain reading of the insurance law, which addresses reorganization of a mutual insurer, Arthurs is clearly the policy holder. *New York Insurance Law §7312* states in part, "Policyholder" means a person, as determined by the records of a mutual life insurer, who is deemed to be the "policyholder" of a policy or annuity contract...". Gilly Arthurs is the named policyholder. The Plan which was approved by the Department [*4] of Insurance, allows for the policyholder to assign its rights to the profit. In this case, Arthurs refused to assign her rights, thus a plain reading of the contract and law would result in Arthurs receiving any profit from the demutualization and acquisition.

However, Plaintiff argues that this result would be unjust as they have paid the cost of the policy since the inception and have been noted as the policy administrator. To prevail on a theory of unjust enrichment, the Court must consider "...whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered". *Betz v Blatt, 160 AD3d 696, 701, 74 N.Y.S.3d 75 [2d Dept 2018]* (citing *Goel v. Ramachandran, 111 A.D.3d 783, 791, 975 N.Y.S.2d 428*, quoting *Paramount Film Distrib. Corp. v. State of Nov York, 30 N.Y.2d 415, 421, 334 N.Y.S.2d 388, 285 N.E.2d 695*)."). A court should "...look to see if a benefit has been conferred on the defendant under mistake of fact or law, if the benefit still remains with the defendant, if there has been otherwise a change of position by the defendant; and whether the defendant's conduct was tortious or fraudulent. (citations omitted)". *Betz v Blatt, 160 AD3d 696, 701, 74 N.Y.S.3d 75 [2d Dept 2018]*. When considering the above test, there are no allegations of fraud or tortious conduct. Moreover there was no mistake of fact or law if the benefit remains with Defendant as neither party was even aware of this benefit at the time the employment [*5] contract was signed. The benefit still remains with the Defendant as the Department of Insurance considered Plaintiff's claims during the demutualization process and did not change the language of what constitutes an "eligible policyholder", when Plaintiff and others made objections at the public hearing.

Accordingly, upon a review of the foregoing papers, and case law addressing this issue around the State of New York, and considering the specific facts of this case, it is hereby

ORDERED, ADJUDGED and DECREED that Plaintiff's motion for partial summary judgment on the first and eighth causes of action is denied. This Court declares that the "eligible policy holder" is Gilly Arthurs and she is entitled to $4,774.00 as her share of the sale and demutualization as determined by the Plan. The Plan approved by the Department of Insurance allowed for the Policy Holder to assign the benefits, but Defendant, Arthurs chose not to do so. The employment contract required Plaintiff to pay all the premiums of the medical malpractice insurance held by MLMIC, but it did not bargain in the agreement for who should receive any monies which might flow should there be a demutualization and sale, and it [*6] is further

ORDERED, ADJUDGED and DECREED that Plaintiff's motion for a finding of unjust enrichment is also denied. There has been no unjust enrichment because Plaintiff agreed to pay the premiums as part of the employment agreement offered to Dr. Arthurs. "To prevail on a claim of unjust enrichment, a party must show that (1) the other party was enriched, (2) at that party's expense, and (3) that it is against equity and good conscience to permit [the other party] to retain what is sought to be recovered" (citing *Goel v. Ramachandran, 111 A.D.3d 783, 791, 975 N.Y.S.2d 428* [internal quotation marks omitted])." *FoxStone Group, LLC v Calvary Pentecostal Church, Inc., 173 AD3d 978, 981, 104 N.Y.S.3d 663 [2d Dept 2019]*. While Dr. Arthurs may be enriched by receiving this profit, she is not being enriched at the expense of the Plaintiff. Plaintiff fully expected to pay all the insurance premiums, without repayment, as part of the compensation to Defendant, when the employment contract was signed. No one anticipated that MLMIC would be demutualized with a profit paid to the policyholders. Therefore, Defendant's enrichment is not at Plaintiff's expense, but rather an unforeseen benefit of the bargain, and it is further,

ORDERED that Defendants, MLMIC and Computershare take all steps necessary to transfer the payment now being held in escrow, to Gilly Arthurs [*7] within 30 days of the posting of this notice to NYSCEF.

Counsel is directed to serve Defendants with a copy of this Order within 30 days of the date of this decision.

The foregoing constitutes the Decision and Order of the Court.

Dated: October 7, 2019

Goshen, New York

ENTER,

/s/ Maria S. Vazquez-Doles

Hon. Maria S. Vazquez-Doles, J.S.C.

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Neutral
As of: May 9, 2021 1:34 AM Z

GHVHS Med. Group, P.C. v Cornell

Supreme Court of New York, Orange County

January 16, 2020, Decided

EF001610/2019

Reporter
69 Misc. 3d 611 *; 132 N.Y.S.3d 235 **; 2020 N.Y. Misc. LEXIS 1883 ***; 2020 NY Slip Op 20104 ****

[****1] GHVHS MEDICAL GROUP, P.C. and ORANGE REGIONAL MEDICAL CENTER, Plaintiffs, against DAVID CORNELL, MEDICAL LIABILITY MUTUAL INSURANCE COMPANY and COMPUTERSHARE TRUST COMPANY, N.A., Defendants.

Notice: THE LEXIS PAGINATION OF THIS DOCUMENT IS SUBJECT TO CHANGE PENDING RELEASE OF THE FINAL PUBLISHED VERSION.
THIS OPINION IS UNCORRECTED AND SUBJECT TO REVISION BEFORE PUBLICATION IN THE PRINTED OFFICIAL REPORTS.

Prior History: *GHVHS Med. Grp., P.C. v. Arthurs, 2019 N.Y. Misc. LEXIS 7166 (N.Y. Sup. Ct., Oct. 7, 2019)*

Case Summary

Overview

ISSUE: Whether a physician or the health care provider that employed the physician was entitled to a distribution payment made by medical malpractice insurance company that issued a policy covering the physician that was paid for as part of the employment contract by the provider as the physician's employer. HOLDINGS: [1]-The "eligible policy holder" pursuant to *Insurance Law § 7307(e)(3)* was the physician, and he was entitled to his share from the distribution of the sale of the mutual insurer as determined by the plan for the insurer. Furthermore, the physician was not unjustly enriched, and the plan allowed for the policy holder to assign the benefits if it chose to do so, but the physician chose not to assign the proceeds.

Outcome
Physician's motion for summary judgment granted. Provider's motions for summary judgment and to dismiss denied.

Judges: [***1] HON. MARIA S. VAZQUEZ-DOLES, J.S.C.

Opinion by: MARIA S. VAZQUEZ-DOLES

Opinion

[**236] [*612] Maria S. Vazquez-Doles, J.

The following papers numbered 1 - 18 were read on plaintiffs' motion for summary judgment on their first and eighth causes of action or, in the alternative, on their fifth and eighth causes of action against the defendants and dismissing defendant, David Cornell's counterclaim:

Notice of Motion/Berns Affidavit/Exhibits A - G/Anesi Affidavits/

Exhibits A-F/Memorandum of Law 1 - 7

Gitomer Affirmation in Opposition/Cornell Affidavit/Exhibits 1-2/

Memorandum of Law 8 - 11

DeLaHoz Affirmation in Response/Exhibit 1 12, 13

Craw Affidavit in Response/Exhibit A 14, 15

Reply Affirmation/Exhibit A/ Memorandum of Law 16 - 18

In this action, the single legal issue is whether the physician employee, defendant, David Cornell, or the employer, Orange Regional Medical Center together with GHVHS Medical Group, P.C., (the "Provider") is entitled to a distribution payment made by Medical Liability Mutual Insurance Company ("MLMIC"). MLMIC is a medical malpractice insurance company that issued a policy covering Cornell [**237] that was paid for as part of the employment contract, by the Provider as his employer. The parties seek, in essence, [***2] a declaratory judgment resolving this one central issue.

GHVHS Medical Group, P.C. (the "P.C.") is affiliated with two not-for-profit hospitals, one of which is plaintiff, Orange Regional Medical Center ("ORMC") located in Orange County, New York. ORMC is an acute care hospital licensed to operate 383 beds in Middletown, New York. Pursuant to the employment agreement effective October 22, 2013, between Cornell as employee and ORMC as employer, Cornell served as Medical Director for ORMC's trauma program. The Agreement was later assigned to the PC on December 1, 2014. Cornell was employed by the PC until September 10, 2015. The Agreement [*613] details Cornell's compensation [****2] and other party obligations. It specifies that the employer is to provide medical malpractice coverage to the Physician at the employer's expense (Agreement at ¶5). There is no dispute that Plaintiff/Provider was designated by Cornell to serve as his agent for the purpose of administering the policy, the coverages, the reporting requirements, and the payment of the premium.

The policy insuring Cornell was issued by MLMIC. At the time the insurance policy was issued, MLMIC was a mutual insurance company owned by its policyholders, [***3] one of whom was Cornell. Thereafter, MLMIC negotiated a sale of its business to a subsidiary of Berkshire-Hathaway, which formed a stock company, and paid MLMIC $2.5 Billion for the MLMIC assets. This demutualization plan ("the Plan") was approved by the New York State Department of Financial Services pursuant to *Insurance Law §7307*. The Plan includes the methodology for the pro rata distribution of the proceeds of the sale to parties in interest. As for Cornell's policy, the amount for the distribution allotted to the policy is $197,539.89 ("the Payment" - $181,104.82 related to Cornell's employment with ORMC and $16,435.07 related to his employment with the PC. The question presented here is whether Cornell or plaintiffs are entitled to the Payment.

Defendants, MLMIC and Computershare respond to the instant motion without taking a position as to the merits. MLMIC admits that on October 4, 2018, due to a 'misclassification', MLMIC issued the allocable share of cash consideration related to Cornell's employment with ORMC in the amount of $181,104.82 directly to Cornell. Thus, based upon the disagreement of the parties, only a portion of the Payment is being held in the MLMIC escrow account pending resolution [***4] of the dispute. The escrow amount is $16,435.07. MLMIC sent a letter to Cornell on January 7, 2019 demanding return of the distributed cash consideration, but despite such demand, Cornell has not returned the funds.

The Amended complaint asserts eight causes of action including; *inter alia*, declaratory judgment; breach of contract and unjust enrichment. The answer of Cornell includes a counterclaim for declaratory judgment in his favor. Plaintiffs now move for summary judgment, in essence seeking a declaration that they are entitled to the Payment.

Plaintiffs ask the Court to follow the recent decision of

the Appellate Division, First Department in *Matter of Schaffer, [*614] Schonholz & Drossman, LLP v. Rachel Title, MD, 171 AD3d 465, 96 N.Y.S.3d 526* (the "Matter of Schaffer"), decided April 4, 2019. Plaintiffs argue that it is dispositive of the issues raised in this matter.

In the *Matter of Schaffer*, the parties, pursuant to CPLR 3222(b)(2), filed directly with the Appellate Court a statement of [**238] stipulated facts, together with their briefs. The statement of facts includes a section entitled "Controversy Presented ... Issue a declaratory judgment determining whether SS & D or Dr. Title is entitled to the disputed amount..."

A review of the facts in the *Matter of Schaffer* reveals that the litigation, [***5] like this action, involved a physician named as insured on a MLMIC policy. The doctor's employer, similar to the Provider, purchased the policy and paid all of the premiums and costs related to the policy. Like Cornell, the doctor acknowledged that she did not pay any of the premiums or any of the other costs related to the policy. Further, like Cornell, the doctor designated her employer as the 'Policy Administrator'. Plaintiff argues that as policy administrator, they had the right to receive return premiums, including dividends when due. Both doctors acknowledged that she did not [****3] bargain for the benefit of the demutualization proceeds, but then neither did the hospital/provider. Under the facts of *Schaffer*, the court held that: "Awarding [the doctor] the cash proceeds of MLMIC's demutualization would result in her unjust enrichment (citations omitted)." Similar to the *Matter of Schaffer*, the named employer here purchased and paid all of the premiums on the medical professional insurance policy covering the physician who now seeks the distribution payment based on the policy.

In the instant case, Defendant/Cornell attempts to distinguish the facts from the facts in the *Matter of [***6] Schaffer* alleging that he specifically bargained for the right to obtain and receive his own MLMIC professional liability insurance policy and all benefits that flowed from such policy including the right to any demutualization proceeds. Cornell acknowledges that he agreed to designate Plaintiff as a "policy administrator' but that designation said nothing about demutualization proceeds. Cornell submits the policy administrator change form in support of this argument. This form states in part, [*615] "*The Policy Administrator is the agent of all insureds herein for the paying of the premium, requesting changes in the policy, including cancellation thereof and receiving dividends and any return premiums when due. By designating a Policy Administrator each insured gives us permission to release information about each such Insured, your practice or any other information that we may have to such Policy Administrator*." Nowhere in this form does it mention proceeds of demutualization.

In support of his claim to have bargained for the benefit of the Payment, Cornell submits an affidavit in which he acknowledges the Employment Agreement which requires that the Provider provide the physician with malpractice [***7] "coverage", from a company of the Providers choice, including self-insured plans. There was no requirement that the physician be provided with a policy from a mutual insurer featuring ownership benefits. Cornell further argues that this medical coverage was an employment incentive- "...was part of my compensation..."(Cornell Aff'd ¶9), and that this contract was carefully negotiated with his attorney. Cornell makes no allegation that the Agreement is ambiguous in any way and does not allege that demutualization was discussed at all, simply that neither party anticipated the demutualization event.

Cornell further argues that the First Department's decision in the *Matter of Schaffer* is not binding on this court as this case was filed in the Second Department. Cornell further contends that, in any event, the First Department's determination based on the principles of unjust enrichment was in error because the issue [**239] was not properly argued to the appellate court.

While it is true that courts are bound by the doctrine of *stare decisis*, to apply precedent established in another Department until a contrary rule is established by the Appellate Division in its own Department or by the Court of [***8] Appeals, (see *Phelps v. Phelps, 128 AD3d 1545, 9 N.Y.S.3d 519 [4th Dept. 2015]*; *D'Alessandro v. Carro, 123 AD3d 1, 992 N.Y.S.2d 520 [4th Dept. 2015]*; *see Mountain View Coach Lines v. Storms, 102 AD2d 663, 664-665, 476 N.Y.S.2d 918 [2d Dept. 1984]*,) caution must be applied in some cases. (See *People v Hobson, 39 NY2d 479, 489-90, 348 N.E.2d 894, 384 N.Y.S.2d 419 [1976]*, which recognized that conclusory assertions should be carefully scrutinized.) In this instance, the First Department's two

paragraph decision summarily concludes [*616] that it would be an unjust enrichment to award the proceeds to the doctor.

In the facts of this case, the parties agreed upon an extensive employment contract. It is clear from the terms of the contract that the cost of medical malpractice insurance would be additional compensation for the doctor as it was being paid by the Provider. Neither party [****4] anticipated or bargained for the demutualization, and there are no terms in the contract which suggest how the profits should be disbursed. Applying the clear law of contracts to the case at bar, two contract principals are present in this case. First "... a contract is to be construed in accordance with the parties' intent, which is generally discerned from the four corners of the document itself. Consequently, 'a written agreement that is complete, clear and unambiguous on its face must be enforced according to the plain meaning of its terms' " (citing *MHR Capital Partners LP v. Presstek, Inc., 12 NY3d 640, 645, 884 N.Y.S.2d 211, 912 N.E.2d 43*, quoting *Greenfield v. Philles Records, 98 NY2d 562, 569, 750 N.Y.S.2d 565, 780 N.E.2d 166*)." *Legum v Russo, 133 AD3d 638, 639, 20 N.Y.S.3d 124 [2d Dept 2015]*. Moreover, this Court is mindful of the fact [***9] that "...courts may not by construction add or excise terms, nor distort the meaning of those used and thereby 'make a new contract for the parties under the guise of interpreting the writing.' (citing *Heller v. Pope, 250 NY 132, 135, 164 N.E. 881*; *Friedman v. Handelman, 300 NY 188, 194, 90 N.E.2d 31*.)" *Morlee Sales Corp. v Manufacturers Tr. Co., 9 NY2d 16, 19-20, 172 N.E.2d 280, 210 N.Y.S.2d 516 [1961]*. Applying this law to this employment contract, there are no terms which address proceeds of demutualization.

A review of the Superintendent's Decision approving the demutualization plan orders that the proceeds shall go to the " eligible policyholders", or their "assignees" unless an objection is timely filed, in which case the proceeds are to be held in escrow until the dispute is resolved. *Insurance Law §7307(e)(3)* defines the group of persons who are eligible to receive the proceeds of demutualiztion as "Eligible Policyholders". There is no dispute that Dr. Cornell is the 'eligible policyholder'. This definition does not differentiate between who pays the premiums and who does not. In fact, because every situation/employment contract is different, a [*617] process was set up to put disputed funds in escrow until the dispute is resolved by the courts or arbitration. In the instant case, Dr. Cornell, the eligible policy holder, chose not **to** assign the proceeds to the Provider and is contesting their right to [***10] the same.

To prevail on a theory of unjust enrichment, the Court must consider "...whether it is against equity and good conscience to permit the defendant to retain [**240] what is sought to be recovered ". *Betz v Blatt, 160 AD3d 696, 701, 74 N.Y.S.3d 75 [2d Dept 2018]* (citing *Goel v. Ramachandran, 111 AD3d 783, 791, 975 N.Y.S.2d 428*, quoting *Paramount Film Distrib. Corp. v. State of New York, 30 NY2d 415, 421, 334 N.Y.S.2d 388, 285 N.E.2d 695*."). A court should "...look to see if a benefit has been conferred on the defendant under mistake of fact or law, if the benefit still remains with the defendant, if there has been otherwise a change of position by the defendant, and whether the defendant's conduct was tortious or fraudulent. (citations omitted)". *Betz v Blatt, 160 AD3d 696, 701, 74 N.Y.S.3d 75 [2d Dept 2018]*. When considering the above test, there are no allegations of fraud or tortious conduct. Moreover there was no mistake of fact or law as neither party was even aware of this benefit at the time the employment contract was signed. A close reading of the Department of Insurance decision reveals that Plaintiff's claims were considered during the demutualization process, but they did not change the language of what constitutes an "eligible policyholder", even though Plaintiff and others made objections at the public hearing. Accordingly there is no unjust enrichment if the Defendant/doctor receives the money in this case.

In rendering this decision, the Court [***11] has considered its prior ruling in the case of GHVHS MEDICAL GROUP, P.C. v. GILLY ARTHURS, et al under Orange County Index No. EF001609-2019 wherein this Court found that the rightful owner of those funds was the policy [****5] holder, Gilly Arthurs. Although the Second Department has not addressed one of these cases thus far, many similar cases have been filed in Orange County. To rule that the Providers should receive the money in every case would unjustly enrich the Providers who never bargained for this windfall. Furthermore, it may open the flood gates to every type of profession which negotiated the payment of malpractice insurance as part of the employment contract. This Court believes the issue is fact specific,

and turns on the language of each individual [*618] contract of employment. Plaintiff argues the catchall phrase of 'unjust enrichment' to support a finding that this windfall profit should go to them. However, factually no one knew that this company would be demutualized and there were no contract terms addressing the situation. This Court finds that when a contract fails to state the terms specifically, a ruling must be against the drafter of the contract, which in this case is [***12] the provider. (See for example, *Mejia v Trustees of Net Realty Holding Tr., 304 AD2d 627, 628, 759 N.Y.S.2d 91 [2d Dept 2003]*).

The court has considered the additional contentions of the parties not specifically addressed herein. To the extent any relief requested by either party was not addressed by the court, it is hereby denied. Accordingly, it is hereby

ORDERED, ADJUDGED and DECREED that plaintiffs' motion, made pursuant to *CPLR §3212*, for an order granting Plaintiff summary judgment on the first and eighth causes of action in the complaint for a declaratory judgment as against all defendants is denied; and it is further

ORDERED, ADJUDGED and DECREED that plaintiffs' motion for an order granting summary judgment on the fifth and eighth causes of action in the complaint as against all defendants is denied. There has been no unjust enrichment because Plaintiff agreed to pay the premiums as part of the employment agreement offered to Dr. Cornell. While Dr. Cornell may be enriched by receiving this profit, he is not being enriched at the expense of the Plaintiff. Plaintiff fully expected to pay [**241] all the insurance premiums, without repayment, as part of the compensation to Defendant, when the employment contract was signed. No one anticipated that MLMIC would be demutualized with a profit [***13] paid to the policyholders. Therefore Defendant's enrichment is not at Plaintiff's expense, but rather an unforeseen benefit of the bargain, and it is further

ORDERED, ADJUDGED and DECREED that the second, third, fourth, sixth and seventh causes of action in the complaint are dismissed as moot; and it is further **ORDERED, ADJUDGED and DECREED** that Defendant, David Cornell's counterclaim for a declaratory judgment in his favor, is granted. This Court declares that the "eligible policy holder" is David Cornell and he is entitled to both the $181,104.82, already disbursed, as the amount of the ORMC payment, and the escrowed amount of $16,435.07 as the amount of the PC payment, as his share of the sale and demutualization as determined by the Plan. **The Plan approved by the Department of Insurance allowed for the Policy Holder to assign the benefits if they chose to do so, further** [*619] **illustrating that the rightful owner of the proceeds would be the Policy Holder, Dr. Cornell, and no one else. However, Defendant Dr. Cornell chose not to assign the proceeds; therefore he is entitled to the distribution**, and it is further

ORDERED, ADJUDGED AND DECLARED that Defendant, David Cornell, MD, is entitled [***14] to the receipt from the escrow agent currently holding funds due it in the amount of $16,435.07 plus accrued interest, if any, as to said amount representing the pro rata amount [****6] assigned to the account of DAVID CORNELL, which amount shall be paid to Defendant, David Cornell, within fifteen (15) days of the service of this Order, with Notice of Entry, upon the escrow agent; and it is further

ORDERED, ADJUDGED and DECREED that upon compliance with this Order, namely payment of the amounts due defendant, the action shall be dismissed with prejudice.

The foregoing constitutes the Decision and Order of this Court.

Dated: January 16, 2020

Goshen, New York

ENTER:

HON. MARIA S. VAZQUEZ-DOLES, J.S.C.

End of Document

At a term of the IAS Part of the Supreme Court of the State of New York, held in and for the County of Orange located at 285 Main Street, Goshen, New York 10924 on the 6th day of January, 2020.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ORANGE

To commence the statutory time for appeals as of right (CPLR 5513 [a]), you are advised to serve a copy of this order, with notice of entry, on all parties.

GHVHS MEDICAL GROUP, P.C.,

PLAINTIFF,

-AGAINST-

LORI SIDORSKI-NUTT; MEDICAL LIABILITY MUTUAL NSURANCE COMPANY and COMPUTERSHARE TRUST COMPANY, N.A.,

DEFENDANTS.

DECISION AND ORDER
Index No. EF001620-2019
Motion Date: 9/6/19
Motion Seq. #1

VAZQUEZ-DOLES, J.S.C.

The following papers numbered 1 - 31 were read on Plaintiff's motion for summary judgment on the first and eighth causes of action, or in the alternative its fifth and eighth causes of action, and to dismiss Defendants' counterclaims;

Notice of Motion/Affirmation of Mitchell Berns Esq./Exhibits A - G/ Affidavit of Joseph Anesi/Exhibits A - F/Memorandum of Law. ..... 1 - 17
Affirmation in Opposition of Justin Heller, Esq./Exhibits A - F/Memorandum of Law/Affidavit of Lori Sidorski-Nutt/Exhibits A - D ..... 17 - 30
Memorandum of Law in Reply 31

Plaintiff commenced this action to determine its right to receive monies from the sale and demutualization of Defendant *Medical Liability Mutual Insurance Company*, (hereinafter MLMIC). MLMIC demutualized the insurance company with the approval of the NYS Department of Insurance, and sold their company to Berkshire Hathaway. As part of the plan which was approved by the NYS Department of Insurance, each "Eligible Policyholder" or its "Designee" were to receive a payment reflecting its pro rata share of the cash consideration, allocated according to the amount of the premium paid on the policy. If there was a dispute over who the cash consideration should be paid to, the monies were to be deposited in an escrow account until a determination was made by a court or arbitrator. In this case, Defendant Nurse Practioner, Lori Sidorski-Nutt is an eligible policy holder entitled to a cash consideration of

$14,315.61. Dr. Sidorski-Nutt did not assign her cash contribution to anyone and the money was deposited in an escrow account with Defendant, Computershare Trust Company.

Plaintiff now moves for partial summary judgment seeking a declaration that they should receive the cash consideration of $14,316 which is being held for the policy holder, Defendant Sidorski-Nutt. Plaintiff argues that they are the designated "policy administrator" who purchased and paid all the premiums on the malpractice insurance policy for Dr. Sidorski-Nutt, from April 2014 through October , 2016. Plaintiff further argues that they administered the policy and received the benefits of ownership as they were credited with dividends to pay down premiums. (See Memo of Law pg 8). Plaintiff argues that this Court should follow the First Department case of *Matter of Schaffer, Schonholz & Drossman, LLP v. Title*, 171 A.D.3d 465 (1st Dep't April 4, 2019), which held that the doctor would be unjustly enriched should they be the recipient of the cash considerations.

Dr. Sidorski-Nutt opposes this motion and argues that she should be the recipient of those funds for several reasons. First, under the terms of her Employment Agreement, Plaintiff agreed to pay all the premiums of her malpractice insurance in addition to her salary and in exchange for her professional services. She argues that the contract is silent as to how to distribute funds upon demutualization. Secondly, she argues that the funds in dispute are the Cash Consideration payable to her for the extinguishment of her *Membership Interest* as a policy holder in MLMIC, and are not fees for my professional services rendered to Plaintiff's patients, as addressed in the employment contract. Finally, Dr. Sidorski-Nutt argues that the form which designates Plaintiff as the 'policy administrator' merely makes Plaintiff an agent for the paying of premiums, requesting changes in the policy, and for receiving dividends and any return premiums when due. She argues that the form does not change her ownership status as the policy holder, and she

should receive the cash consideration.

Upon all the papers and proceedings held herein, and a consideration of the cases around the State of New York, this Court finds and declares that Lori Sidorski-Nutt is the 'policy holder' who is entitled to the cash consideration of demutualization in the amount of $14,315.61.

The MLMIC's Plan of Conversion provided that the "Eligible Policy Holders" or their "Designees", would receive their portion of the cash consideration for the extinguishment of their policy holder membership interests. In this case, the Defendant policy holder did not designate Plaintiff as its designee to receive this cash consideration, nor did the parties bargain for this event in their employment agreement.

Moreover, this Court finds that there will be no unjust enrichment if Dr. Sidorski-Nutt receives this cash contribution. To prevail on a theory of unjust enrichment, the Court must consider "...whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered", *Betz v Blatt,* 160 AD3d 696, 701 [2d Dept 2018] (citing *Goel v. Ramachandran*, 111 A.D.3d 783, 791, 975 N.Y.S.2d 428, quoting *Paramount Film Distrib. Corp. v., State of New York,* 30 N.Y2d 415, 421, 334 N.Y.S.2d 388, 285 N.E.2d 695)."). A court should "...look to see if a benefit has been conferred on the defendant under mistake of fact or law, if the benefit still remains with the defendant, if there has been otherwise a change of position by the defendant, and whether the defendant's conduct was tortious or fraudulent. (citations omitted)". *Betz v Blatt,* 160 AD3d 696, 701 [2d Dept 2018]. When considering the above test, there are no allegations of fraud or tortious conduct. Moreover there was no mistake of fact or law as neither party was even aware of this benefit at the time the employment contract was signed. Finally, the Court finds that Plaintiff has already received the benefit of the bargain from the dividends which reduced the premiums the Plaintiff paid before MLMIC converted.

Accordingly, it is hereby

ORDERED, ADJUDGED and DECREED that plaintiffs' motion, made pursuant to CPLR §3212, for an order granting Plaintiff summary judgment on the first and eighth causes of action in the complaint for a declaratory judgment as against all defendants is denied; and it is further

ORDERED, ADJUDGED and DECREED that plaintiffs' motion for an order granting summary judgment on the fifth and eighth causes of action in the complaint as against all defendants is denied; and it is further

ORDERED, ADJUDGED and DECREED that the second, third, fourth, sixth and seventh causes of action 1n the complaint are dismissed as moot; and it is further

ORDERED, ADJUDGED and DECREED that Defendant, Lori Sidorski-utt's counterclaim for a declaratory judgment in her favor, is granted. This Court declares that the "eligible policy holder" is Lori Sidorski-Nutt's, and she is entitled to the escrowed amount of $14,315.61 as her share of the sale and demutualization of MLMIC as determined by the Plan which was approved by the Department of Insurance, and it is further

ORDERED, ADJUDGED and DECREED that Defendants, MLMIC and Computershare Trust Co., NA shall pay to Defendant, LORI SIDORSKI-NUTT the amount of $14,315.61 within fifteen (15) days of the service of this Order, with Notice of Entry, upon the escrow agent.

The foregoing constitutes the Decision and Order of the Court.

Dated: January 6, 2020
Goshen, New York

Enter

Hon. Maria S. Vazquez-Doles, J.S.C.

To: Counsel of record via NYSCEF.

Grossman v Akker

Supreme Court of New York, New York County

August 8, 2016, Decided

652402/15

Reporter
2016 N.Y. Misc. LEXIS 3007 *; 2016 NY Slip Op 31551(U) **

[**1] HOWARD L. GROSSMAN, on behalf of himself and all others similarly situated, Plaintiff, -against- MICHAEL AKKER, EVELYN F. MURPHY, DAVID JEFFERSON, DEBORAH AGUIAR-VELEZ, THERESA BALOG, SAMUEL M. BEMISS III, G. THOMAS ROGERS, ROBERT DAMANTE and PROSPERITY LIFE INSURANCE GROUP, LLC as successor to SBLI USA MUTUAL LIFE INSURANCE COMPANY, INC., Defendants. Index No. 652402/15;In the Matter of the Application of HOWARD L. GROSSMAN, on behalf of himself and all others similarly situated, Petitioner, -against- BENJAMIN W. LAWSKY, Superintendent of Financial Services New York Banking Department, ROBERT EASTON, Executive Deputy Superintendent, Insurance Division and DEPARTMENT OF FINANCIAL SERVICES, Respondents. Index No. 100199/15

Notice: THIS OPINION IS UNCORRECTED AND WILL NOT BE PUBLISHED IN THE PRINTED OFFICIAL REPORTS.

Prior History: *Grossman v. Akker, 2016 N.Y. Misc. LEXIS 3060 (N.Y. Sup. Ct., Aug. 8, 2016)*

Judges: [*1] Joan B. Lobis, J.S.C.

Opinion by: Joan B. Lobis

Opinion

Motions bearing sequence numbers 002 and 003 in the action commenced under index number 652402/15 are consolidated for disposition. Motions bearing sequence numbers 001 and 002 in the special proceeding commenced under index number 100199/15 are consolidated for [**2] disposition.

This is a class action (Class Action) and a special proceeding under *Article 78 of the CPLR* (*Article 78* proceeding), arising in connection with the conversion of SBLI Mutual Life Insurance Company (SBLI) from a mutual life insurance company into a stock life insurance company, pursuant to *New York Insurance Law § 7312*. In the *Article 78* proceeding, respondents Benjamin Lawsky, Robert Easton and the Department of Financial Services move to dismiss the petition of petitioner Howard L. Grossman (Grossman), which seeks an order setting aside a decision by respondents which approved the conversion of SBLI. In motion sequence 002, respondents move for an order granting consolidation of the Class Action and the *Article 78* proceeding.

In the Class Action, in motion sequence 003, defendants Michael Akker, Evelyn F. Murphy, David [*2] Jefferson, Deborah Aguiar-Velez, Theresa Balog,

Samuel M. Bemiss III, G. Thomas Rogers, Robert Damante (collectively, the Individual defendants) and Prosperity Life Insurance Group, LLC (Prosperity) move, pursuant to CPLR 3211 (a) (1) and (7), for an order dismissing the amended complaint. Defendants also move, in sequence 002, for an order granting consolidation of the Class Action and the Article 78 proceeding.

For the reasons stated below, the motions for consolidation are denied as moot. The motion to dismiss the amended complaint is granted. The motion to dismiss the petition is granted.

[**3] **Parties**

Grossman was a policyholder of SBLI, which was a mutual life insurance company organized under the laws of the State of New York. Essentially, a mutual life insurance company is one which is owned by the policyholders (Policyholders), who have voting rights and who receive dividends arising from their ownership interests.

Michael Akker was the President and Chief Executive Officer of SBLI and a member of its board of directors. Robert Damante was an Executive Vice President and the Chief Financial Officer of SBLI and a member of its board of directors.

Defendants Evelyn Murphy, David Jefferson, Deborah Aguiar-Velez, Theresa Balog, Samuel [*3] M. Bemiss III and G. Thomas Rogers were also members of SBLI's board of directors. According to the amended complaint, these defendants, along with Akker and Damante, comprised the board of SBLI at the time the plan to convert SBLI was approved. Prosperity is a privately held life and annuity insurance holding company, and is the successor to SBLI.

Benjamin Lawsky was the Superintendent of Financial Services New York Banking Department (Superintendent) when the conversion was approved and one of the parties under whose name the decision to approve the conversion was issued. Robert Easton was Executive Deputy Superintendent, Insurance Division of Financial Services at the relevant time, and was also a [**4] signatory to the decision approving the conversion. The Department of Financial Services is the agency of the State of New York which approved the conversion.

Background

According to the amended complaint, SBLI began in 1939 as The Savings Banks Life Insurance System. It was incorporated as SBLI Mutual Life Insurance Company of New York, Inc. in 1999 and was licensed to issue life insurance, annuities, and accident and health insurance on December 28, 1999.

The complaint alleges that, at [*4] some point thereafter, SBLI invested a significant portion of its assets in mortgage-backed securities (MBS). However, the value of such MBS's collapsed in 2008, which caused SBLI's financial condition to deteriorate to the point that the New York Superintendent of Insurance ordered SBLI to stop writing new insurance policies.

The complaint states that, in March 2012, Prosperity contacted SBLI with a proposal and plan (Plan) for a sponsored demutualization in which Prosperity, through a subsidiary, would acquire SBLI. Specifically, SBLI would be converted to a domestic stock company, which would then issue stock to be acquired by Prosperity.

The parties executed a Stock Purchase and Investment Agreement in October 2012, [**5] and on November 25, 2013, SBLI's Board of Directors unanimously approved a merger agreement to complete the acquisition. The merger agreement was executed on November 27, 2013 and provided, as relevant here, for $36 million to be paid to the Policyholders.

In order for the demutualization and merger to be effective, New York Insurance Law § 7312 required: (1) approval by three-fourths of the board of directors upon finding it fair and equitable to the Policyholders; (2) approval by two-thirds of [*5] participating voting Policyholders; and (3) a determination by the Superintendent, after a public hearing, that the demutualization plan is fair and equitable to the Policyholders.

In July 2014, the SBLI Board approved the Plan, and, soon thereafter, mailed an information booklet (Information Booklet) to the Policyholders, which included a copy of the Plan as well as a notice of public hearing, as required by Insurance Law § 7312 (i).

On August 21, 2014, the Superintendent held a public hearing to consider: 1) the reasons and purposes for SBLI's demutualization; 2) the fairness of the Plan; 3) whether the reorganization was in SBLI's interest and in the interest of the Policyholders; and 4) whether demutualization was detrimental to the public.

Five witnesses spoke in support of the Plan, while eight Policyholders spoke in [**6] opposition. The Superintendent also received an written submissions, six of which supported the Plan and seven of which opposed it, including written submissions from Grossman in opposition. One of the main issues raised by opponents was whether the compensation provided to Policyholders was too low.

The Superintendent approved SBLI's demutualization in a 41-page written decision dated October 8, [*6] 2014. The Superintendent found that the Plan satisfied *Insurance Law § 7312* because, among other things, it provided fair and equitable compensation to the Policyholders, it was not detrimental to the public, it did not violate the Insurance Law and it left SBLI with sufficient resources for its future solvency.

Relevant here, the Superintendent also reviewed and approved the contents of the Information Booklet, determining that it provided sufficient information to SBLI's Policyholders to enable them to make an informed decision about the merits of the Plan.

The Policyholder vote was held on August 28, 2014. Out of the 186,211 Policyholders eligible to vote, 34,769 Policyholders actually voted with respect to the Plan. 81.82% of the voting Policyholders voted in favor of the Plan. 18.18% voted against the Plan.

On February 6, 2015, Grossman commenced the instant *Article 78* proceeding against [**7] the Superintendent and the individual officials who approved the Plan. Grossman seeks a determination that the Superintendent's approval of the Plan was improper, and seeks rescissory damages.

On July 7, 2015, Grossman commenced the instant Class Action on behalf of himself and other Policyholders against SBLI's Board [*7] of Directors and against Prosperity. The amended complaint asserts three causes of action. The first cause of action alleges: 1) that defendants violated *section 7312 of the Insurance Law* because the Information Booklet failed to provide Policyholders with sufficient information to cast a meaningful vote; and 2) that the terms of the Plan were not fair and equitable to the Policyholders.

The second cause of action is for breach of the implied covenant of good faith and fair dealing. Specifically, it alleges that the Policyholders entered into contracts with SBLI, and that defendants breached the implied covenant of good faith and fair dealing in those contracts by disseminating an insufficient Information Booklet and by approving an unfair plan for SBLI's demutualization and reorganization.

The third cause of action is against Prosperity for unjust enrichment. The amended complaint alleges Prosperity obtained SBLI through the Plan at less than fair value.

[**8] **Consolidation**

As noted above, the defendants in the Class Action and the respondents in the *Article 78* proceeding have moved for consolidation of the two matters. However, at oral argument, on March 29, 2016, the parties to both the *Article 78* proceeding and the Class [*8] Action agreed that, in lieu of consolidation, the parties would conduct both cases in a coordinated manner. Therefore, the motions to consolidate are denied as moot.

Class Action/Collateral Attack

Defendants move, pursuant to *CPLR 3211 (a) (1)* and *(7)*, for an order dismissing the amended complaint in the Class Action. As set forth above, plaintiffs assert three causes of action, each of which arises from plaintiffs' central contention that the terms of the demutualization and conversion of SBLI were not fair or equitable to the Policyholders and that the Information Booklet failed to provide Policyholders with sufficient information to cast a meaningful vote.

Defendants contend that these causes of action must be dismissed because they constitute an impermissible collateral attack on the Superintendent's approval of SBLI's demutualization Plan. Specifically, defendants argue that the determinations as to whether the Plan was fair, and whether the Information Booklet was sufficient, were solely within the purview of the

Superintendent in considering whether to approve the Plan. As such, defendants contend that any party challenging the Superintendent's determination that the Plan was fair, or that the Information [*9] [**9] Booklet was sufficient, may only do so by means of an *Article 78* proceeding, and plaintiffs are therefore precluded from relitigating these issues in a plenary action.

Plaintiffs contend that the collateral attack doctrine does not apply here because: 1) nothing in *Insurance Law § 7312* indicates an intent to extinguish the rights of Policyholders who object to a demutualization plan to assert claims in a plenary action; and 2) the Superintendent's decision was not the result of a quasi-judicial proceeding which permitted Policyholders a fair opportunity to be heard prior to the Superintendent making his determination.

For the reasons stated below, the court finds that the three causes of action in the amended complaint constitute an impermissible collateral attack on determinations made by the Superintendent in approving the Plan, and, as such, the amended complaint must be dismissed. To sustain these causes of action would permit plaintiffs to relitigate, through a plenary action, issues that were previously decided by the Superintendent, as required by *Insurance Law § 7312*, and which therefore must be challenged in an. *Article 78* proceeding.

It is well-settled that a party challenging the Superintendent's approval of a demutualization [*10] plan under *Insurance Law § 7312* must do so in a proceeding under *CPLR article 78*. See *Fiala v. Metropolitan Life Ins. Co., 6 A.D.3d 320, 321, 776 N.Y.S.2d 29 (1st Dep't 2004)*; Financial Services Law *§ 308*; *CPLR 7801*. This is because, in the context of a demutualization plan, "'the Legislature [**10] expressly placed the determination as to whether a plan of reorganization complied with the statute and was fair and equitable to policyholders in the (exclusive jurisdiction) of the Superintendent [citation omitted]." *ABN AMRO Bank, N.V. v. MBIA Inc., 17 N.Y.3d 208, 225, 952 N.E.2d 463, 928 N.Y.S.2d 647 (2011)*(ABN AMRO).

Under the collateral attack doctrine, a party is precluded from indirectly challenging the Superintendent's approval of a demutualization plan through a plenary action. See *Fiala v. Metropolitan Life Ins. Co., 6 A.D.3d at 321*; *Chatlos v. MONY Life Ins. Co., 298 A.D.2d 316, 749 N.Y.S.2d 230 (1st Dep't 2002)*, In other words, because the Superintendent has exclusive jurisdiction to determine whether a plan complies with the statute, litigants may not use a plenary action as a means to achieve a different result, but rather, must avail themselves of *CPLR Article 78*.

The collateral attack doctrine is limited, however, to the extent that "where a claim challenges the sufficiency of a plan approved by the Superintendent . . . . the preclusive effect of the Superintendent's decision is necessarily limited by the scope of the Superintendent's review." *Aurelius Capital Master. Inc. v. MBIA Ins. Corp., 695 F. Supp. 2d 68, 74 (S.D.N.Y. 2010)*, citing *Fiala, 6 A.D.3d at 321*. Thus, a plaintiff "cannot be precluded from litigating an issue upon which the Superintendent [*11] did not pass." *Aurelius Capital Master, Inc., 695 F. Supp. 2d at 74*.

In the case at hand, it is undisputed that, before the public hearing was held, SBLI was [**11] required to send the Policyholders "a true and complete copy of the plan, or . . . a summary thereof approved by the Superintendent, and such other explanatory information as the superintendent shall approve or require." See *Insurance Law § 7312 (j)*. SBLI was then required to demonstrate to the Superintendent that the Plan was fair and equitable to the Policyholders. See *Insurance Law § 7312 (c)*, *(j)*.

Relevant here, SBLI was also required to send a true and complete copy of the Plan to the Policyholders before the vote on whether to approve or disapprove the Plan, and the Superintendent was authorized to supervise such vote. See *Insurance Law § 7312 (k) (1)* and *(3)*.

In the Decision, the Superintendent considered both whether the Information Booklet, which contained a copy of the Plan, was sufficient to permit voters to make an informed decision and ultimately, whether the Plan was fair and equitable to the Policyholders. The Superintendent found that the Information Booklet, along with related policyholder notices and accompanying documents, "contained sufficient information about the proposed Demutualization to enable Eligible Policyholders to make an informed [*12] decision regarding the Plan and, for that

reason, were approved by the Department pursuant to *Sections 7312 (i)* and *(k) (1)*." Decision at 38. The Superintendent then found, after a detailed analysis, that the Plan was fair and equitable to the Policyholders. Id. at 36.

[**12] As described above, each cause of action in the amended complaint arises directly from plaintiffs' contentions that: 1) the terms of the demutualization and conversion of SBLI were not fair or equitable to the Policyholders; and 2) that the Information Booklet failed to provide Policyholders with sufficient information to make an informed decision in voting whether to approve the Plan.

However, both of these issues were necessarily addressed and decided by the Superintendent in approving the Plan, under his exclusive jurisdiction to determine whether the demutualization of SBLI complied with the statute. Therefore, for this court to sustain plaintiffs' causes of action asserted in the Class Action would impermissibly enable the Class Action plaintiffs to collaterally attack the Superintendent's decision through a plenary action, rather than through an *Article 78* proceeding. See *Fiala, 6 A.D.3d at 321*. This would clearly violate the plain language of *Insurance Law § 7312* and plaintiffs' claims must therefore [*13] be dismissed.

Despite the foregoing, plaintiffs argue that the amended complaint should not be dismissed because there is nothing in *Insurance Law § 7312* which indicates an intent to extinguish all rights of Policyholders who object to a demutualization plan to assert claims in a plenary action. However, that is not the issue here and defendants do not make such an argument.

It is clear that certain claims may arise in connection with a demutualization plan that [**13] were not within the purview of the Superintendent, and not addressed by the Superintendent, and, as such, are sustainable in a plenary action. See *Fiala, 6 A.D.3d at 321*; see also *ABN AMRO, 17 N.Y.3d at 225* (sustaining causes of action under the Debtor and Creditor Law in connection the corporate restructuring of an insurance company, which restructuring was approved by the Superintendent). However, this is not such a case, as discussed above, because the issues underlying plaintiffs' claims were specifically delegated to the Superintendent by the Insurance Law.

Plaintiffs also argue that their claims should not be dismissed because the public hearing conducted by the Superintendent here was not quasi-judicial in nature. This argument is also unpersuasive. "An administrative decision is quasi-judicial [*14] in character when it is rendered pursuant to the adjudicatory authority of an agency to decide cases brought before its tribunals employing procedures substantially similar to those used in a court of law [internal quotation marks and citations omitted]." *ABN AMRO, 17 N.Y.3d at 226*. Here, it is undisputed that the public hearing and proceeding conducted by the Superintendent did not rise to the full level of those employed in a court of law. However, plaintiffs have not demonstrated that a quasi-judicial proceeding was required under *Insurance Law § 7312*.

Plaintiffs' argument arises from the decision in *ABN AMRO, 17 N.Y.3d 208, 952 N.E.2d 463, 928 N.Y.S.2d 647*, in which the Court found that policyholders were not collaterally estopped from bringing claims in a plenary action under the Debtor and Creditor Law in connection with the corporate restructuring of [**14] an insurance company, where the restructuring was approved by the Superintendent. In that case, the Court found that the plaintiffs' claims were sustainable for two reasons. First, nothing in the Insurance Law placed the review of claims asserted under the Debtor and Creditor Law under the exclusive jurisdiction of the Superintendent. Therefore, the statute did not specifically exclude the assertion of such claims in a plenary action. [*15]

Furthermore, even if the Superintendent had addressed the Debtor and Creditor claims, which it did not, the plaintiffs could not be collaterally estopped from asserting such claims because they had not had a full and fair opportunity to contest the issues. Specifically, for collateral estoppel to apply, the proceeding conducted by the Superintendent would have to have been quasi-judicial in nature, which, as described above, would be one employing procedures substantially similar to those used in a court of law. *Id. at 226*.

In finding that the plaintiffs did not have a full and fair opportunity in that case, the Court noted that the corporate defendant had submitted a private application to the Superintendent and the Superintendent accepted the truth of defendants' submissions. Id. The Court also noted that the Superintendent did not conduct public hearings or provide public notice before rendering his

determination. Id.

The case at hand is distinguishable from the decision in *ABN AMRO*. Here, the [**15] issues underlying plaintiffs' causes of action were specifically placed within the exclusive purview of the Superintendent, to be decided pursuant to the procedures set forth in the Insurance Law. Further, [*16] such procedures, unlike those at issue in ABN AMRO, provided plaintiffs with an opportunity to be heard by the Superintendent before the Plan was approved.

Specifically, a copy of the Plan was provided to the Policyholders along with notice of the public hearing. Moreover, the Superintendent held such a public hearing and Grossman, among others, spoke at the hearing and submitted written opposition to the Plan to the Superintendent. In fact, it is undisputed that the objections raised in Grossman's submission, particularly as to the fairness of the Plan, were directly considered by the Superintendent and rejected. Moreover, unlike ABN AMRO, the Policyholders here were given a chance to vote to approve or disapprove the Plan, and they voted overwhelmingly to approve it. In light of the foregoing, the court finds that plaintiffs have not demonstrated that the public hearing held by the Superintendent had to be quasi judicial in nature as described in the ABN AMRO decision.

In sum, the Court finds that the issues underlying plaintiffs' causes of action, i.e., whether the terms of the demutualization and conversion of SBLI were fair or equitable to the Policyholders and whether the Information [*17] Booklet provided Policyholders with sufficient information to make an informed decision in voting whether to approve the Plan, are within the exclusive jurisdiction of the Superintendent to determine in the first instance. As such, they must [**16] be challenged pursuant to *CPLR Article 78*, as Grossman has done under a separate index number, rather than in a plenary action. Therefore, the motion to dismiss the amended complaint is granted and the amended complaint is dismissed.

Article 78

Grossman commenced the instant *Article 78* proceeding in February 2015, against the Superintendent and the individual officials who approved the Plan. Grossman seeks a determination that the Superintendent's approval of the Plan was improper, and seeks rescissory damages. Respondents move to dismiss the petition for failure to state a cause of action. For the reasons stated below, the motion is granted and the petition is dismissed.

The petition sets forth two causes of action. The first cause of action alleges that the Superintendent abused his discretion by electing, under such discretion, to hold an adjudicatory hearing, i.e. a quasi-judicial hearing, rather than an informational public hearing as required by *Insurance Law § 7312 (i)*. The petition [*18] further alleges that, in holding such a hearing, the Superintendent failed to follow the procedures for such adjudicatory hearings as set forth in the New York State Administrative Procedure Act (APA), *§ 301, et seq.*

This cause of action is dismissed. *Insurance Law § 7312 (i)* provides that, in the context of a demutualization,

> [**17] "The superintendent shall hold a public hearing upon the fairness of the terms and conditions of the plan of reorganization, the reasons and purposes for the mutual life insurer to demutualize, and whether the reorganization is in the interest of the mutual life insurer and its policyholders, and not detrimental to the public."

It further provides, in relevant part, that

> "Notice stating the time, place and purpose of the hearing shall be mailed by the mutual life insurer to each policyholder entitled to notice of the hearing . . . . Such notice shall be preceded or accompanied by a true and complete copy of the plan, or by a summary thereof approved by the superintendent, and such other explanatory information as the superintendent shall approve or require."

Here, it is undisputed that the Superintendent held a public hearing after proper notice to the Policyholders. Further, it is undisputed that several [*19] of the Policyholders, including Grossman, submitted oral and/or written arguments against the Plan, which submissions were directly considered by the Superintendent in the Decision. In light of these facts, it is clear that the Superintendent followed the requirements of *section 7312*.

Grossman's assertion that the Superintendent, in fact, held an adjudicatory hearing, is unpersuasive. First, the Decision specifically states that "[c]ontrary to Mr.

Grossman's assertion, the public hearing required by *Section 7312(i)* does not constitute an adjudicatory proceeding under the New York State Administrative Procedure Act." Decision at 10, n. 33. Moreover, it is well-established that public hearings do not generally rise to the level of quasi-judicial hearings. See [**18] *Tuccio v. Central Pine Barrens Joint Planning and Policy Commn, 67 A.D.3d 689, 692, 888 N.Y.S.2d 562 (2d Dep't 2009)*; *Yilmaz v. Foley, 63 A.D.3d 955, 956, 881 N.Y.S.2d 154 (2d Dep't 2009)*.

Nothing in the record here indicates that the Superintendent held an adjudicatory hearing, such as would be governed by the APA. The record indicates that the Superintendent held a public hearing as set forth in the Insurance Law, and that Grossman availed himself of the opportunity to participate in that hearing and to have his arguments considered by the Superintendent.

The court notes Grossman's assertion that the hearing held by the Superintendent was flawed because the Superintendent [*20] failed to accept a supplemental submission from Grossman, which, Grossman admits, was submitted after the deadline for such submissions. However, the Decision specifically states that "on September 12, 2014, over a week after the hearing record closed, the Department received a supplemental submission from Howard Grossman. This submission was not made a part of the hearing record but was considered as part of the Department's review and analysis of the Sponsored Demutualization." Decision at 10, n 33. Thus, Grossman's assertion that the Superintendent failed to consider his supplemental submission is unpersuasive.

In light of the foregoing, the first cause of action in the petition is dismissed.

[**19] Grossman's second cause of action asserts that the superintendent's approval of the Plan is not supported by substantial evidence, under *CPLR 7803 (4)*. Specifically, the petition alleges that the Superintendent erred in finding the compensation provided to the Policyholders was fair and equitable. The gravamen of the petition is that the amount of such compensation was derived from an inaccurate assessment of SBLI's financial health at the time of the demutualization. Grossman alleges that, after the Plan was conceived by the [*21] SBLI's board, SBLI's financial status improved, as the market for mortgage-backed securities improved. Thus, the petition contends that the Policyholders are entitled to an increased amount of monetary compensation.

As a threshold matter, the court finds that whether the Decision is supported by substantial evidence is not the appropriate standard of review here. As discussed above, the public hearing held by the Superintendent was not quasi-judicial in character, "employing procedures substantially similar to those used in a court of law." *ABN AMRO, 17 N.Y.3d at 226*. As such, review under *CPLR 7803 (4)* is not appropriate. See *Board of Trustees of Inc. Vil. of E. Williston v. Board of Trustees of Inc. Vil. of Williston Park, 119 A.D.3d 679, 679 (2d Dep't 2014)*.

Instead, the court finds that review of the Superintendent's decision is appropriate under *CPLR 7803 (3)*, which provides, in relevant part that the court must review whether a determination was made in violation of lawful procedure, was affected by an error of law or was arbitrary and capricious or an abuse of discretion. Grossman contends that the petition should be [**20] granted, in any event, because the Superintendent's decision was arbitrary and capricious and not supported by the facts.

"The test for whether an administrative agency's determination is arbitrary and capricious is whether the determination is without [*22] sound basis in reason and is generally taken without regard to the facts." *Muhammad v. Zucker, 137 A.D.3d 429, 430, 26 N.Y.S.3d 276 (1st Dep't 2016)*(internal quotation marks omitted), quoting *Pell v. Board of Educ. of Union Free School Dist. No. 1 of Towns of Scarsdale & Mamaroneck. Westchester County, 34 N.Y.2d 222, 231, 313 N.E.2d 321, 356 N.Y.S.2d 833 (1974)*; *Mankarios v. New York City Taxi & Limousine Commn., 49 A.D.3d 316, 317, 853 N.Y.S.2d 69 (1st Dep't 2008)*.

"[I]t is not the role of the court to weigh the desirability of the proposed action, choose among alternatives, resolve disagreements among experts, or substitute its judgment for that of the agency." *Coalition Against Lincoln W., Inc. v. Weinshall, 21 A.D.3d 215, 222, 799 N.Y.S.2d 205 (1st Dep't 2005)* (internal quotation marks and citations omitted); see *Roosevelt Islanders for Responsible Southtown Dev. v. Roosevelt Is. Operating Corp., 291 A.D.2d 40, 54, 735 N.Y.S.2d 83 (1st Dep't*

2001). Here, the petition fails to demonstrate that the Decision is arbitrary and capricious or without sound basis in reason or that it was made without regard to the facts. The court finds that the Superintendent based his decision on a detailed analysis of the merits of the Plan and reasonably found that the Plan, particularly the amount of Policyholder compensation, was fair and equitable to the Policyholders.

[**21] In the Decision, the Superintendent recognized that, "[w]hile all of the statutory factors must be satisfied, the issue of whether the Plan fairly and equitably compensates SBLI's policyholders is the overarching concern of *Section 7312*, and is the fundamental issue for the Department's review." Decision at 12. In order to determine whether the compensation was fair, the Superintendent considered expert [*23] opinions as well as the testimony and objections of Policyholders, including Grossman.

The Superintendent conducted a detailed analysis of SBLI's financial history, including its dividend history, as well as its current financial status and its financial prospects. Based on all these factors, the Superintendent first determined that it was in the best interests of SBLI to be reorganized and sold to a third party, rather than to maintain the status quo or to be placed in receivership.

In determining whether the specific amount of compensation was fair, the Superintendent considered similar cases of demutualization and examined the amount of compensation received in such cases. He noted that SBLI had been searching for a buyer since at least 2004, but had only found one prospect, i.e. Prosperity. The Superintendent noted that

> "Valuing a small life insurance company such as SBLI is imprecise in that there is a limited market for such companies, and, thus few similar transactions available to use as benchmarks. The limited market is due to the fact that the potential profit margin to be realized from acquiring a small life insurance company is small while the potential loss is large, resulting [*24] in an uncertain or even unfavorable [**22] risk/reward calculus."

He also noted that Prosperity's first offer was for only $12.5 million in consideration to eligible Policyholders. However, that offer eventually improved to $36 million, on top of $4 million in expenses. He further stated that, the fact that Prosperity's offer was by far the best that the company had "received either before or after the financial crisis tends to support a determination that the Policyholder Consideration is fair and equitable."

The Superintendent also considered the risk to Prosperity in purchasing SBLI. He stated that

> "In acquiring SBLI, Prosperity will need to rebuild a sales platform and SBLI's name recognition by developing a viable market strategy, constructing products suitable to that strategy and hiring and training sales staff to sell these products. It will have to grapple with the inadequate records left behind by the SBLI System and confront an unusually high expense structure that, despite the fact that SBLI does not have any acquisition expenses, ranks in the fourth quartile for per policy expenses."

"In other words, Prosperity is spending $40 million - $36 million of which will go to Eligible Policyholders [*25] - for the opportunity to right the SBLI ship." Decision at 23.

Based on these factors, and others, the Superintendent reasonably found that the amount of compensation was fair and equitable to the Policyholders.

[**23] The Superintendent also analyzed the sufficiency of the "Closed Block", which "is an accounting mechanism that provides certain protections to owners of traditional dividend-paying life insurance policies. Assets are allocated to the Closed Block to produce income which, together with anticipated revenue from the Closed Block Policies, is reasonably expected to be sufficient to pay claims, expenses, and to maintain SBLI's current dividend scale." Decision at 18.

The Superintendent found that the amount of funds in the Closed Block set forth in the Plan, approximately $900 million, "are estimated to be sufficient to pay for the claims and dividends owed on the Closed Block Policies . . . ." Decision at 26. Grossman has not demonstrated that this finding is without basis in reason or was made without regard to the facts of this case.

With regard to the issue of funding the Closed Block with sufficient assets to maintain SBLI's current dividend scale, the Superintendent acknowledged the complaint of some of the Policyholders [*26] that the current dividend scale was lower than its historical dividend scale. However, the Superintendent reasonably

found that the current dividend scale was the correct means by which to measure such funding because it reflected SBLI's current experience on its in-force policies. Id.

Grossman contends that, in any event, the Superintendent's analysis is flawed because the financial markets began to improve after the Plan was developed. Specifically he contends that, by 2013, the market for mortgage-backed securities had improved, which meant that SBLI's [**24] financial condition was improving. He contends that the Superintendent failed to account for this change. However, in the Decision, the Superintendent specifically addressed this issue, stating

> "Mr. Grossman . . . . believes that the terms of the Sponsored Demutualization are stale, as Prosperity and SBLI entered into an agreement in 2012. However, the terms of the Sponsored Demutualization have changed since that time. The proposal first submitted to the Department called for SBLI policyholders to receive $12.5 million in policyholder consideration. The Department deemed the Policyholder Consideration to be insufficient under the [*27] circumstances. The current terms of the Plan did not come together until November 2013.

As set forth above, the court's role here is not to substitute its judgment for that of the Superintendent, but to determine whether his decision was arbitrary and capricious. Petitioner has not made such a showing. Based on the foregoing review of the Decision, it is clear that the Superintendent's approval of the Plan had a sound basis in reason and was not made without regard to the facts of this case.

Finally, the court notes that the parties sharply dispute two other issues. Specifically, they dispute whether the petition would be moot because, as argued by respondents, SBLI's conversion cannot be undone, and whether rescissory damages would be available to respondents. However, in light of the dismissal of the petition, the court need not address those issues. Accordingly, it is

ORDERED that the motion by defendants Michael Akker, Evelyn F. Murphy, David [**25] Jefferson, Deborah Aguiar-Velez, Theresa Balog, Samuel M. Bemiss III, G. Thomas Rogers, Robert Damante and Prosperity Life Insurance Group, LLC for an order dismissing the amended complaint is granted and the amended complaint is dismissed; [*28] and it is further

ORDERED that defendants' motion for consolidation is denied as moot; and it is further

ORDERED the motion by respondents Benjamin W. Lawsky, Robert Easton and Department of Financial Services move to dismiss the petition is granted; and it is further

ADJUDGED that the petition is denied and the proceeding is dismissed; and it is further

ORDERED that respondents' motion for consolidation is denied as moot; and it is further

ORDERED that the Clerk is directed to enter judgment accordingly.

DATED: August 8, 2016

ENTER:

/s/ Joan B. Lobis

Joan B. Lobis, J.S.C.

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Mell v. Anthem, Inc.

United States District Court for the Southern District of Ohio, Western Division

March 3, 2010, Decided; March 3, 2010, Filed

NO: 1:08-CV-00715

Reporter
2010 U.S. Dist. LEXIS 19056 *; 2010 WL 796751

RONALD D. MELL, SR., et al., Plaintiffs, v. ANTHEM, INC., et al., Defendants.

Subsequent History: Affirmed by *Mell v. Anthem, Inc., 2012 U.S. App. LEXIS 15299 (6th Cir.) (6th Cir. Ohio, 2012)*

Prior History: *Mell v. Anthem, Inc., 264 F.R.D. 312, 2009 U.S. Dist. LEXIS 107539 (S.D. Ohio, 2009)*

Counsel: [*1] Ronald D. Mell, Sr., On Behalf of Themselves and All Others Similarly Situated, Estate of Frieda M. Wilmes, On Behalf of Themselves and All Others Similarly Situated, Robert K. Espel, On Behalf of Themselves and All Others Similarly Situated, James C Matacia, On Behalf of Themselves and All Others Similarly Situated, Plaintiffs: Dennis P. Barron, LEAD ATTORNEY, Cincinnati, OH; Eric H Zagrans, Michael F Becker, LEAD ATTORNEYS, Elyria, OH; Alphonse Adam Gerhardstein, Gerhardstein & Branch Co. LPA, Cincinnati, OH.

For Anthem, Inc., now known as Wellpoint, Inc., Anthem Insurance Companies, Inc., Community Insurance Company, formerly known as Community Mutual Insurance Company, Defendants: Christopher G Scanlon, PRO HAC VICE, Paul Alan Wolfla, LEAD ATTORNEYS, Anne K Ricchiuto, PRO HAC VICE, Baker & Daniels LLP, Indianapolis, IN; Glenn Virgil Whitaker, Kent Allen Britt, LEAD ATTORNEYS, Vorys Sater Seymour & Pease - 1 Atrium Two, Cincinnati, OH; Robert Neal Webner, LEAD ATTORNEY, Vorys Sater Seymour and Pease LLP, Columbus, OH; Adam K Levin, PRO HAC VICE, Hogan & Hartson, Washington, DC; Craig A Hoover, Peter R. Bisio, PRO HAC VICE, Hogan & Hartson LLP, Washington, DC.

For City of Cincinnati, [*2] Ohio, Charlie Luken, former mayor of Cincinnati City Council, and his successors in office, Laketa Cole, former members of Cincinnati City Council, and his successors in office, Minette Cooper, former members of Cincinnati City Council, and his successors in office, John Cranley, former members of Cincinnati City Council, and his successors in office, David Crowley, former members of Cincinnati City Council, and his successors in office, Pat DeWine, former members of Cincinnati City Council, and his successors in office, Chris Monzel, former members of Cincinnati City Council, and his successors in office, David Pepper, former members of Cincinnati City Council, and his successors in office, Alicia Reece, former members of Cincinnati City Council, and his successors in office, James Tarbell, former members of Cincinnati City Council, and his successors in office, Defendants: Paul Alan Wolfla, LEAD ATTORNEY, Baker & Daniels LLP, Indianapolis, IN; Terrance A Nestor, LEAD ATTORNEY, City of Cincinnati, Cincinnati, OH.

Judges: S. Arthur Spiegel, United States Senior District Judge.

Opinion by: S. Arthur Spiegel

Opinion

OPINION AND ORDER

This matter is before the Court on the cross motions of the parties: The Wellpoint [*3] Defendants' Motion for Summary Judgment (doc. 32), Plaintiffs' Response in Opposition (doc. 47), and Defendants' Reply (doc. 50); Plaintiffs' Motions for Partial Summary Judgment on Liability (docs. 33, 36), The City of Cincinnati's Response in Opposition (doc. 45), The Wellpoint Defendants' Response in Opposition (doc. 46), and Plaintiffs' Reply (doc. 52); and the City of Cincinnati's Motion for Summary Judgment (doc. 37), Plaintiffs' Response (doc. 48), and the City's Reply (doc. 51). The Court held a hearing on these matters on November 4, 2009, after which it found it appropriate to order supplemental discovery. The Court held a second hearing, on February 25, 2010, at which time it considered the outcome of such discovery, as well as the arguments of the parties as to Defendants' Motion to Certify Question to the Supreme Court of Ohio (doc. 87) and Plaintiffs' Response in Opposition (doc. 89).

For the reasons indicated herein, the Court GRANTS the Wellpoint Defendants' motion for summary judgment, DENIES the Plaintiffs' motions, GRANTS IN PART AND DENIES IN PART the City's motion, and DENIES Defendants' motion to certify as MOOT.

I. General Background

This case involves Plaintiffs' [*4] claims that they were cheated out of proceeds as insureds, when Defendant Anthem Insurance ("Anthem") demutualized in 2001 and issued 870,021 shares of stock to the City of Cincinnati ("the City"), Plaintiffs' employer, instead of to Plaintiff policy holders (doc. 1). The City ultimately sold the stock for approximately $ 55 million, the amount Plaintiffs seek to recover in this action (*Id.*). Plaintiffs allege they are a class of 2,460 individuals named as insured persons, or who were members of a group of insured persons covered under the Group Policy during the relevant time period (*Id.*). In addition to Anthem and the City, Plaintiffs name as Defendants Anthem, Inc. (n/k/a "Wellpoint Inc."), the parent corporation of both Defendant Anthem Insurance and its subsidiary, Defendant Community Insurance Company ("CIC"). Plaintiffs assert numerous state common law claims in diversity for breaches of multiple contracts, conversion, and misappropriation, aiding and abetting conversion and misappropriation, breach of fiduciary duties, breach of agency agreement and fraudulent concealment, and seek compensatory damages and other relief (*Id.*).

On November 4, 2009, the Court conditionally certified [*5] this matter as a class action encompassing employees and retirees of the City who were named insureds or members of groups named as insureds, insured continuously from June 18, 2001, to November 2, 2001 (doc. 53). The class includes two subsets, 1) "Class A," those who had insurance prior to the merger between Community Mutual Insurance Company ("CMIC") and Anthem in 1995, and 2) "Class B," those who received insurance post-merger (*Id.*).

The parties filed cross motions for summary judgment (docs. 32, 33, 36, 37), all asserting there are no genuine issues of fact in dispute, while taking diametrically opposing views of how the law applies to this case. Essentially, Plaintiffs argue Ohio law entitles Class A members to demutualization proceeds. They premise their argument on the definition section in the Ohio demutualization statute, *Ohio Rev. Code § 3913.20(B)*, which defines the person "named as the insured," as the policyholder. They contend under the law the policyholder is entitled to demutualization proceeds. Plaintiffs argue they are the persons named as the insureds and therefore they were entitled to the demutualization proceeds as policyholders under Ohio law. Plaintiffs further [*6] argue that Class B members are entitled to proceeds based on express terms in the merger agreement, and, at least originally, based on a certificate in the possession of one of the class representatives. Defendants argue Ohio demutualization law does not apply, and even if it does, that Plaintiffs misinterpret such law. Defendants contend there is no dispute the City owned the group policy, and as such, even if Ohio law applies, the City appropriately took the proceeds of the demutualization. Defendants further

argue the Plaintiffs incorrectly assert claims for Class B members, because there was never a requisite break in insurance coverage to trigger the rights they assert. Finally, Defendants contend the document Plaintiff Schenck (o/b/o Wilmes) proffers proves nothing as it does not identify the insured and contains no information tying it to the City's retiree benefit plan. At the February 25, 2010 hearing, it appears that all parties agreed the Schenck document, and the few others unearthed in discovery, do not serve to establish rights of Class B members. [1]

II. The Summary Judgment Standard

Although a grant of summary judgment is not a substitute for trial, it is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." *Fed. R. Civ. P. 56*; *see also, e.g.,* Poller v. Columbia Broadcasting System, Inc., 368 U.S. 464, 82 S. Ct. 486, 7 L. Ed. 2d 458 (1962); LaPointe v. United Autoworkers Local 600, 8 F.3d 376, 378 (6th Cir. 1993); Osborn v. Ashland County Bd. of Alcohol, Drug Addiction and Mental Health Servs., 979 F.2d 1131, 1133 (6th Cir. 1992) (per curiam). In reviewing the instant motion, [*8] "this Court must determine whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." Patton v. Bearden, 8 F.3d 343, 346 (6th Cir. 1993), *quoting in part* Anderson v. Liberty Lobby, Inc., 477 U.S. 242 251-252, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986) (internal quotation marks omitted).

The process of moving for and evaluating a motion for summary judgment and the respective burdens it imposes upon the movant and non-movant are well settled. First, "a party seeking summary judgment … bears the initial responsibility of informing the district court of the basis for its motion, and identifying those portions of [the record] which it believes demonstrate the absence of a genuine issue of material fact [.]" Celotex Corp. v. Catrett, 477 U.S. 317, 323, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986); *see also* LaPointe, 8 F.3d at 378; Guarino v. Brookfield Township Trustees, 980 F.2d 399, 405 (6th Cir. 1982); Street v. J.C. Bradford & Co., 886 F.2d 1472, 1479 (6th Cir. 1989). The movant may do so by merely identifying that the non-moving party lacks evidence to support an essential element of its case. *See* Barnhart v. Pickrel, Shaeffer & Ebeling Co. L.P.A., 12 F.3d 1382, 1389 (6th Cir. 1993).

Faced [*9] with such a motion, the non-movant, after completion of sufficient discovery, must submit evidence in support of any material element of a claim or defense at issue in the motion on which it would bear the burden of proof at trial, even if the moving party has not submitted evidence to negate the existence of that material fact. *See* Celotex, 477 U.S. at 317; Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986). As the "requirement [of the Rule] is that there be no genuine issue of *material* fact," an "alleged factual dispute between the parties" as to some ancillary matter "will not defeat an otherwise properly supported motion for summary judgment." Anderson, 477 U.S. at 247-248 (emphasis added); *see generally* Booker v. Brown & Williamson Tobacco Co., Inc., 879 F.2d 1304, 1310 (6th Cir. 1989). Furthermore, "[t]he mere existence of a scintilla of evidence in support of the [non-movant's] position will be insufficient; there must be evidence on which the jury could reasonably find for the [non-movant]." Anderson, 477 U.S. at 252; *see also* Gregory v. Hunt, 24 F.3d 781, 784 (6th Cir. 1994). Accordingly, the non-movant must present "significant probative evidence" demonstrating that "there [*10] is [more than] some metaphysical doubt as to the material facts" to survive summary judgment and proceed to trial on the merits. Moore v. Philip Morris Cos., Inc., 8 F.3d 335, 339-340 (6th Cir. 1993); *see also* Celotex, 477 U.S. at 324; Guarino, 980 F.2d at 405.

Although the non-movant need not cite specific page numbers of the record in support of its claims or defenses, "the designated portions of the record must be presented with enough specificity that the district court

[1] Counsel for Plaintiff stated, "The rights in Group B. . .to demutualization compensation when Anthem demutualized, are [*7] similarly not dependent on any of the documents that were produced in the supplemental discovery." Moreover, Plaintiffs stated in their Reply to Defendants' Responses to Plaintiffs' Motion to Approve Notice to Non-Class Members, "These documents [the Summary of Benefits form and the Certificate of Membership form] do not provide the legal entitlement to demutualization compensation; they merely demonstrate which path to demutualization compensation the worker is entitled." (doc. 82).

can readily identify the facts upon which the non-moving party relies." *Guarino, 980 F.2d at 405*, *quoting Inter-Royal Corp. v. Sponseller, 889 F.2d 108, 111 (6th Cir. 1989)* (internal quotation marks omitted). In contrast, mere conclusory allegations are patently insufficient to defeat a motion for summary judgment. *See McDonald v. Union Camp Corp., 898 F.2d 1155, 1162 (6th Cir. 1990)*. The Court must view all submitted evidence, facts, and reasonable inferences in a light most favorable to the non-moving party. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587, 106 S. Ct. 1348, 89 L. Ed. 2d 538 (1986)*; *Adickes v. S.H. Kress & Co., 398 U.S. 144, 90 S. Ct. 1598, 26 L. Ed. 2d 142 (1970)*; *United States v. Diebold, Inc., 369 U.S. 654, 82 S. Ct. 993, 8 L. Ed. 2d 176 (1962)*. Furthermore, the district [*11] court may not weigh evidence or assess the credibility of witnesses in deciding the motion. *See Adams v. Metiva, 31 F.3d 375, 378 (6th Cir. 1994)*.

Ultimately, the movant bears the burden of demonstrating that no material facts are in dispute. *See Matsushita, 475 U.S. at 587*. The fact that the non-moving party fails to respond to the motion does not lessen the burden on either the moving party or the Court to demonstrate that summary judgment is appropriate. *See Guarino, 980 F.2d at 410*; *Carver v. Bunch, 946 F.2d 451, 454-455 (6th Cir. 1991)*.

III. Mutual Companies and Demutualization

The insurance industry is organized under two basic corporate structures: stock and mutual. In general, mutual insurance exists where several persons have joined together for their united protection, each member contributing to a fund for the payment of losses and expenses. [2] Generally speaking, each member is both an insurer and an insured, and the mutual company is owned and controlled by its policyholders. [3] Most mutual insurers are incorporated under state laws that establish provisions for such entities. [4]

Stock insurance companies, by contrast, are owned by their shareholders, and their purpose is primarily to earn profit for their shareholders. [5] Stock companies can issue stock and therefore possess the ability to increase their reserves and surplus beyond what mutual companies can generate internally. [6] For this primary reason, among others, there has been a strong trend of mutual companies changing their corporate structure to stock companies, through a process called demutualization. [7]

The demutualization process involves a variety of professional disciplines and legal issues, and requires expert actuarial, legal, and accounting advice. [8] The process of demutualizing requires preparing and printing substantial information to policyholders. [9] The mutual must make a determination, based on the company's by-laws, articles of incorporation, and applicable law, as to which policyholders are entitled to vote on the demutualization and receive consideration. [10] Moreover, in the context of group policies, the mutual must determine who the owner is, the employer or the

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[2] Lee R. Rust and Thomas F. Segalla, *Couch on Insurance 3D*, § 39.15 (1995).

[3] *Id*.

[4] Robert E. Keeton [*12] and Alan I. Widiss, *Insurance Law: A Guide to Fundamental Principles, Legal Doctrines and Commercial Practices*, § 2.1(a)(3) (1988).

[5] John Alan Appleman, *18 Insurance Law and Practice*, Ch. 344, § 10041 (1945).

[6] James A. Smallenberger, Insurance Law Annual: Restructuring Mutual Life Insurance Companies, *49 Drake L. Rev. 513 (2001)*. Naturally, restructuring implicates other issues, as the company must also be prepared to deal with consequences of a new corporate structure including proxy solicitations, periodic shareholder reports, and the risks of proxy contests and takeover threats. Gordon O. Pehrson, Jr., David R. Woodward, and James H. Mann, Demutualization of Insurance Companies: A Comparative Analysis [*13] of Issues and Techniques, *27 Tort & Ins. L.J. 709 (1992)*.

[7] *Id*. Since the 1930's over 200 mutual companies converted to stock companies. *Couch on Insurance 3D*, § 39:43. From 1996 to 2001, twenty-eight mutual life insurance companies either completed or announced plans to reorganize into a different corporate structure. Smallenberger, 517. By the end of 1999, only 106 out of 1470 life insurance companies in the United States were mutual companies. *Id*.

[8] Gordon O. Pehrson, Jr., David R. Woodward, and James H. Mann, Demutualization of Insurance Companies: A Comparative Analysis of Issues and [*14] Techniques, *27 Tort & Ins. L.J. 709 (1992)*.

[9] *Id*.

[10] Smallenberger, 532.

individual insureds. [11]

In Ohio, the conversion of mutual companies to stock companies is governed by *Ohio Revised Code §§ 3913.10 to 3913.23*. The provisions are divided such that the initial sections pertain to the conversion of mutual life insurance policies, while the latter sections pertain to non-life insurance policies. *Section 3913.21* sets out a detailed procedure by which a mutual company can convert to a stock company. [12] The rights of mutual policy holders are set out in *Section 3913.22*. Each mutual policyholder is entitled to such shares of stock in the new corporation as his or her portion of equitable value of the mutual company will purchase. *Ohio Rev. Code § 3913.22*. "Shares shall be issued to the owner or owners of a mutual policy in force on the date of the examination. . . as such owner or owners appear on the face of the policy." *Id*. at *§ 3913.22(C)*. In an earlier definitional section, which Plaintiffs rely on in this case, the Ohio statute also states "'Policyholder' means the person, group of persons, association, corporation, partnership, or other entity named as the insured under a mutual policy of insurance. [*15] . ." *Id*. at *§ 3913.20*. [13] As such, the Ohio demutualization statute uses both the terms "owner" and "policyholder," in relation to demutualization proceeds.

IV. The Record

The factual background, as taken from the record, is as follows. In February 1986 the City entered into a Master Contract with Community Mutual Insurance Company ("CMIC") to provide Blue Cross/Blue Shield medical and hospitalization coverage for its employees, in addition to dental coverage for City firefighters. CMIC, an Ohio mutual insurance company, [*17] had bylaws in place stating that each policy holder of the company is a member, but then more specifically stated that "[i]n the case of a master contract for group insurance, the member shall be the holder of the master policy, and the holder of any certificate or contract issued subordinate to such master policy shall not be a member unless it makes specific provision for such membership."

In October 1995 CMIC merged with an Indiana company, Associated Insurance Companies ("AIC"), a predecessor of the Wellpoint Defendants. The merger was governed by *Ohio Revised Code § 3941.35 et seq*., which requires the merging entities to seek approval from their members and to file an agreement with the state superintendent of insurance to petition for approval of the merger. In their Joint Petition, CMIC and AIC stated that group policyholders are members and "[t]he holders of certificates of benefits issued under CMIC's group policies are not members of CMIC, are not entitled to vote and do not have proprietary rights in CMIC." The Ohio superintendent of insurance queried whether the certificate holders under CMIC's group contracts, rather than the employers, would receive guaranty policies/membership [*18] certificates, and thus become members of AIC. In response, CMIC stated the terms of the guaranty policies would provide that "the group policyholders (e.g., the employers), not the certificate holders (e.g. the employees), are the members. . .and will have equity rights. . ." The superintendent ultimately approved the merger in all respects. As a result of the merger, CMIC ceased to

[11] *Id*., 533.

[12] The process involves filing a resolution adopted by majority vote, along with financial statements and other documentation, with the Ohio superintendent of insurance. The superintendent, after a review of the documents, if satisfied that the proposed conversion is not contrary to law, must order an examination of the company, after which the superintendent should appoint an appraisal committee. The committee makes a determination of value of the company and determines the number of shares of the new corporation. Within sixty days of such determination, the policyholders, who must have thirty days notice, are called to a meeting to vote on the proposed conversion. If a majority favors conversion, then the superintendent sets a hearing, providing thirty days notice to all policyholders and notice by publication in a newspaper of the county where the home office of the company is located. If after the hearing, the superintendent is satisfied the conversion is proper, he shall issue an order accepting the report of the appraisal committee [*16] and authorizing the conversion. After such order issues, the new articles of incorporation of the new corporation shall by filed with the secretary of state.

[13] Indiana has a similar statutory scheme authorizing and regulating the process of demutualization. *Ind. Code Ann. § 27-15-1-1 et seq*. Instead of using the terms "policyholder," "owner" or "insured," Indiana uses the term "member," and defines members to be a person that according to the records, articles of incorporation, and bylaws, is a member of the converting mutual. *Ind. Code Ann. § 27-15-1-9*. Members are given "interests" in voting rights, as provided by law and by the company's articles of incorporation and bylaws, as well as rights to receive cash, stock, or other consideration in the event of a conversion to a stock insurance company. *Ind. Code Ann. § 27-15-1-10*.

exist, and its members became insured by Community Insurance Company ("CIC"), a subsidiary of AIC. Although CMIC disappeared, the merger documents provided that the former CMIC members would retain their rights under Ohio law, even though they were now members of an Indiana mutual insurance company. Soon after the merger, AIC changed its name to Anthem Insurance Companies, Inc. ("Anthem").

CMIC was not the only acquistion of AIC/Anthem. In the 1980's and 1990's it merged with numerous companies around the country to expand its geographic presence outside of Indiana. In 1993 AIC/Anthem acquired a Kentucky Blue Cross/Blue Shield licensee, Southeastern Mutual Insurance Company ("Southeastern") and in 1997 it merged with Blue Cross/Blue Shield of Connecticut (BC/BS-CT). As a result of these mergers, AIC/Anthem [*19] had diverse members with grandfathered rights based on the original entities' bylaws and on varying state laws. AIC/Anthem's original Indiana members, for example, were defined as the "enrollees" (the insureds); the group policyholders (the employers) were not.

In June 2001, the Board of Directors of AIC/Anthem approved a plan to demutualize, and submitted their proposal to the Indiana Department of Insurance. The Indiana Department completed a review of the merger documents, CMIC bylaws, and the Ohio superintendent's approval of the merger, and then conducted a public hearing regarding the proposed conversion. Following the hearing, the Indiana Department approved the plan of conversion, issuing an Order stating that "individual certificate holders under group Policies issued to groups by Anthem Insurance's Kentucky, Ohio and Connecticut subsidiaries prior to its mergers with those former mutual companies are not Statutory Members (the group policyholders are Statutory Members)." The demutualization became effective on November 2, 2001, and Anthem issued 870,021 shares of its common stock to the City, as well as shares to others it considered members entitled to proceeds. [14]

V. The Parties' Arguments

The Court has reviewed the briefing in this matter, which is extensive. The Court further held hearings on November 4, 2009, and February 25, 2010, which served to boil [*21] this matter down to its core elements. Those core elements, as the Court sees it, are 1) the issue of what law applies and what that law means 2) the issue of whether new rights were triggered under the merger document, and 3) the significance of the Schenck document and the others like it.

Defendants argued first that the City was the policyholder and member of the mutual by virtue of the CMIC by-laws, that regulators specifically addressed such question in the 1995 merger, and the insureds received what they were entitled to: insurance. In Defendants' view, Ohio demutualization law does not even apply to this case, because when Anthem demutualized in 2001, it was an Indiana company and the process was governed by Indiana law.

The Court queried whether the Plaintiffs would have been entitled to demutualization proceeds in 1994, had CMIC demutualized in Ohio. Defendants took the position that Plaintiffs would not have been entitled to such proceeds, as Ohio demutualization law authorizes and directs that such proceeds go to the owner of the policy. As there is no dispute that the City owned the policy, Defendants contend it would have been entitled to the proceeds.

Looking at the exact [*22] same documents, Plaintiffs arrive at the opposite legal conclusion. Plaintiffs responded that in their view, had CMIC demutualized before the merger, under Ohio law, the City workers would have been entitled to demutualization proceeds.

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[14] Anthem's [*20] demutualization has been no stranger to controversy. Kentucky retirees insured under a Kentucky State Retirement System plan sued claiming entitlement to $ 1.3 million shares of Anthem stock. *Love, et al. v. Board of Trustees of the Kentucky Retirement System, et al.*, No. 02-CI-00122, (Franklin Circuit Court, Division II) May 27, 2004. Connecticut and Ohio employees did so as well. *AFSCME et al. v. Andover, No. X01CV030182395S, 2004 Conn. Super. LEXIS 3240, 2004 WL 2829835, *1 (Conn. Sup. Nov. 3, 2004)*, *Gold v. Rowland, No. CV02813759, 2006 Conn. Super. LEXIS 2837, 2006 WL 2808629, *1 (Conn. Sup. July 26, 2006)*, *Greathouse v. City of East Liverpool, 159 Ohio App. 3d 251, 2004 Ohio 6498, 823 N.E.2d 539 (Ohio Ct. App. 2004)*, *State of Ohio, ex rel. Teamsters Local Union No. 637 v. City of Marietta, 2005 Ohio 7108 (Ohio Ct. App. 2005)*. Even the Indiana insureds, who unlike the Ohio, Kentucky, and Connecticut insureds received demutualization proceeds, sued claiming they did not get their fair share. *Ormond v. Anthem, No. 1:05-CV-1908-DFH-TAB, 2008 U.S. Dist. LEXIS 30230, 2008 WL 906157, *1 (S.D. Ind. March 31, 2008)*.

In Plaintiffs' view, the CMIC bylaws conflict with Ohio law when it comes to demutualization. Under Ohio law, argue Plaintiffs, "policyholder" is defined as the person "named as the insured," which would be the employee, and not the City. Ohio demutualization law applies, contend Plaintiffs, because the rights and interests of CMIC members were frozen in time based on the merger agreement. Under Ohio law, Plaintiffs contend, "policyholders" are entitled to demutualization proceeds.

The parties also addressed the issue of the "Class B" Plaintiffs. These Plaintiffs assert rights based on the merger document. As Plaintiffs see it, any new insurance issued after the merger would trigger equity rights for employees. [15] Plaintiffs contend that a human organ transplant rider ("HOT rider") added in 1998 did just that. Moreover, at the November hearing, Plaintiffs proffered a certificate of membership held by Plaintiff Schenck that states "As long as the guarantee [*23] policy is in effect, you'll be a member of Associated, entitled to all rights of membership in Associated accorded to members of a mutual insurance company under the Indiana Insurance Law. . .including. . .equity rights in the event of. . .demutualization." Plaintiffs argued this certificate, dated October 1995, evidences new coverage issued post-merger, and on its face shows Plaintiffs have equity rights.

Defendants responded that the merger documents provide that there must be a break in coverage in order to trigger equity rights for the employees. In their view, so long as the original master contract was renewed, amended or replaced, without a lapse in coverage, the City retained its status as "member" post-merger. At the November hearing, Defendants further contended the Schenck document "makes no sense at all," all the other documentary evidence is inconsistent, and no other employee or retiree from the City has come forward with a similar document.

Plaintiffs [*24] replied at the November hearing that no other employee had come forward with a document like Schenck's document because the Defendants refused to provide a list of class members until the Court would certify this matter as a class action. As such, Plaintiffs contended at they did not have the opportunity to survey the class to see if others had such a document. For this reason, the Court ordered discovery on the question, so as to leave no stone unturned, and set the issue of the significance of the Schenck document, and any others like it, for the second hearing on February 25, 2010 (docs. 58, 62, 85).

At the November hearing, the City also proffered a copy of its "Group Guaranty Health Policy and Certificate of Membership," on its face dated "Rev. 4/97," which explicitly states that enrollees or covered persons shall not "receive any equity rights by virtue of being an Enrollee." Because Plaintiffs are saying they are a third-party beneficiary to the Guaranty Policy, the City argued the very terms of such policy preclude Plaintiffs from claiming demutualization proceeds, and such claims should fail.

A final matter addressed at the November hearing was the question of the statute of [*25] limitations. Plaintiffs filed their Complaint in October 2008. Plaintiffs contend that as to their contract claims, the applicable statute is fifteen years, and so there is no statute of limitations issue as to such claims. As for their tort claims, Plaintiffs contend a four-year statute of limitations applies, but even if the City is correct that a two-year limitations period applies, they timely filed their Complaint because they discovered their claims in December 2007 and in April of 2008.

Defendants argue the discovery rule does not apply to toll the statute of limitations because the 2001 demutualization and relevant transactions were public facts about which Plaintiffs undoubtedly were aware. In Defendants' view, constructive knowledge of facts, rather than their legal significance, is enough to start the statute of limitations running. Here, Defendants contend, Plaintiffs claim to have "discovered" their injuries after they were contacted by a lawyer. Such a "discovery," Defendants claim, should not allow Plaintiffs to circumvent the statute of limitations.

VI. Analysis

Having reviewed this matter, the Court finds that Plaintiffs' theory as to Class A members is predicated on [*26] the view that Ohio law categorically excludes a

[15] Plaintiffs premise their theory regarding the new insurance "trigger" on an unexecuted boilerplate form entitled "Group Policy for Future Community Contract Holders" (doc. 31-21), which Defendants contend the City never possessed.

group policy holder from possessing equity rights in a mutual insurance company. Under this view, CMIC's bylaws were ultra vires, and in conflict with Ohio law, which would require that employees automatically gain equity rights when provided insurance through a mutual company.

The two Ohio demutualization cases cited by the parties *Greathouse v. City of East Liverpool, 159 Ohio App. 3d 251, 2004 Ohio 6498, 823 N.E.2d 539 (Ohio Ct. App. 2004)*, and *State of Ohio, ex rel. Teamsters Local Union No. 637 v. City of Marietta, 2005 Ohio 7108 (Ohio Ct. App. 2005)* cast some light on whether Plaintiffs' view is correct. Only *Greathouse* made a determination of who was entitled to demutualization proceeds, and the decision was predicated on the determination that the employer owned the insurance policy. The state appellate court found that because "the City, not appellant, contracted with Anthem and owned the policy, appellant was not entitled to the stock proceeds. As a benefit of his employment, the City provided appellant with health insurance--nothing more. Appellant cannot contend that he somehow owned the policy and was entitled to the stock proceeds." Such decision is not [*27] inconsistent with *Ohio Revised Code § 3913.22(C)* which states that in a demutualization "[s]hares shall be issued to the owner or owners of a mutual policy. . .as such owners appear on the face of the policy."

Although the court in *State of Ohio, ex rel. Teamsters Local Union No. 637* found the reasoning of the *Greathouse* court "sound," it expressly declined to decide the issue of who owned the policy because of the different procedural postures of the cases. *Greathouse* involved an appeal from summary judgment, whereas the *State of Ohio, ex rel. Teamsters Local Union No. 637* case involved an appeal from a Ohio R. Civ. P. 12(B)(6) dismissal. *2005 Ohio 7108, *P12-14*. [16]

In its analysis the state appeals court found the allegation that the bylaws granted equity rights to the plaintiffs precluded the granting of a motion to dismiss. *2005 Ohio 7108 at *P13*. However, the Court made no finding that Ohio law categorically excludes the possibility that an employer could possess the equity rights in a mutual insurance company. Indeed, the very fact that the Court remanded the matter for further proceedings concerning the issue of who owned the policy shows the state court of appeals did not read Ohio law to automatically grant equity rights to insured employees.

Plaintiffs argue the definition section in *Ohio Revised Code § 3913.20* makes them the "policyholder" because they were "named as the insured under a mutual policy." Putting aside the fact that the Court has no policy before it naming any of the Plaintiffs as insured, the Court [*30] finds no question that Plaintiffs were insured by the City's contract with CMIC for group coverage. There appear to be competing authorities on the question of whether insureds in a group policy context are automatically considered "policyholders." At the February 25, 2010 hearing, Plaintiffs' Counsel cited the Ohio Health Insurance Guide, Couch on Insurance, and Anthem's own documents for the proposition that in a group policy those "named as insured" are policyholders. However, the portion of the Ohio Revised Code pertaining to group sickness and accident

[16] In *State of Ohio, ex rel. Teamsters Local Union No. 637 v. City of Marietta*, the appellant union and employees had claimed they were entitled to demutualization proceeds instead of the City of Marietta. *2005 Ohio 7108*. The City filed a motion to dismiss pursuant to ***Rule 12(b)(6)***, which the Washington County Court of Common Pleas granted. *Id*. Appellants challenged such ruling on appeal, contending they had alleged in their complaint that the insurer historically provided in its articles of incorporation and/or bylaws that [*28] employees under a group health insurance plan were the policyholders or owners of the plan. *Id*. The Ohio Court of Appeals reasoned that it had to accept such allegation as true for purposes of evaluating the City's motion to dismiss, and could not look beyond the complaint to evaluate the allegation. *Id*. The Court reversed the trial court's judgment and remanded the matter for further proceedings. *Id*. The Court noted that the question of whether appellants were in fact owners of the health insurance policies was an issue to be explored in further detail on summary judgment, as was presumably done in *Greathouse*. The instant case, too, obviously is in a different procedural posture as the Court has the CMIC bylaws before it, and not mere allegations. The CMIC bylaws specifically state that "In the case of a master contract for group insurance, the member shall be the holder of the master policy, and the holder of any certificate or contract issued subordinate to such master policy shall not be a member unless it makes such provision for such membership." The bylaws then give members (the City here) rights as are prescribed by law for members of mutual insurance companies organized under [*29] the laws of Ohio, by the Articles of [CMIC], the regulations and bylaws, and any policy of insurance issued by CMIC and held by the member (doc. 32-2, Ex. A). The group policy the City held, moreover, explicity states "No Enrollee [insured employee]. . .shall receive any equity rights by virtue of being an Enrollee." (doc. 46-3).

insurance, *Ohio Revised Code § 3923.12(C)(2)*, appears to define the policyholder in group insurance contexts as the employer. Finally, Plaintiffs' Complaint indicates there is no dispute the City owned the policy, and states it may have been deemed a "policyholder" for other purposes, including voting, but contends the City was not a policyholder within the meaning of the demutualization statute.

The Court notes that *Section 3913.22*, which delineates the "Rights of Mutual Policyholders" in a demutualization, uses both the terms policyholder and owner. The term, "policyholder" is defined in *section 3913.20*, while the term "owner" is [*31] not defined. Under the plain meaning rule of statutory construction, the word "owner" can be presumed to be used in its ordinary sense. *Caminetti v. United States, 242 U.S. 470, 485-486, 37 S. Ct. 192, 61 L. Ed. 442 (1917)*("Statutory words are uniformly presumed, unless the contrary appears, to be used in their ordinary and usual sense, and with the meaning commonly attributed to them.") Here, even if Plaintiffs' interpretation is correct that they are "policyholders" under the definition in *section 3913.20*, there is no dispute: they certainly were not owners. *Section 3913.22* states the "shares shall be issued to the owner or owners." [17] *Section 3913.22* specifically addresses who is ultimately entitled to demutualization shares. Effect should be given to every clause and part of a statute, with specific terms prevailing over the more general which otherwise might be controlling. *D. Ginsberg & Sons, Inc. v. Popkin, 285 U.S. 204, 208, 52 S. Ct. 322, 76 L. Ed. 704 (1932)*. Here, should the Court interpret the Ohio statute to only allow insureds to possess equity rights in demutualization proceeds, such interpretation would give no effect to the express specific terms of *section 3919.22(C)* which the Court understands gives "owners" such right. A [*32] better reading of the statute, in the Court's view, is that as a general rule, "policyholders" are the insureds, who are typically "owners" and entitled to proceeds. However in some specific situations, like the one at bar where the City is indisputably the owner of the group policy, the insureds do not necessarily have equity rights.

The Court does not believe the legislature intended to automatically grant employees in the group insurance context equity rights by the simple happenstance of the corporate structure of the mutual insurance company with whom their employer contracted. Nor does the Court believe the legislature intended to prohibit an employer from owning a group policy. The Plaintiffs here had nothing to do with the choice of insurance carrier, nor with its governance, and they received what they bargained with the City [*33] to get: insurance coverage. The employees were not so concerned about what insurance entity provided their coverage, or what legal form such entity took, but rather whether the benefits they had been promised by the employer would be available. There is no evidence in this case the employees were ever denied the benefits they were promised, when the insurer was a mutual or later a stock company. [18]

The Court's conclusion is consistent with the limited Ohio authority on the subject, [*34] but also with the Ohio insurance superintendent's approval of the 1995 merger, and with the Indiana Department of Insurance's approval of the demutualization. [19] Having thus concluded, the Court finds Plaintiffs' interpretation of Ohio law incorrect, and therefore finds that Defendants prevail on their motion for summary judgment as to the Class A Plaintiffs. The City was a legitimate member of CMIC, and after the merger, the City possessed grandfathered rights as a member of the Indiana mutual insurance company. The Indiana demutualization, which took account of the City's rights as a member of CMIC

[17] Plaintiffs read this section to mean that the owner in a group policy context is issued the demutualization proceeds by the insurance company, and then is charged to distribute the proceeds to the insureds. The Court finds Plaintiffs are reading more into the statute than what it says on its face, and opts for traditional statutory construction instead.

[18] From the Court's point of view, unless the terms of the policies or the state law governing insurance have clearly and unqualifiedly stated the employees were entitled to demutualization proceeds, then the Plaintiffs carry a heavy burden to upend the determination that they are not so entitled. Here the Court finds no real question that the insurance policy and the law give equity rights to the employer. In the Court's mind, however, should there be any doubts in this regard, such doubts should be resolved in favor of the employer because the employees, under their compensation package, have never been denied insurance coverage provided for in their insurance agreements. They got what they bargained for.

[19] The Court notes that the regulatory actions by state agencies are entitled to deference, and that the Ohio superintendent was required under law, *Ohio Revised Code § 3941.38(B)(2)*, to ensure the protection of the equity rights of the members. The Court believes the superintendent did so.

pre-merger, therefore properly awarded the demutualization proceeds to the City.

As for Class B members, the Court further finds Plaintiffs' interpretation of the merger document incorrect. Plaintiffs frame the "triggering event," that would provide equity rights to Class B Plaintiffs, as the issuance [*35] of new insurance. No doubt, the issuing of new riders to the underlying policy could be viewed as new insurance. However the merger document does not state that new insurance is the "triggering event." It states:

> The Associated guaranty insurance policy/membership certificate shall continue in effect as long as (a) the insurance policy or health care benefits contract assumed by CIC pursuant to Clause (A) of this Section 3.1 is in effect, or has been renewed, amended, or replaced, without a lapse in coverage, by any CIC insurance policy or health care benefits contract and (b) the membership fees required. . .are paid when due. . .

The Court's reading of this provision is that the guaranty stays in effect so long as there is no lapse in coverage. The Court finds there has been no lapse in coverage in this case. The City has continually maintained its Group Guaranty Health Policy. For this reason, the Court rejects the theory that those Class B "newly-insureds" with human organ transplant coverage gained equity rights.

Finally, the Court finds the existence of the Schenck document proves nothing. First, it cannot serve, as Plaintiffs first claimed, as the evidence of "new insurance" triggering [*36] a change in equity rights for the reason articulated above-- there was no lapse in coverage. Second, the certificate was issued subordinate to the Group Guaranty Policy. The only Group Guaranty Policy in the record, although on its face apparently post-dating the Schenck document, expressly contradicts it. Under both Ohio and Indiana law the terms and conditions of an insurance policy trump any terms listed in the certificate of coverage. *Talley v. Teamsters, Chauffeurs, Warehousemen, and Helpers, Local No. 377, 48 Ohio St. 2d 142, 357 N.E.2d 44, 46-47 (Ohio 1976)*("It is generally held that the certificate of coverage merely evidences the employee-member's right to participate in the insurance provided under the terms and conditions imposed in the group policy. Consequently, the provisions of the group policy are controlling over the provisions in the certificate, and the rights of the parties in a group insurance enterprise are dependent upon the group contract."), *American Family Insurance Co. v. Globe American Casualty Co., 774 N.E.2d 932, 939 (Ct. App. Indiana, 2002)*(the insurance certificate evidences that insurance has been obtained but in itself does not constitute a policy, nor can its terms contradict [*37] the terms of the policy). Third, the Schenck document fails to name who the "member" is or to identify specifically what group policy it relates to. Finally, at the February 25, 2010 hearing, it became clear that discovery only yielded a confusing result in that Class A Plaintiffs possessed documents one would presume would be found in the possession of Class B Plaintiffs, and vice-versa. Although the Court expressed its dismay at Defendants' position that Athem issued the documents by mistake, it appears the documents are simply legally irrelevant here. Under these circumstances, and in the light of the overwhelming record evidence to the contrary, the Court cannot find that the Schenck document or those similar to it salvage any of Plaintiffs' claims to demutualization proceeds.

Because the Court has visited the core issues at stake and concluded Defendants are entitled to summary judgment, it need not devote substantial attention to the other arguments raised by Defendants, which as it has indicated before, it considers as affirmative defenses. However, the Court does find it appropriate to indicate that it finds that Plaintiffs have alleged both contract and tort claims, but that [*38] in its view, this case sounds in tort, that is, in the various alleged breaches of fiduciary duty allegedly owed to Plaintiffs under Ohio demutualization law. There can be no contract claims, because the controlling group policy is between Anthem and the City, and such policy explicitly excludes enrollees (that is insured employees) from possessing equity rights in the mutual insurance company. The Court does not find such provision contrary to Ohio law. Moreover, Plaintiffs' Complaint alleged breaches of contract based on Schenck document, which as explained above, is trumped by the group policy as a matter of law.

The Court further disagrees with the City that it is entitled to immunity under Ohio Revised Code § 2744, because clearly, Plaintiffs' claims arise out of their employment relationship with the City. *Ohio Revised Code § 2744.09*. Finally, because Plaintiffs contend they were oblivious to their claims due to Defendants' alleged concealment and fraudulent misrepresentation,

the Court finds the application of the discovery rule appropriate here, such that there is no issue of Plaintiffs' action being barred by the statute of limitations. [20] A reasonable person very well would [*39] not have known of his or her potential rights in the context of a demutualization, and moreover, the interests of justice here call for the Court to reach the merits of this matter, so as to bring clarity, and put it to rest.

VII. Conclusion

The Court finds no genuine dispute of material fact and concludes that as a matter of law, the City, by express terms of the CMIC bylaws, was the party entitled to equity interests in mutual insurance policy that it contracted and owned. It concludes that the award of demutualization proceeds to the City did not violate Ohio law. Accordingly, the Court GRANTS The Wellpoint Defendants' Motion for Partial Summary Judgment (doc. 32), DENIES the Plaintiffs' Motions (docs. 33, 36), and DENIES IN PART the City's Motion as to its immunity and statute of limitations defenses (doc. 37), while GRANTS IN PART the City's Motion as to the legal determination that [*40] it was the eligible statutory member entitled to demutualization proceeds (doc. 37). Finally, the Court DENIES as MOOT the Joint Motion of Defendants to Certify Question to the Supreme Court of Ohio (doc. 87), and DENIES as MOOT Defendants' Joint Motion to Stay Pending Ruling on Petition for Permission to Appeal Order on Class Certification (doc. 56). The Court DISMISSES this matter from the docket.

SO ORDERED.

Dated: March 3, 2010

/s/ S. Arthur Spiegel

S. Arthur Spiegel

United States Senior District Judge

End of Document

[20] Decedent Plaintiff Wilmes was the first to learn of her potential claims, in December 2007, Plaintiffs Espel and Matacia learned of their claims on April 3, 2008. Plaintiffs filed this action on October 15, 2008, within four years of discovery of their potential claims. *Ohio Revised Code § 2305.09(C)*.

Town of N. Haven v.

Superior Court of Connecticut, Judicial District of New Haven, At New Haven

January 5, 2004, Decided ; January 5, 2004, Filed

CV030474463

Reporter
2004 Conn. Super. LEXIS 15 *

Town of North Haven et al. v. North Haven Education Association

Notice: [*1] THIS DECISION IS UNREPORTED AND MAY BE SUBJECT TO FURTHER APPELLATE REVIEW. COUNSEL IS CAUTIONED TO MAKE AN INDEPENDENT DETERMINATION OF THE STATUS OF THIS CASE.

Case Summary

Procedural Posture
The case was an action brought by plaintiffs, a town and a board of education, against defendant education association seeking a declaratory judgment that the issues raised by shares of common stock received by the town as a result of the demutualization were not arbitrable under the employment contract between the association and the board. Plaintiffs sought a permanent injunction to that effect.

Overview
The issue or issues pertaining to a stock distribution as a result of demutualization were subject to arbitration under the contract between the association and the board. The issues became confused because the action was also brought by the town to avoid arbitration. The town, however, was a mere interloper. The association did not seek to arbitrate the issues with the town. Although the proceeds received from the sale of the stock may have gone into the pocket of the town as a result of the actions of the board, it remained a dispute in which the proper subject of arbitration was between the association and the board. Arbitration was proper under the positive assurance test. Arbitration was not to be denied where it could not be said with positive assurance that the arbitration clause was not susceptible of an interpretation that covered the asserted dispute. Doubts were resolved in favor of coverage.

Outcome
The request for a declaratory judgment and an injunction were denied and the board of education was ordered to proceed with the arbitration in accordance with the contract.

Judges: Robert I. Berdon, Judge Trial Referee.

Opinion by: Robert I. Berdon

Opinion

MEMORANDUM OF DECISION

This is an action brought by the plaintiffs, Town of North Haven (Town) and the North Haven Board of Education (Board) against the North Haven Education Association (Association) seeking a declaratory judgment that the-issues raised by the shares of Anthem common stock received by the Town as a result of the demutualization of Anthem Blue Cross/Blue Shield is not arbitrable under the employment contract between the Association and the Board and the plaintiffs seek a permanent injunction to that effect.

The Board is a separate entity from the Town. The Board is the employer of the members of the Association, has its own budget, and provides certain benefits for its employees including the teachers who are represented by the Association. These benefits are paid pursuant to the provisions of the contract between the Board and Association. The specific contract at the time that Anthem was demutualized covered the period of September 1, 2000 through [*2] August 31, 2004. (Contract.) One of the benefits under the Contract was that the Board would provide the teachers medical coverage through Anthem. Article XXVII of the Contract specifically provides the following: "The *Board shall* provide for each teacher . . . the following medical . . . benefits. Teachers participating in the insurance coverages . . . shall contribute ten percent (10%) of the premium cost of the applicable coverage . . . [for] . . . Anthem Blue Cross/Blue Shield Century Preferred (PPO) Plan, with a $ 15.00 co-pay on the Home and Office Benefit." (Emphasis supplied.) The Board, instead of paying the premium directly to Anthem and obtaining its own policy, received this coverage through the Town's policy with Anthem.

During the period of 2001-02 Anthem was demutualized. As a result, Anthem distributed shares of stock to the Town based upon the premiums paid by the Town and Board including the premiums paid by the teachers. The Town sold the stock for the sum of $ 1,505,564. The teachers neither received their proportionate share of the $ 1,505,564 nor was that portion of the health premiums paid by the teachers reduced as a result of the Anthem stock distribution. [*3] Through the Association's lens, the distribution of Anthem stock was in reality a return of premiums and the members of the Association should share to the extent of the premiums paid by its members.

On February 14, 2002, the Association pursuant to the Contract filed the following grievance against the Board: "Article XXVII requires all teachers half or full time . . . to contribute ten percent (10%) of the premium cost of the applicable coverage . . . through payroll deduction. The Board/Town of North Haven is receiving a share value rebate that represents past premium contributions from Anthem Blue Cross Blue Shield and the employee share of said shares should be paid to the teacher/participants." The Superintendent of Schools and the Board denied the grievance. Thereafter, the Association filed a demand for arbitration before the American Arbitration Association in accordance with the Contract describing the nature of the dispute as follows: "The Board of Education has withheld from teachers a portion of a returned insurance premium, which results in an overpayment of premium by teachers. This violates the Agreement's Medical Insurance Benefits provision."

Although there is only [*4] one issue before the Court--that is, whether the issue or issues pertaining to the Anthem stock distribution as a result of its demutualization are subject to arbitration under the Contract--the Court feels compelled to comment on the fairness of the position of the Board and Town. *Fairness* dictates that the teachers should share in the proceeds received by the Town to the extent that the amount of the premiums paid by them bears to the total amount of the premiums paid by the Town upon which the total stock distribution was based. [1] The number of shares of Anthem stock received by the Town was based in part on the ten percent of the premiums paid by the teachers to the Board and eventually received by the Town. The

[1] A *rough calculation* of the amount at issue based upon the premiums paid by the Town for the year 2002 are as follows: The Town paid total premiums to Anthem in the amount of $ 5,950,000 of which $ 3,640,000 or 61 percent was attributed to the employees of the Board; 61 percent of $ 1,505,564 the Town received as a result of the sale of Anthem stock attributed to the premiums the Board paid is $ 918,394; 10 percent paid by the employees of the board would amount to $ 91,839. The litigation costs to prosecute and defend this case could exceed $ 91,839, the approximate amount that is at issue.

position that the Board and Town in this case take is indefensible.

[*5] "Whether a dispute is an arbitrable one is a legal question for the court rather than for arbitrators, in the absence of a provision in the agreement giving arbitrators such jurisdiction. The parties may manifest such a purpose by an express provision or by the use of broad terms such as were employed in [*International Brotherhood v. Trudon & Platt Motor Lines, Inc., 146 Conn. 17, 21, 147 A.2d 484 (1958)]*. But unless they do, the determination of the question of the arbitrability of a particular dispute is the function of the court. (Citations omitted in part.) *Connecticut Union of Telephone Workers, Inc. v. Southern New England Telephone Company, 148 Conn. 192, 197, 169 A.2d 646 (1961)*. In the present case, the parties agree that the issue of whether the dispute is arbitrable is one for the Court.

"In determining whether a party is bound to arbitrate, the courts look at the language employed in the contract. A contract is to be construed as a whole and all relevant provisions will be considered together. A court will not torture words to import ambiguity where the ordinary meaning leaves no room for ambiguity and words do not become ambiguous [*6] simply because lawyers or laymen contend for different meanings." (Citation omitted; internal quotations marks omitted.) *Scinto v. Sosin, 51 Conn.App. 222, 239, 721 A.2d 552 (1998)*.

The Court, accordingly, looks to the Contract between the Association and the Board. The Board points out that it is a separate entity from the Town and it was the Town that was the policyholder of Blue Cross which enabled it to obtain the shares of Anthem stock upon the demutualization of Anthem. However, the Board unilaterally decided to fulfill its Contract obligation with the Association through the Town. The contract is clear that it was the Board's obligation to obtain the coverage with Anthem. Article 27 of the Contract provides: "the Board shall provide for such coverage with Anthem." Although the plaintiffs produced an abundance of evidence that the Board and the Town to prove that they were separate entities, there was not a scintilla of evidence that the Board was required to obtain the coverage through the policy of the Town. If the Board had fulfilled its contractual obligation for medical coverage directly, as the contact obviously contemplated, it would have received the [*7] shares of stock from Anthem. If that had occurred, the issue of whether the teachers should share in the proceeds would be arbitrable.

Notwithstanding that the policy was in the name of the Town and the Anthem stock was distributed to the Town this grievance filed by the Association is arbitrable under the Contract. The Contract defines grievance as follows: " 'Grievance' shall mean a claim by a teacher or group of teachers or the Association based upon an alleged violation, misinterpretation or misapplication of a specific contract provision." Article XXX, § 30.1a. The issue involves the obligation on the part of the members of the Association to pay ten percent of the premium as required by Article XXVII. It clearly is a grievance that falls within the provisions of the Contract. [2]

[*8] After providing for levels of review for a grievance filed (which was done in this case XI) the Contract provides that--the "Association shall submit such grievance to the American Arbitration Association for processing by a single arbitrator in accordance with the voluntary rules and regulations of the American Arbitration Association then in effect except as modified herein within eight (8) days of the receipt of the Board's decision."

The issues in this case become confused because this action was also brought by the Town to avoid arbitration. The Town in this matter, however, is a mere interloper. The Association does not seek to arbitrate the issues with the Town. The demand for arbitration filed by the Association seeks an arbitration with the Board, to wit: "North Haven Board of Education c/o Mary Jane Sheehy, Supt." [3] Although the proceeds received from the sale of the stock may have gone into the pocket of the Town as a result of the actions of the Board, it remains a dispute which is the proper subject of an arbitration between the Association and the Board.

[*9] Any question as to the arbitrability of the issue is put to rest when the "positive assurance" test is applied. "It has . . . been clearly established that the *Warrior*

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[2] Indeed, the Superintendent of Schools and the Board considered the claim of the Association as a grievance. They both denied the Association's grievance when presented to them under levels two and three of formal grievance procedures. Article XXX of the Contract.

[3] Application made to the American Arbitration Association, dated January 23, 2003, Exhibit E.

'positive assurance' test is the law in Connecticut. Under the positive assurance test, judicial inquiry . . . must be strictly confined to the question whether the reluctant party did agree to arbitrate the grievance . . . An order to arbitrate the particular grievance should not be denied unless it may be said with *positive assurance* that the arbitration clause is not susceptible of an interpretation that covers the asserted dispute. Doubts should be resolved in favor of coverage." (Citations omitted; internal quotation marks omitted in part.) *Board of Education v. Frey, 174 Conn. 578, 582, 392 A.2d 466 (1978)*; *United Steelworkers of America v. Warrior & Gulf Navigation Co., 363 U.S. 574, 582-83, 4 L. Ed. 2d 1409, 80 S. Ct. 1347 (1960)*.

The Court concludes that the issue with respect to that portion of the proceeds realized from the sales of Anthem stock which was received as a result of the ten percent paid by the participating members of the Association is subject to the arbitration clause [*10] of the Contract. Accordingly, the request of the plaintiffs Town of North Haven and North Haven Board of Education for a declaratory judgment and injunction are denied [4] and the North Haven Board of Education is ordered to proceed with the arbitration in accordance with the Contract.

[*11] Robert I. Berdon

Judge Trial Referee

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[4] The defendant has called to the Court's attention that there are two other trial court opinions, contrary to this opinion, which are on appeal, involving the same issue. They are: *Wallingford Board of Education v. Wallingford Education Association* (Docket No. CV03-0472527, J.D. of New Haven dated New Haven, dated May 14, 2003, DeMayo, J.), and *Region 14 Board of Education v. Nonnewaug Teachers' Association* (Docket No. CV03-0089873, J.D. of Litchfield, Pickard, J.) (35 Conn. L. Rptr. 46). If this decision is appealed, counsel should alert the Staff Attorney's Office so the three cases can be assigned to the same panel of judges. In the alternative, the Association and/or the Board may wish to move to have it decided by the Supreme Court of Connecticut calling to its attention the other pending appeals. ***Conn. Practice Book § 65-2***.

Positive
As of: May 9, 2021 2:08 AM Z

U.S. Underwriters Ins. Co. v. Landau

United States District Court for the Eastern District of New York

June 8, 2010, Decided; June 9, 2010, Filed

05-CV-2049 (ENV) (SMG)

Reporter
2010 U.S. Dist. LEXIS 57462 *; 2010 WL 2517196

U.S. UNDERWRITERS INSURANCE COMPANY, Plaintiff, -against- RACHEL LANDAU, MORDECHI LANDAU, VINTAJE GENERAL CONSTRUCTION INC., EDNA DEVEAUX, Public Administrator of Kings County, as administrator of the Estate of JULIUS DRECKETTS, RANJETTE COMBS, BERNARD BARHAM, ALLSTATE INSURANCE COMPANY a/s/o MIGUEL MEDRANO and VINCENT ALEXIS, GREENWICH INSURANCE COMPANY a/s/o RACHEL LANDAU, Defendants. RACHEL LANDAU and MORDECHI LANDAU, Third-Party Plaintiffs, -against- SECURE INSURE BROKERAGE INC. d/b/a INSURESECURE BROKERAGE INC., and LEON G. SILVER & ASSOCIATES, LTD., Third-Party Defendants.

Prior History: *U.S. Underwriters Ins. Co. v. Landau, 679 F. Supp. 2d 330, 2010 U.S. Dist. LEXIS 3430 (E.D.N.Y., 2010)*

Case Summary

Procedural Posture
Plaintiff insurer and defendant, a neighboring property owner, filed respective motions for reconsideration of the court's order granting plaintiff's motion for summary judgment, in part, and denying it in part. Plaintiff brought a declaratory judgment action against the neighboring property owner and defendants, an insured and other neighboring property owners and their insurers.

Overview

Plaintiff had issued a premises liability insurance policy to the insured, whose building suffered a major fire that fatally injured one of its tenants and caused physical damage to neighboring property. Out of that incident, four negligence suits arose. Plaintiff challenged the order of the court finding that notice of the occurrence was provided to plaintiff via its agent and found plaintiff's disclaimers invalid insofar as they were based on late notice of the occurrence. The court found that it erred when it determined that notice was properly provided to plaintiff's agent as plaintiff's policies imposed separate duties on its insured to provide notice of the occurrence. Thus, notice of the fire was only provided to one insurer, not plaintiff. The court found no merit to the neighboring property owner's motion for reconsideration as the court did not fail to distinguish between the property damage and bodily injuries claims. The court found plaintiff, as a matter of law, was not only compliant with *New York Insurance Law § 3420(d)(2)* by disclaiming both claims shortly after it received actual notice, but conformed to the purpose of *§ 3420* to expedite the disclaimer process.

Outcome
The court granted plaintiff's motion for reconsideration

and denied the neighboring property owner's motion for reconsideration. The court granted summary judgment in favor of plaintiff, declaring that it had no obligation to defend and/or indemnify or make payments on any judgment obtained against the insured in the four tort actions.

Counsel: [*1] For U.S. Underwriters Insurance Company, Plaintiff: Steven Verveniotis, LEAD ATTORNEY, Adam I. Kleinberg, Miranda Sambursky Slone Sklarin Verveniotis LLP, Mineola, NY; Michael Anthony Miranda, Miranda Sokoloff Sambursky Slone Verveniotis LLP, Mineola, NY.

For Rachel Landau, Mordechi Landau, Defendants, ThirdParty Plaintiffs: Robert E Michael, LEAD ATTORNEY, Robert E. Michael & Associates PLLC, New York, NY.

For Edna Deveaux, Public Administrator of Kings County, as administrator of the Estate of, Defendant: Steven Glen Schiesel, Pecoraro & Schiesel, New York, NY.

For Julius Drecketts, Defendant: Paul A Marber, The Cochran Firm, New York, NY.

For Allstate Insurance Company, a/s/o Miguel Medrano and Vincent Alexis, Defendant: Adam I. Kleinberg, Miranda Sambursky Slone Sklarin Verveniotis LLP, Mineola, NY; Stuart D. Markowitz, Law Offices of Stuart D. Markowitz, P.C., Jericho, NY.

For Greenwich Insurance Company, a/s/o Rachel Landau other Rachel Landau, Defendant: William G. Hanft, Gennet Kallmann Antin & Robinson, PC, New York, NY.

For SECURE INSURE BROKERAGE INC. d/b/a INSURESECURE BROKERAGE, INC., ThirdParty Defendant, Cross Defendant, Cross Claimant: Scott C Perez, Fiedelman Garfinkel & [*2] Lesman, New York, NY.

For SECURE INSURE BROKERAGE INC. d/b/a INSURESECURE BROKERAGE, INC., Counter Claimant: Heidi M. Weiss, LEAD ATTORNEY, Jacobwitz, Garfinkel & Lesman, New York, NY; Scott C Perez, Fiedelman Garfinkel & Lesman, New York, NY.

For Leon G. Silver Assoc., Ltd., ThirdParty Defendant: Jeannie Valentine, Jonathan B. Bruno, LEAD ATTORNEYS, Kaufman, Borgeest & Ryan LLP, New York, NY; Lynn Marie Dukette, Furman Kornfeld & Brennan LLP, New York, NY.

For Leon G. Silver Assoc., Ltd., Cross Claimant, Cross Defendant: Jeannie Valentine, Jonathan B. Bruno, LEAD ATTORNEYS, Kaufman, Borgeest & Ryan LLP, New York, NY.

Judges: ERIC N. VITALIANO, United States District Judge.

Opinion by: ERIC N. VITALIANO

Opinion

MEMORANDUM AND ORDER

VITALIANO, D.J.

On January 15, 2010, the Court issued a Memorandum and Order granting in part and denying in part the summary judgment motion of plaintiff U.S. Underwriters Insurance Company ("USU"). See *U.S. Underwriters Ins. Co. v. Landau, 679 F. Supp. 2d 330 (E.D.N.Y. 2010)*. USU entered into a contract for premises liability insurance with defendant Rachel Landau, whose building suffered a major fire that fatally injured one of its tenants, Julius Drecketts, and caused physical damage to [*3] neighboring property. Out of the flames arose four negligence lawsuits against Landau, all filed in Kings County Supreme Court, three

of which were property damage claims brought by defendants Allstate Insurance Company ("Allstate"), Greenwich Insurance Company ("Greenwich") and Edna Deveaux; the fourth was a bodily injury/wrongful death claim brought by Drecketts's estate. USU seeks a declaratory judgment disclaiming coverage. Familiarity with the facts and the January 15th Memorandum and Order is presumed.

The Court is now faced with two motions for reconsideration. USU argues that the Court overlooked applicable law and key facts in finding that notice of the occurrence was timely provided by the insured, and that the Court was in error when it determined that there was a material factual dispute with respect to the timeliness of USU's disclaimer of the Drecketts claim. Deveaux cross-moves, contending that the Court overlooked "bodily injury" claims in her underlying action against Landau that would put her claims within the scope of *New York Insurance Law § 3420(d)*. For the reasons set forth below, the Court grants USU's motion for reconsideration, but denies the cross-motion. [1] [*4]

Background

While familiarity with the underlying facts is presumed, the Court here reiterates and supplements certain facts integral to the instant motions. Of course, this being reconsideration of summary judgment, the evidence is viewed in the light most favorable to the nonmoving parties on the original motions. See *Allstate Ins. Co. v. Hamilton Beach/Proctor Silex, Inc., 473 F.3d 450, 456 (2d Cir. 2007)*.

Rachel Landau and her husband sought insurance coverage for their property through retail broker Secure Insure Brokerage, Inc. ("SIB"), which, in turn, solicited coverage from wholesale broker Leon G. Silver & Associates ("Silver Associates"). Through this chain of brokers, the Landaus acquired first party coverage from Greenwich and third party liability coverage from USU. Silver Associates had an "Agency and Brokerage Agreement" with USU, pursuant to which it was to "report all losses [*5] and claims to the Company [USU] immediately after receipt by the Agent [Silver Associates] of notice of the loss or claim." (Affirmation of Andrew M. Bernstein ("Bernstein Aff.") Ex. T.) [2]

The Landaus' policy with USU contained standard language regarding their "duties in the event of occurrence, offense, claim or suit," providing that "[y]ou must see to it that we are notified as soon as practicable of an 'occurrence' or an offense which may result in a claim," and, independently, that "[i]f a claim or 'suit' is brought against any insured, you must … see to it that we receive written notice of the claim or 'suit' as soon as practicable." The policy defined "occurrence" as "an accident" (including "repeated exposure") and "suit" as "a civil proceeding in which damages . . . are alleged." (Declaration of Steven Verveniotis ("Verv. Decl.") Ex. 1.)

The fire at the Landaus' property occurred on June 15, 2004. The following day, SIB faxed an "Acord" form to Silver Associates titled "property loss notice." This form listed Greenwich as the "company" [*6] and included the Landaus' Greenwich policy number, but did not include any reference to the USU policy or liability coverage generally. The form also listed the "loss" as an "explosion," with handwritten notes stating "fire erupted in basement." (Verv. Decl. Ex. 25.) After receiving this form, Silver Associates passed on notice of the incident to a receiving agent of Greenwich, but did not contact USU or any other liability insurer.

On September 29, 2004, Allstate wrote a letter to SIB providing notice of its subrogation claim against the Landaus. USU was not directly contacted until October 14, 2004, when it received an Acord form from SIB that informed it of the Allstate claim. Claims examiner Dolores Foreman was assigned by USU to the Landau file. By October 29, USU had learned from Mordechi Landau that Drecketts sustained injuries in the fire, though Landau did not know the extent of the injuries, nor whether there were "any claims being submitted from any of the [insured]'s tenants." On December 14, Foreman wrote in her file notes that "[w]e were all uncertain on whether or not our company has any obligation to address the potential BI [bodily injury]

[1] No other aspects of the January 15th Order are challenged by the parties, including the Court's finding that the independent contractor exclusion is valid and applicable, and its grant of summary judgment in favor of USU with respect to coverage of the property damage claims by Greenwich and Allstate.

[2] The various sworn statements to which the Court refers were submitted in connection with the parties' original motions for summary judgment.

claim in the disclaimer, should [*7] one be sent, since a claim has not been presented." (Declaration of Paul Marber ("Marber Decl.") Ex. I.)

On December 28, 2004, Foreman sent the Landaus a letter disclaiming coverage for claims by the following "Claimants:" "Allstate Insurance" and "Julius Dreckett[s]." The letter copied Allstate and Drecketts -- who Foreman did not know was deceased -- "to inform [them] of the disclaimer of coverage and grounds for the disclaimer." USU provided two bases for its decision: (1) "you failed to provide timely notice of this occurrence . . . as you were aware of the incident on the date of loss;" and (2) "the incident arose out of the act of an independent contractor." (Verv. Decl. Ex. 34.) On January 12, 2005, Foreman wrote that her letters to Drecketts were returned as "unable to forward." (Marber Decl. Ex. I.)

On January 11, 2005, counsel for Deveaux, another neighbor of the Landaus, sent a letter to Mordechi Landau providing notice of Deveaux's intent to pursue claims because "[a]s a result of the fire and explosion . . . [Deveaux's] building . . . was destroyed." USU learned of the Deveaux claim on February 2, 2005, when SIB forwarded this notice to Silver Associates (Declaration of [*8] Steven Pecoraro ("Pecoraro Decl.") Ex. G), and disclaimed coverage in a February 22, 2005 letter to the Landaus. (Verv. Decl. Ex. 42.) On March 16, 2005, Deveaux filed suit against the Landaus, alleging that she had "suffered damage to her real property and personal property, and suffered related losses including but not limited to income losses, and . . . expenses incurred in obtaining new living quarters." (Verv. Decl. Ex. 19.) Over one year later, on May 19, 2006, Deveaux amended her complaint to assert claims on behalf of both herself and a relative, Shamese, who also had lived in the damaged premises. This complaint newly alleged that both plaintiffs "suffered the emotional trauma, pain, distress, and anguish of losing [their] home and virtually all belongings, including but not limited to those of sentimental value . . . and of having to endure the humility of being homeless . . . and otherwise suffered, and continues to suffer, severe emotional distress." (Pecoraro Decl. Ex. A.)

On March 18, 2005, the Public Administrator of Kings County asserted a personal injury and wrongful death claim arising out of the injuries to Drecketts. USU copied Drecketts on its March 29 letter disclaiming [*9] the Allstate claims, and subsequently issued an additional letter disclaiming coverage for the estate's claim on April 11, 2005. The April 11 letter carbon copied counsel for the administrator of Drecketts's estate, and noted that USU "has previously disclaimed coverage by letters dated December 28, 2004 and March 29, 2005 for injuries or damages sustained by any claimant in connection with said incident . . . [w]e attach hereto copies of those prior letters, applicable to all claims including the claims now asserted in the Dreckett[s] lawsuit and the DeVeaux lawsuit." (Verv Decl. Ex. 44.)

Discussion

I. Legal Standard

Pursuant to *Local Civil Rule 6.3*, a party seeking reconsideration must "set [] forth concisely the matters or controlling decisions which [it] believes the court has overlooked." "The standard for granting such a motion is strict, and reconsideration will generally be denied unless the moving party can point to . . . matters . . . that might reasonably be expected to alter the conclusion reached by the court." *Shrader v. CSX Transp., Inc., 70 F.3d 255, 257 (2d Cir. 1995)*; see *EEOC v. Fed. Express Corp., 268 F. Supp. 2d 192, 195 (E.D.N.Y. 2003)* (holding that local *rule 6.3* [*10] "is to be narrowly construed and strictly applied so as to avoid repetitive arguments on issues that have been considered fully by the court"). Whether or not to grant a motion to reconsider "is within the sound discretion of the district court," id., but it "should not be granted where the moving party seeks solely to relitigate an issue already decided." *Shrader, 70 F.3d at 257*. Rather, "reconsideration allows a court to correct for clear error, to prevent manifest injustice, or to review in the light of newly available evidence." *Asia Project Servs. v. Usha Martin Ltd., 09-CV-5084, 2010 U.S. Dist. LEXIS 37801, at *3 (S.D.N.Y. Apr. 8, 2010)*; see *RST (2005) Inc. v. Research in Motion Ltd., 597 F. Supp. 2d 362, 365 (S.D.N.Y. 2009)* ("The major grounds justifying reconsideration are 'an intervening change in controlling law, the availability of new evidence, or the need to correct a clear error or prevent manifest injustice.'") (quoting *Virgin Atl. Airways, Ltd. v. Nat'l Mediation*

Bd., 956 F.2d 1245, 1255 (2d Cir. 1992)).

II. USU's Motion For Reconsideration

In the January 15th Order, the Court found that notice of the occurrence was provided to USU when Silver Associates received the [*11] Acord form in June 2004. As the Court explained, although generally insurance brokers are considered agents of the insured, in this case Silver Associates was an agent vested with authority to receive notice of an occurrence on behalf of USU. Therefore, the Court found USU's disclaimers invalid insofar as they were based on late notice of *occurrence*. However, the disclaimers were also based on the independent contractor exclusion, and thus would be effective so long as USU was not estopped for failure to disclaim "as soon as [was] reasonably possible after it first learn[ed] of the accident or of grounds for disclaimer of liability or denial of coverage," as required by *§ 3420(d)* for bodily injury claims. *Hartford Ins. Co. v. County of Nassau, 46 N.Y.2d 1028, 1029, 416 N.Y.S.2d 539, 540, 389 N.E.2d 1061, 1062 (1979)*; see *N.Y. Univ. v. First Fin. Ins. Co., 322 F.3d 750, 753 n.3 (2d Cir. 2003)*. The Court determined that there remained a fact question whether the six month gap between USU's learning of the incident and its disclaimer of the Drecketts claims constituted an unreasonable delay under *§ 3420(d)*.

USU challenges the Court's finding that the June 2004 notice to Silver Associates [*12] constituted notice of the occurrence to USU based on *Sorbara Constr. Corp. v. AIU Ins. Co., 11 N.Y.3d 805, 868 N.Y.S.2d 573, 897 N.E.2d 1054 (2008)*, a New York Court of Appeals decision published after the parties submitted their original summary judgment briefs. In that case, an employer had two separate insurance policies with one insurer: a workers' compensation policy and a liability policy. Shortly after an employee was hurt in an accident, the employer submitted to the insurer notice of the occurrence under the workers' compensation policy. Although the employer was soon thereafter sued, it did not notify the insurer of the same occurrence pursuant to the liability policy until five and a half years later. The Court of Appeals held that "[n]otice provided under the workers' compensation policy at the time of the incident did not constitute notice under the liability policy even though both policies were written by the same carrier" since "[e]ach policy imposes upon the insured a separate, contractual duty to provide notice." *11 N.Y.3d at 806, 868 N.Y.S.2d at 573, 897 N.E.2d at 1055*. USU argues that the Sorbara reasoning applies to this case because the June 2004 Acord form provided [*13] to Silver Associates only referenced the Greenwich policy, and not the USU policy.

The Court agrees with USU that *Sorbara* controls and requires reconsideration of the Court's prior holding. Although Silver Associates was an agent of USU, the Greenwich and USU policies imposed separate duties on the Landaus to provide notice of the occurrence. Therefore, if SIB delivered an Acord form to Silver Associates that specified that notice of the fire was being provided pursuant to the USU policy, the Court would deem that notice timely and effective to USU. However, the June 2004 Acord only provided notice pursuant to the Greenwich policy, and did not mention USU at all, much less a specific USU policy. As a result, the Acord failed to satisfy the Landaus' notice obligations under the USU contract as a matter of law, even if USU could have otherwise been made aware of the accident (i.e. from a source other than written notice from the insured) to trigger its independent obligation to timely disclaim coverage under Insurance Law *§ 3420(d)*. See *First Fin. Ins. Co. v. Jetco Contracting Corp., 1 N.Y.3d 64, 67, 769 N.Y.S.2d 459, 461, 801 N.E.2d 835, 837 (2003)* (noting that an "insurer's failure [*14] to provide notice as soon as is reasonably possible precludes effective disclaimer, even though the policyholder's own notice of the incident to its insurer is untimely").

Defendants' attempts to distinguish Sorbara on its facts are unavailing. That there was a five and a half year gap between the occurrence and notification under the liability policy in that case has no bearing on the logic of the New York high court's holding. Moreover, it is irrelevant to the instant case that the court supplemented its holding by recognizing that "[s]imilarly, an additional insured's notice to the carrier under a different policy does not excuse the insured's obligation to provide timely notice under its policy." *11 N.Y.3d at 806, 868 N.Y.S.2d at 573, 897 N.E.2d at 1055-56*. Finally, although defendants note that Sorbara did not involve any agency issues, they do not provide any persuasive reason why its principle absolving an insurer where notice is defective for the reason presented here should not apply with equal force to an insurer's agent. The agent stands in its principal's shoes, and a right or

defense available to the principal is, without more, also available to the agent.

Extraneous facts [*15] aside, the Sorbara court's reasoning is clear: under New York insurance law, separate policies -- whether issued by the same carrier or different carriers -- create independent obligations to provide separate notices of the same occurrence. Accordingly, the Court holds that the June 2004 Acord did not constitute notice of the occurrence to USU as a matter of law, and USU thus, on the remaining and undisputed facts, did not receive notice of the fire until October 14th, when it received notice of the Allstate claims.

Defendants argue -- both in their original summary judgment papers and on reconsideration -- that, even if notice was not provided until October, USU would still have ran afoul of its § 3420(d) obligation to timely disclaim because two and a half months passed before it issued its December 28th written disclaimer. Yet, this argument overlooks the fact that the December disclaimer was preemptive with respect to Drecketts because at that point there was no hint of a claim by Drecketts, and neither the insured nor the estate of Drecketts had put USU on notice of any potential bodily injury claim, formally or informally. More critically, at the point USU disclaimed it was not [*16] yet on notice of a bodily injury claim by *anyone*.

Stated differently, USU was not yet on notice that it had any obligations with respect to this occurrence under § 3420(d). Applicable only when an insurer is advised of an actual or potential personal injury or wrongful death claim, § 3420(d)(2) requires an insurer to give written notice as soon as reasonably possible *both* "to the insured *and* the injured person or any other claimant" (emphasis added). It stands to reason that if there is no claimant, putative or otherwise, the obligation to disclaim in the manner required by § 3420(d) cannot be triggered. [3] See *Bluestein & Sander v. Chicago Ins. Co., 276 F.3d 119, 122 (2d Cir. 2002)* (explaining that timeliness of a disclaimer is "judged from the time that the insurer is aware of sufficient facts to issue a disclaimer"). Here, USU only learned about Drecketts through its own investigation, and notified the Landaus that it was denying coverage with respect to Drecketts even though no one knew his whereabouts or whether he intended to make a claim. [4] In fact, USU did not receive any notice of the Drecketts claim until March 18, 2005, when the underlying lawsuit was filed. USU subsequently [*17] copied Drecketts on the March 29 letter disclaiming the Allstate claims, and issued a disclaimer specifically for the Drecketts claim on April 11.

In light of "all of the circumstances," the Court finds as a matter of law that USU was not only compliant with § 3420(d) by disclaiming both before and shortly after it received actual notice of the Drecketts claim, but indeed conformed to the purpose of § 3420 to "expedite the disclaimer process, thus enabling a policyholder to pursue other avenues expeditiously." *Jetco, 1 N.Y.3d at 68, 769 N.Y.S.2d at 462, 801 N.E.2d at 838*. The Court therefore grants USU's motion for reconsideration, and holds that USU is entitled to judgment as a matter of law and a declaration of noncoverage with respect to all of the underlying claims made [*18] against the Landaus, including the bodily injury and wrongful death claim made by the estate of Drecketts.

III. Deveaux's Motion For Reconsideration

In the January 15th Order, the Court distinguished between underlying claims against the Landaus for property damage and for bodily injury, explaining that the former do not fall under § 3420(d). With respect to property damage claims, untimely disclaimer only estops an insurer's denial of coverage where the insured was prejudiced by a delay. See *Bluestein, 276 F.3d at 122*; *Amer. Home Assurance Co. v. Republic Ins. Co., 984 F.2d 76, 79 (2d Cir. 1993)*. Accordingly, the Court found that USU's disclaimers with respect to the Allstate, Deveaux, and Greenwich claims were not estopped because the Landaus failed to show any prejudice. In response, Deveaux now argues that the Court did not "realize [] that the Deveaux action involved bodily injury claims" and that her cause of

[3] As determined in the January 15th Order, USU's disclaimer was timely for claims unrelated to personal injury, i.e., where § 3420(d) did not apply.

[4] USU was particularly cautious by listing Drecketts as a "claimant" and attempting to carbon copy him (at his last known address) on the disclaimer letter. Notwithstanding, no bodily injury or wrongful death claim had been made or informally asserted by December 28, 2004.

action against the Landaus should be analyzed under § 3420(d) because she made a claim for "emotional distress."

The Court was fully aware of the parameters of the claims made by Deveaux against the Landaus at the time it issued the initial order, and the reconsideration motion [*19] has not brought anything new to the Court's attention. USU disclaimed coverage for the Deveaux claims on February 22, 2005, 20 days after it received a notice that Deveaux's building "was destroyed." Deveaux's underlying lawsuit was actually filed three weeks after USU's disclaimer, and that lawsuit did not allege any bodily injury claim. Although Deveaux subsequently added another plaintiff and crafted emotional distress claims, these amendments were not part of the suit until well over a year after the disclaimer was issued. Unquestionably, the amended complaint was the first notice of a personal injury claim and, in any event, the initial disclaimer was without limitation and clearly would cover any claim of personal injury. To be sure, the initial disclaimer satisfies the letter and spirit of § 3420(d). Deveaux does not -- and cannot -- show anything that could alter this conclusion. Accordingly, Deveaux's motion for reconsideration is denied. [5]

IV. "Third Party" Actions

In the January 15th Order, the Court dismissed the Landaus' third party complaints against SIB and Silver Associates, in which they requested declarations that both brokers were negligent and therefore jointly and severally liable for "damages, costs, and expenses arising out of [USU]'s assertion that [*21] it was not properly or timely advised of the fire." (Verv. Decl. Exs. 8, 10.) Similarly, the Court dismissed both brokers' crossclaims against each other, which sought solely contribution and indemnification for potential damages arising out of the Landaus' third party complaints. Having held that the notice to Silver Associates was effective notice to USU, the Court reasoned that "there was no injury or damage to the Landaus vis-a-vis the actions or omissions of SIB or Silver Associates, much less any damages proximately caused by either broker's breach of any alleged duties owed to the Landaus." Landau, 679 F. Supp. 2d at 345.

Notwithstanding the Court's current finding that notice of the fire was not validly and timely provided to USU in June 2004 when the Acord was sent to Silver Associates on the Greenwich policy, the Court adheres to its dismissal of the Landaus' actions against both brokers (and their crossclaims against each other) because the Landaus have suffered no damages as a result of the initial, ineffective notice of the occurrence to USU. First, regardless whether USU's disclaimer based on late notice is valid, the Court has also already held that USU's alternative [*22] grounds for disclaimer -- the independent contractors exclusion -- is valid and applicable to the facts at bar. Id. at 338-41. Further, as discussed above, the § 3420(d) analysis in this case turns not on the provision of notice of the *occurrence*, but rather on the fact that USU did not have notice of the Drecketts *claim* or even of a *potential claim* by Drecketts or by any other person when it provided its initial disclaimer. In other words, even assuming that SIB and Silver Associates acted properly and diligently, and USU received notice of the fire in June 2004, the Landaus would nonetheless be in the same exact position with respect to the timeliness of USU's disclaimer of the Drecketts claim -- the disclaimer satisfies § 3420(d).

As reconsideration makes clear, there is no showing that the insured, SIB, or Silver Associates had notice of any potential personal injury claim by anyone, and certainly not Drecketts, at the time that the Greenwich Acord was sent. Even four months later, the Landaus told USU's investigator that they did not know if any claims were being submitted by their tenants. USU actually disclaimed before it had, it is undisputed, any notice of a

[5] Collaterally, the Court observes, Deveaux's causes of action for emotional distress are of dubious merit. Under New York law, a claim for negligent infliction of emotional distress where the plaintiff suffers no physical injury herself [*20] can be premised on either of two theories: (1) a "bystander" theory, which applies when a plaintiff is "threatened with physical harm as a result" of negligence and consequently "suffers emotional injury from witnessing the death or serious bodily injury of a member of her immediate family"; or (2) a "direct duty" theory, which permits recovery when a plaintiff "suffers an emotional injury from defendant's breach of a duty which unreasonably endangered her own physical safety." Mortise v. United States, 102 F.3d 693, 696 (2d Cir. 1996); see ***Stephens v. Shuttle Assocs., L.L.C., 547 F. Supp. 2d 269, 275-76 (E.D.N.Y. 2008)***. The "duty," however, "must be specific to the plaintiff, and not some amorphous, free-floating duty to society." Mortise, 102 F.3d at 696. Based on the allegations in Deveaux's amended complaint, it is highly unlikely that either theory applies.

potential Drecketts [*23] claim that would have started the *§ 3420(d)* clock. Any alleged negligence on the part of the brokers is, therefore, without consequence to the Landaus, and the Landaus' actions based on that negligence must be dismissed, along with the crossclaims of the brokers.

Conclusion

For the reasons discussed above, plaintiff U.S. Underwriters Insurance Company's motion for reconsideration is granted, and defendant Deveaux's motion for reconsideration is denied. Summary judgment is granted in favor of USU declaring that it has no obligation to defend and/or indemnify (or make payments on any judgment obtained against) the Landaus in the following actions brought in Kings County Supreme Court: (1) Allstate Insurance Company a/s/o Miguel Medrano and Vincent Alexis v. Landau, Index No. 5504/05; (2) Deveaux v. Landau, Index No. 7840/05; (3) Public Administrator v. Landau, No. 8255/2005; and (4) Greenwich Insurance Company a/s/o Rachel Landau v. Landau, Index No. 13460/06.

The Landaus' actions against third parties Silver Associates and SIB are dismissed, as are any and all third party counterclaims and the cross-claims between SIB and Silver Associates.

Finally, the Court dismisses the action against [*24] remaining defendants Vintaje General Construction, Inc., Bernard Barham, and Ranjette Combs, none of whom have appeared in this litigation. [6] The amended complaint barely mentions -- much less seeks relief against -- these three independent contractors working at the Landaus' premises, and USU has, in any event, now obtained the declaratory judgment that it sought in the instant action. To the extent that plaintiff intended to pursue claims against these defendants, those claims are now moot.

Plaintiff is directed to settle judgment on notice within five (5) business days from the date this Memorandum and Order is docketed.

SO ORDERED.

Dated: Brooklyn, New York

June 8, 2010

/s/ ENV

ERIC N. VITALIANO

United States District Judge

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[6] The Court previously denied as procedurally defective plaintiff's attempt to move for default judgment against Vintaje and Barham within its summary judgment motion. *Landau, 679 F. Supp. 2d at 333 n.1*. Plaintiff has not subsequently sought either entries of notation or default judgment against any of these parties, nor has it otherwise proceeded against them.

APPROVAL # 65

CHAPTER 657

LAWS OF 19 81

SENATE BILL 3822

ASSEMBLY BILL

3822

1981-1982 Regular Sessions

IN SENATE

March 3, 1981

Introduced by Sen. DUNNE—(at request of the Insurance Department)—read twice and ordered printed, and when printed to be committed to the Committee on Insurance

AN ACT to amend the insurance law, in relation to the conversion of a domestic mutual casualty, surety, fire or marine insurer or advance premium corporation into a domestic stock insurer and establishing procedures for conversions of such companies not in rehabilitation, and the standards for approval by the superintendent of insurance of certain agreements under article fifteen of such law

IN THE ASSEMBLY BY: Lasher

A 6596

Bill compared by

DATE RECEIVED BY GOVERNOR:

ACTION MUST BE TAKEN BY:

GOVERNOR'S ACTION:

DATE JUL 21 1981

Memorandum No.

1981

SENATE

The Senate Bill
by Mr. DUNNE Calendar No. 730 Senate No. 3822
Assem. Rept. No. _____
Entitled: "

3822

AN ACT to amend the insurance law, in relation to the conversion of a domestic mutual casualty, surety, fire or marine insurer or advance premium corporation into a domestic stock insurer and establishing procedures for conversions of such companies not in rehabilitation, and the standards for approval by the superintendent of insurance of certain agreements under article fifteen of such law

" was read the third time

The President put the question whether the Senate would agree to the final passage of said bill, the same having been printed and upon the desks of the members in its final form at least three calendar legislative days, and it was decided in the affirmative, a majority of all the Senators elected voting in favor thereof and three-fifths being present, as follows:

AYE	Dist.		NAY
	12	Mr. Ackerman	
	47	Mr. Anderson	
	49	Mr. Auer	
	16	Mr. Babbush	
	45	Mr. Barclay	
	18	Mr. Bartosiewicz	
	23	Mr. Beatty	
	9	Mrs. Berman	
	33	Mr. Bernstein	
	28	Mr. Bogues	
	41	Mr. Bruno	
	7	Mr. Caemmerer	EXCUSED
	34	Mr. Calandra	
	25	Mr. Connor	
	48	Mr. Cook	
	60	Mr. Daly	
	46	Mr. Donovan	
	6	Mr. Dunne	
	54	Mr. Eckert	
	44	Mr. Farley	
	59	Mr. Floss	
	35	Mr. Flynn	EXCUSED
	32	Mr. Galiber	
	56	Mr. Gallagher	
	14	Mr. Gazzara	
	13	Mr. Gold	
	37	Mrs. Goodhue	
	26	Mr. Goodman	
	20	Mr. Halperin	
	4	Mr. Johnson	

AYE	Dist.		NAY
	52	Mr. Kehoe	
	15	Mr. Knorr	
	2	Mr. Lack	
	1	Mr. LaValle	
	29	Mr. Leichter	
	8	Mr. Levy	
	50	Mr. Lombardi	
	24	Mr. Marchi	
	5	Mr. Marino	
	19	Mr. Markowitz	
	55	Mr. Masiello	
	21	Mr. Mega	
	30	Mrs. Mendez	
	42	Mr. Nolan	
	27	Mr. Ohrenstein	
	17	Mr. Owens	
	11	Mr. Padavan	
	53	Mr. Perry	
	36	Mr. Pisani	
	57	Mr. Present	
	39	Mr. Rolison	
	31	Mr. Ruiz	
	40	Mr. Schermerhorn	
	51	Mr. Smith	
	22	Mr. Solomon	
	43	Mr. Stafford	
	3	Mr. Trunzo	
	58	Mr. Volker	
	10	Mr. Weinstein	
	38	Mrs. Winikow	

AYES 58
NAYS 0

¶ Ordered, that the Secretary deliver said bill to the Assembly and request its concurrence therein.

NEW YORK STATE ASSEMBLY

REPRINT NO: 002 DATE: 07/03/1981
DATE: 07/07/81 TIME: 03:23:14 PM

BILL: S3822(A6596) R.R. NO: 1112 SPONSOR: DUNNE

AN ACT TO AMEND THE INSURANCE LAW, IN RELATION TO THE CONVERSION OF A DOMESTIC MUTUAL CASUALTY, SURETY, FIRE OR MARINE INSURER OR ADVANCE PREMIUM CORPORATION INTO A DOMESTIC STOCK INSURER AND ESTABLISHING PROCEDURES FOR CONVERSIONS OF SUCH COMPANIES NOT IN REHABILITATION, AND THE STANDARDS FOR APPROVAL BY THE SUPERINTENDENT OF INSURANCE OF CERTAIN AGREEMENTS UNDER ARTICLE FIFTEEN OF SUCH LAW

YEA	ABRAMSON,E*	YEA	HAWLEY,RS	NAY	PILLITTERE,JT*
NAY	BARBARO,FJ*	YEA	HEALEY,PB	YEA	PRESCOTT,DW
YEA	BEHAN,JL	YEA	HEVESI,AG*	YEA	PROUD,G*
ABS	BIANCHI,IW*	YEA	HINCHEY,MD*	YEA	RAPPLEYEA,CD
YEA	BOYLAND,TS*	YEA	HIRSCH,S*	YEA	RATH,DE
YEA	BRAGMAN,MJ*	YEA	HOBLOCK,MJ	YEA	REILLY,JM
YEA	BRANCA,JR*	YEA	HOCHBRUECKNER,GJ*	YEA	RETTALIATA,AP
YEA	BURROWS,GW	ELB	HOWARD,LT	YEA	RIFORD,LS
YEA	BUSH,WE	EOR	HOYT,WB*	YEA	ROBACH,RJ*
NAY	BUTLER,DJ*	YEA	JACOBS,RS*	NAY	ROBLES,VL*
YEA	CASALE,AJ	NAY	JENKINS,A*	YEA	RUGGIERO,RS*
YEA	CHESBRO,RT	NAY	JOHNSON,CR*	YEA	RYAN,AW
YEA	COCHRANE,JC	YEA	KEANE,RJ*	YEA	SALAND,SM
NAY	COHEN,DL*	YEA	KELLEHER,NW	YEA	SANDERS,S*
YEA	CONNELLY,EA*	YEA	KENNEDY,RL	YEA	SCHIMMINGER,RL*
YEA	CONNERS,RJ*	YEA	KIDDER,RE*	YEA	SCHMIDT,FD*
YEA	COOKE,AT	YEA	KISOR,RM	YEA	SEARS,WR
YEA	DAMATO,AP	NAY	KOPPELL,GO*	YEA	SEMINERIO,AS*
YEA	DANDREA,RA	YEA	KREMER,AJ*	YEA	SERRANO,JE*
YEA	DANIELS,GL*	YEA	KUHL,JR	YEA	SHAFFER,GS*
YEA	DAVIS,G*	YEA	LAFAYETTE,IC*	YEA	SHEFFER,JB
YEA	DEARIE,JC*	YEA	LANE,CD	NAY	SIEGEL,MA*
YEA	DEL TORO,A*	YEA	LARKIN,WJ	YEA	SILVER,S*
YEA	DICARLO,DL	YEA	LASHER,HL*	YEA	SIWEK,CA
NAY	DUGAN,EC*	YEA	LENTOL,JR*	YEA	SKELOS,DG
YEA	EMERY,JL	YEA	LEVY,E	YEA	SMOLER,H*
YEA	ENGEL,EL*	YEA	LEWIS,W*	YEA	SPANO,NA
YEA	ESPOSITO,JA	YEA	LIPSCHUTZ,GE*	YEA	STAVISKY,LP*
NAY	EVE,AO*	YEA	LOPRESTO,JG	YEA	STEPHENS,WH
NAY	FARRELL,HD*	YEA	MACNEIL,HS	YEA	STRANIERE,RA
NAY	FELDMAN,D*	YEA	MADISON,GH	YEA	SULLIVAN,EC*
NAY	FERRIS,J*	YEA	MARCHISELLI,VA*	YEA	SULLIVAN,FM
YEA	FINNERAN,WB*	YEA	MAZZA,GR	YEA	SULLIVAN,PM
YEA	FLACK,JT	YEA	MCCABE,JW*	YEA	TALLON,JR*
YEA	FLANAGAN,JJ	YEA	MILLER,HM	YEA	TALOMIE,FG
NAY	FORTUNE,TR*	YEA	MILLER,MH*	YEA	VANN,A*
YEA	FOSSEL,JS	NV	MONTANO,A*	YEA	VELELLA,GJ
YEA	FRIEDMAN,G*	YEA	MORAHAN,TP	YEA	VIGGIANO,PM*
YEA	GOLDSTEIN,R*	YEA	MURPHY,MJ*	YEA	WALSH,DB*
YEA	GORSKI,DT*	YEA	MURTAUGH,JB*	YEA	WALSH,SP*
NAY	GOTTFRIED,RN*	NAY	NADLER,J*	YEA	WARREN,GE
YEA	GRABER,VJ*	YEA	NAGLE,JF	NAY	WEINSTEIN,HE*
YEA	GRANNIS,A*	YEA	NEWBURGER,MW*	YEA	WEMPLE,CC
NAY	GREEN,RL*	NAY	NINE,LM	YEA	WEPRIN,S*
YEA	GRIFFITH,E*	YEA	NORTZ,HR	YEA	WERTZ,RC
YEA	HAGUE,JB	YEA	ONEIL,JG	YEA	WILSON,CE*
YEA	HANNA,TA	YEA	ORDIO,AF*	YEA	WISNER,GH
YEA	HANNON,K	YEA	PAPOLA,TE	YEA	YEVOLI,LJ*
NAY	HARENBERG,PE*	YEA	PARGANIGNTE,WF*	YEA	ZIMMER,MN*
YEA	HARRIS,CH	YEA	PERONE,JM		MR. SPEAKER*

YEAS: 124 NAYS: 21

CONTROL: 80239332 CERTIFICATION:_____

LEGEND: YEA=YES,NAY=NO,NV=ABSTAIN,ABS=ABSENT,
ELB=EXCUSED FOR LEGISLATIVE BUSINESS,EOR=EXCUSED FOR OTHER REASONS.

STATE OF NEW YORK
EXECUTIVE CHAMBER
ALBANY 12224

JUL 21 1981

MEMORANDUM filed with the following bills:

Senate Bill Number 3822, entitled:

CHAPTER 657
APPROVAL # 65

"AN ACT to amend the insurance law, in relation to the conversion of a domestic mutual casualty, surety, fire or marine insurer or advance premium corporation into a domestic stock insurer and establishing procedures for conversions of such companies not in rehabilitation, and the standards for approval by the superintendent of insurance of certain agreements under article fifteen of such law"

Senate Bill Number 6905, entitled:

CHAPTER 658
APPROVAL # 66

"AN ACT to amend the insurance law, in relation to conversion of certain insurance companies"

A P P R O V E D

The bills amend the Insurance Law to authorize the conversion of domestic mutual casualty, surety, fire or marine insurers or advance premium corporations not in rehabilitation, into domestic stock insurance insurers and establish detailed procedures to be followed to effect such conversion.

The bills, which are effective upon signing, set forth statutory procedures and guidelines for the conversion of such companies, including procedures for the filing of an application with the Superintendent of Insurance, examination and appraisal of the insurer and the holding of a public hearing by the Superintendent.

The bill authorizes the Superintendent to approve, refuse to approve or request modification of the plan before granting approval. Approval by the Superintendent is predicated upon his finding that the plan does not violate the Insurance Law, is not inconsistent with law, is fair and equitable and in the best interests of the policyholders and the public.

If, after approval by the Superintendent, the plan is adopted by vote of two-thirds of the votes cast by the policyholders, the Superintendent shall issue a new certificate of authority and the mutual company would become a stock corporation.

The bill contains safeguards to protect the integrity of the new stock insurer, including a prohibition against redomestication outside of the State for a period of ten years.

In order to obtain additional surplus, a mutual company is limited to borrowing funds or soliciting contributions from its membership or to merger with another mutual insurance company. Mutual insurers do not issue equity securities, and the present interest rates make borrowing extremely difficult.

The bills would provide a vehicle for raising capital through the conversion of a mutual insurer into a stock corporation, while at the same time providing adequate safeguards for equitable treatment of policyholders and fair procedures in the execution of the conversion.

A company converted into a stock corporation would also obtain certain advantages which are currently enjoyed by stock corporations, including greater flexibility in attracting or retaining qualified personnel.

The Insurance Department, at whose request the bills were introduced, recommends that they be approved.

Approval of the bills is also recommended by the New York State Mutual Insurance Association.

The bills are approved.

S-3822

MA

JUL 14 RECD

THE SENATE
STATE OF NEW YORK
ALBANY 12247

JOHN R. DUNNE
6TH DISTRICT
CHAIRMAN
COMMITTEE ON
CORPORATIONS, AUTHORITIES
AND COMMISSIONS

PLEASE REPLY TO:
☒ RM. 711-LOB
ALBANY, N. Y. 12247
(518) 455-2111
☐ 100 GARDEN CITY PLAZA
GARDEN CITY, N. Y. 11530
(516) 746-7500
☐ 550 STEWART AVE
GARDEN CITY, N. Y. 11530
(516) 222-0068

July 14, 1981

John G. McGoldrick, Esq.
Counsel to the Governor
Executive Chamber
The Capitol
Albany, New York 12224

Re: Senate Bills 3822 and 6905

Dear Mr. McGoldrick:

This letter is in support of Senate Bills 3822 and 6905 (a Chapter Amendment to 3822) which I sponsored at the request of the Insurance Department. The bills would authorize the conversion of a domestic mutual casualty, surety, fire or marine insurance company or advance premium corporation into a domestic stock insurer, establishing detailed procedures to be followed for the conversion of such insurers not in rehabilitation.

New York is one of the few remaining states which prohibits the conversion of mutual insurers to stock companies. The prohibition is an anachronism in the New York Statutes and should be eliminated. In order to obtain additional surplus, a mutual insurance company is limited to borrowing funds or soliciting contributions from its membership or merging with another mutual company. With prime rates fluctuating between 19% and 22% borrowing or soliciting funds are impractical alternatives at this time. Mergers between domestic mutuals are also infrequent and generally unattractive. The ability to offer equity participation in the company via stock ownership is clearly the most attractive alternative.

The Senate and Assembly have passed this legislation with the endorsement of the Insurance Department. It represents an effort to enhance the ability of New York mutual insurers to operate in our state and I encourage the Governor's support.

Sincerely,

John R. Dunne

JRD/TF:edg

MA

S- 3822

TEN DAY BILL C-657

FORM B-201(a) **BUDGET REPORT ON 10 AND 30 DAY BILLS** Session Year 1981

SENATE	Introduced by:	ASSEMBLY
No. 3822	Senator Dunne	No.

Law: Insurance

JUL 20 REC'D

Subject and Purpose (Brief Recapitulation): The purpose of this bill is to improve the probability of success for mutual insurance companies (not in rehabilitation) by the establishment of a mechanism for the conversion of such organizations into domestic stock insurers.

Division of the Budget recommendation on the above bill:

Approve:_____ Veto:_____ No Objection: X No Recommendation:_____

This bill is identical to (X) very similar to ( )

Insurance No. 31 which
(department or agency)

was submitted as a departmental proposal this year. The points made in our earlier analysis of the departmental proposal are still valid and our recommendation is unchanged.

(If the very similar category is checked, list below the changes contained in the bill as passed and discuss them to the required extent.)

Date: July 15, 1981 Examiner: Michael F. Gross

Disposition:_____ Chapter No. 114 Veto No._____

S - 3822

MA

STATE OF NEW YORK
INSURANCE DEPARTMENT
TWO WORLD TRADE CENTER
NEW YORK 10047

ALBERT B. LEWIS
SUPERINTENDENT OF INSURANCE

July 14, 1981

Honorable John McGoldrick
Counsel to the Governor
Executive Chamber
State Capitol
Albany, New York 12224

RE: Senate Bill 3822 (Senator Dunne)
Senate Bill 6905 (Senator Dunne)

JUL 15 1981

Dear Jack:

This is in response to your request for our comments concerning the two captioned bills. Senate Bill 3822 is the principal bill, and Senate Bill 6905 is a chapter amendment thereto. The bills should be considered together and are both discussed in this memorandum.

Senate Bill 3822 is the Insurance Department's Legislative Proposal #31 for 1981. The bill would authorize the conversion of a domestic mutual casualty, surety, fire or marine insurance company or advance premium corporation into a domestic stock insurer, establishing detailed procedures to be followed for the conversion of such insurers not in rehabilitation. The bill would take effect immediately. A copy of the Insurance Department's Memorandum in Support is attached.

Senate Bill 6905, also introduced at the request of the Insurance Department, makes provision for the manner of treating the holders of notes issued in accordance with the provisions of Section 76 of the Insurance Law.

The Insurance Department recommends approval of both bills.

Respectfully submitted,

ALBERT B. LEWIS
Superintendent of Insurance

Attachment

STATE OF NEW YORK
INSURANCE DEPARTMENT
TWO WORLD TRADE CENTER
NEW YORK 10047

ALBERT B. LEWIS
SUPERINTENDENT OF INSURANCE

(INS. DEPT. #31-1981)

Senate No. _____

Assembly No. _____

M E M O R A N D U M

AN ACT to amend the insurance law, in relation to the conversion of a domestic mutual casualty, surety, fire or marine insurer or advance premium corporation into a domestic stock insurer and establishing procedures for conversions of such companies not in rehabilitation, and the standards for approval by the superintendent of insurance of certain agreements under article fifteen of such law

1. Purpose:

To authorize the conversion of a domestic mutual casualty, surety, fire or marine insurance company or advance premium corporation into a domestic stock insurer, establishing detailed procedures to be followed for the conversion of such insurers not in rehabilitation.

2. Summary of provisions:

Section 1 of the bill would amend Section 54 of the Insurance Law to provide that no mutual insurance corporation shall be converted into a stock corporation except pursuant to the provisions of Article XV which are applicable to the conversion of such insurance corporation.

Section 2 of the bill makes a technical change in the definition of "conversion" set forth in Section 480(3) to delete the prohibition of conversion of mutual insurers.

Section 3 of the law amends Section 486 of the Insurance Law, dealing with the approval by the Superintendent of agreements of merger or consolidation or for the acquisition of assets. The bill would require the Superintendent to consider whether the agreement "does not tend to substantially lessen competition in any line of insurance or tend to create a monopoly therein..."

Section 4 of the bill adds a new Section 487-b, relating to insurers not in rehabilitation, which provides that a domestic mutual insurer which

is authorized to issue non-assessable policies only, or a domestic advance premium corporation which issues non-assessable policies only, may apply to the Superintendent for permission to convert into a domestic stock insurer. The section sets forth detailed procedures for: the filing of the resolution by the board of directors; examination and appraisal of the insurer by order of the Superintendent; submission of the examination report and the appraisal to the board; the Superintendent's granting of permission to the board to prepare a conversion plan for review by the Superintendent, which plan would include the manner and basis of determining and exchanging the equitable share of policyholders; and the holding of a public hearing by the Superintendent.

The bill authorizes the Superintendent to approve, refuse to approve or request modification of the plan before granting approval. Approval by the Superintendent is predicated upon his finding that the plan does not violate the Insurance Law, is not inconsistent with law, is fair and equitable and in the best interests of the policyholders and the public.

After approval by the Superintendent the conversion plan would be submitted to a vote of the policyholders. The votes of two-thirds of the votes cast shall be necessary for the adoption of the plan. If the plan is adopted by the policyholders, the Superintendent would issue a new certificate of authority and the mutual company would immediately become a stock corporation.

Section 487-b also sets forth safeguards to protect the integrity of the new stock insurer, including a prohibition against redomestication outside of the State for a period of ten years.

Section 5 of the bill provides an immediate effective date.

3. Existing Law:

Section 54 of the Insurance Law provides that no mutual insurance corporation and no fraternal benefit society shall be converted into a stock corporation. The prohibition against the conversion of a fraternal benefit society or a mutual insurer, other than a mutual casualty, surety, fire or marine insurer or advance premium corporation would continue unchanged.

4. Statement in Support:

In order to obtain additional surplus a mutual insurance company is limited to borrowing funds or soliciting contributions from its membership or merger with another mutual insurance company. Mutual insurers do not issue equities, and the present interest rates make borrowing extremely difficult.

It is often difficult for a mutual insurer to obtain needed capital, since its alternatives for the infusion of funds are extremely limited. Section 487-b as added by this bill would provide a vehicle for raising capital through the conversion of the insurer into a stock corporation, while at the same time providing adequate safeguards for equitable treatment of policyholders and fair procedures in the execution of the conversion.

A company converted into a stock corporation would also obtain certain advantages which are currently enjoyed by stock corporations, including greater flexibility in attracting or retaining qualified personnel.

A separate bill is being introduced by the Insurance Department to authorize the conversion of such insurers in rehabilitation (1981 Legislative Proposal #12).

5. Budget implications:

None.

Information on this bill may be obtained from John P. Gemma, Special Counsel to the Superintendent, N.Y. (212) 488-4652 or Milton L. Freedman, Assistant General Counsel, N.Y. (212) 488-4183.

MA

C-651

S-3822

b J

STATE OF NEW YORK
OFFICE OF COURT ADMINISTRATION
270 BROADWAY
NEW YORK, N. Y. 10007
(212) 488-6543

HERBERT B. EVANS
CHIEF ADMINISTRATIVE JUDGE

PAUL A. FEIGENBAUM
COUNSEL

July 13, 1981

Honorable John G. McGoldrick
Counsel to the Governor
Executive Chamber
State Capitol
Albany, New York 12224

JUL 14 RECD

Re: Senate 3822

Dear Mr. McGoldrick:

This will acknowledge your request for comment on the above-listed legislation.

This measure would amend the Insurance Law, in relation to the conversion of a domestic mutual casualty, surety, fire or marine insurer or advance premium corporation into a domestic stock insurer and establishing procedures for conversions of such companies not in rehabilitation, and the standards of approval by the Superintendent of Insurance of certain agreements under Article 15 of such law.

Since this measure has no impact on court administration, this Office is taking no position on this bill.

Very truly yours,

Paul A. Feigenbaum

PAF:eas

53822

YEA

STATE OF NEW YORK
BANKING DEPARTMENT
TWO WORLD TRADE CENTER
NEW YORK, N.Y. 10047

MURIEL SIEBERT
SUPERINTENDENT

July 13, 1981

JUL 15 RECD

BANKING DEPARTMENT
MEMORANDUM ON BILL
BEFORE THE GOVERNOR
FOR EXECUTIVE ACTION

SENATE	ASSEMBLY	Introduced by:
3822		Sen. Dunne

RECOMMENDATION: No recommendation

STATUTE INVOLVED: Insurance Law Sections 54, 480, 486 and 487-b

Summary of Provisions of Bill:

This bill permits the conversion of a domestic mutual casualty, surety, fire or marine insurer or advance premium corporation into a domestic stock insurer.

Comment:

The subject of this bill is outside the expertise and jurisdiction of the Banking Department. Accordingly, no recommendation is made.

oOo

NLA

JUL 15 RECD

S-3822

WILLIAM D. HASSETT, JR.
COMMISSIONER

STATE OF NEW YORK
DEPARTMENT OF COMMERCE
99 WASHINGTON AVENUE
ALBANY, NEW YORK 12245

John J. Kelliher
Deputy Commissioner & Counsel
(518) 474-4102

TEN-DAY BILL MEMO

July 15, 1981

TO: JOHN G. McGOLDRICK
COUNSEL TO THE GOVERNOR

FROM: John J. Kelliher, Counsel
Department of Commerce

SUBJECT:

SENATE:
1605-A (Trunzo, Johnson, et al.)
1739 (Lavalle)
3822 (Dunne)
4299 (Bruno)

ASSEMBLY: 8994 (Committee on Rules)

RECOMMENDATION: No Objection

The Department of Commerce has no objection to the above-referenced bills which are before the Governor.

J.J.K.

MA

C-657 S-3822

THE CITY OF NEW YORK
OFFICE OF THE MAYOR

MARGARET L. WEISS
LEGISLATIVE REPRESENTATIVE

111 Washington Avenue
Albany, New York 12210
(518) 462-5611

52 Chambers Street
New York, New York 10007
(212) 566-5135

JUL 16 1981

July 16, 1981

M E M O R A N D U M

TO: Honorable John G. McGoldrick
Counsel to the Governor

FROM: Margaret L. Weiss

RE: Senate Bill No. 3822 - By Senator Dunne

AN ACT to amend the insurance law, in relation to the conversion of a domestic mutual casualty, surety, fire or marine insurer or advance premium corporation into a domestic stock insurer and establishing procedures for conversions of such companies not in rehabilitation, and the standards for approval by the superintendent of insurance of certain agreements under article fifteen of such law

You have requested the comments and recommendation of the Mayor concerning the above bill which is before the Governor for executive action.

Please be advised that the Mayor has no recommendation with respect to said legislation.

N/R

MA

S 3822

JUL 15 Rec'd

TO COUNSEL TO THE GOVERNOR

RE: SENATE 3822

~~ASSEMBLY~~

Inasmuch as this bill does not appear to relate to the functions of the Department of Law, I am not commenting thereon, at this time. However, if there is a particular aspect of the bill upon which you wish comment, please advise me.

ROBERT ABRAMS
Attorney General

Dated: JUL 9 1981

S-3822

NEW YORK STATE MUTUAL INSURANCE ASSOCIATION

EXECUTIVE PARK EAST
ALBANY, NEW YORK 12203
PHONE (518) 489-1554

July 10, 1981

Hon. John G. McGoldrick
Executive Chamber
State Capitol
Albany, New York 12224

JUL 13 RECD

Dear Mr. McGoldrick:

Several bills of interest to the insurance industry have recently passed both Houses of Legislature, with respect to which we anticipate affirmative action by the Governor.

It is with that thought in mind that I would like to suggest that even a brief bill-signing ceremony would be most appropriate.

Getting down to further details, one group of bills would, in essence, permit insurers who are licensed to sell Workers' Compensation insurance to engage in the investigation and processing of compensation claims on behalf of self-insurers.

Another bill would permit certain types of domestic mutual insurers to convert to stock corporate form, upon the approval of the Superintendent of Insurance. This is a program bill of the State Insurance Department and one we support and have supported fully.

The conversion bill is Senate 3822. The Workers' Compensation bills are Assembly 7350-A; Assembly 8954 and Assembly 9012.

NEW YORK STATE MUTUAL INSURANCE ASSOCIATION

Representatives of such corporate giants as the Continental, the Royal Globe, the Aetna and the Traveller's would welcome a chance to be present should the prior bill be approved, while the officers of our Association would welcome an opportunity to witness the approval of the Insurance Department's bill.

Very truly,

Joseph J. Rose

JJR/bml

Joseph J. Rose,
Executive Director
and Secretary

S-3822

NEW YORK STATE MUTUAL INSURANCE ASSOCIATION

EXECUTIVE PARK EAST
ALBANY, NEW YORK 12203
PHONE (518) 489-1554

July 10, 1981

Hon John C. McGoldrick
Counsel to the Governor
Executive Chamber
State Capitol
Albany, New York 12224

JUL 13 1981

Re: Senate 3822

Dear Mr. McGoldrick:

This Association, together with the insurance industry, wholeheartedly support this bill, introduced at the request of the New York State Insurance Department. We do so for the specific reasons given in our memorandum of support, which is attached hereto. You will note our observation therein that only seven states (including New York and Massachusetts) have statutes which prohibit conversion. We understand that Massachusetts is now considering legislation which will permit the conversion of a mutual insurer to stock form.

Approval of this bill, therefore, will keep New York competitive with our sister States and, in the long run, may well foster the growth of New York's own domestic insurance industry.

We compliment the Insurance Department on its foresight in sponsoring this bill and we urge its approval.

Very truly,

Joseph J. Rose,
Executive Director
and Secretary

JJR/bml
Att.

NEW YORK STATE MUTUAL INSURANCE ASSOCIATION

EDWARD P. LALLEY, President
THOMAS P. BONAROS, First Vice President
ROBERT B. PROPER, Second Vice President
JOSEPH J. ROSE, Executive Director & Secretary
CHARLES J. CLAUSS, Treasurer

EXECUTIVE PARK EAST
ALBANY, NEW YORK 12203
PHONE (518) 489-1554

MEMORANDUM IN SUPPORT OF

SENATE 3822 (by Mr. Dunne)

This bill would amend the Insurance Law, to permit a domestic mutual casualty, surety, fire or marine insurer or an advance premium corporation to convert into a domestic stock insurance corporation. It also establishes the procedures for the conversion of such companies, if they are not in rehabilitation, as well as the standards for approval by the Superintendent of Insurance of certain agreements under Article 15 of the Insurance Law.

We support this bill and urge its enactment, for the following reasons:

1. It will modernize this aspect of our Insurance Law, bringing New York in line with the vast majority of the other states. Twenty-four states and one territory have a statute that allows conversion; nineteen states and one district do not have a conversion statute. (Demutualization probably can be accomplished in those states that do not have laws specifically authorizing it.) Only seven states prohibit conversion. Those seven states are as follows:

Alaska	New York
Hawaii	South Dakota
Idaho	Washington
Massachusetts	

Examination of the list of seven states which prohibit conversion, (with the possible exception of Massachusetts) readily shows little or no domestic insurance interest anyway, but for New York. We thus remain one of the last two major states to prohibit the conversion of a mutual to a stock corporation and have fallen far behind the lead of our sister states in this area. This bill will make New York competitive once again.

2. The bill is an economic necessity for our domestic mutual insurance industry. The most frequent reason for a mutual to become a stock company is to be able to acquire additional sources of capital from external

sources. The enactment of a conversion statute will give the management of mutual (and advance premium) companies a means by which to raise capital. It is generally agreed that one of the most difficult problems faced by mutual companies is the difficulty in having a lack of capital for expansion. While our insurance Law allows mutual companies to borrow money, it contains restrictions that make potential lenders reluctant to participate. For example, lenders are placed in a subordinated position with respect to repayment of the loan and repayment requires the approval of the Superintendent. With such restrictions it is obvious that potential lenders become wary. From the borrower's point of view, such loans involve making interest payments in good times and bad, wheras dividends on common stock can follow the fortunes of the company, a vital factor when one considers the cyclical nature of this business. Equally important, even if all restrictions upon borrowing and repayment were to be eliminated, the current high interest rates would discourage borrowing, anyway.

3. Conversions generally are in the public interest. We submit that there are many excellent mutual insurance companies, both large and small, servicing the public well. We have to recognize, at the same time, that the mutual format lacks flexibility, primarily in that additional funds may not be raised other than through earnings from operations. At least 100 mutual and reciprocal property-casualty insurance companies have become stock companies since 1930. A study made a decade ago found that 105 then-existing stock life and health companies had their origins as mutual organizations. Another study has shown that growth usually occurs after conversion, to the benefit of both policyholders and stockholders.

We urge your support of this bill.

Respectfully submitted,

Joseph J. Rose,
Executive Director
and Secretary

EXHIBIT V-1

SIMPLE ANSWERS TO QUESTIONNAIRE REGARDING STATUS OF STATE CONVERSION STATUTES

Seven states prohibit conversion:

Alaska	New York
Hawaii	South Dakota
Idaho	Washington
Massachusetts	

Nineteen states and one district do not have a conversion statute:

California	Nevada
Colorado	New Hampshire
Connecticut	North Carolina
District of Columbia	North Dakota
Illinois	Oregon
Iowa	Rhode Island
Kansas	Tennessee
Michigan	Texas
Mississippi	Alabama
Missouri	New Mexico

Twenty-four states and one territory have a statute that allows conversion:

Arizona	New Jersey
Arkansas	Ohio
Delaware	Oklahoma
Florida	Pennsylvania
Georgia	Puerto Rico
Indiana	South Carolina
Kentucky	Utah
Louisiana	Vermont
Maine	Virginia
Maryland	West Virginia
Minnesota	Wisconsin
Montana	Wyoming
Nebraska	

CALENDER NO. 230

STATE OF NEW YORK

3822

Printed & Placed on MAR 17 1981 Desks of SENATORS

1981-1982 Regular Sessions

IN SENATE

INSENATE MAY 5 - 1981 To First Report

March 3, 1981

Introduced by Sen. DUNNE--(at request of the Insurance Department)--read twice and ordered printed, and when printed to be committed to the Committee on Insurance

AN ACT to amend the insurance law, in relation to the conversion of a domestic mutual casualty, surety, fire or marine insurer or advance premium corporation into a domestic stock insurer and establishing procedures for conversions of such companies not in rehabilitation, and the standards for approval by the superintendent of insurance of certain agreements under article fifteen of such law

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Section fifty-four of the insurance law is amended to read as follows:

§ 54. Prohibited conversion. No [mutual insurance corporation and no] fraternal benefit society shall be converted into a stock corporation. *No mutual insurance corporation shall be converted into a stock corporation except pursuant to the provisions of article fifteen of this chapter which are applicable to the conversion of such insurance corporation.*

§ 2. Subdivision three of section four hundred eighty of such law, as amended by chapter one hundred ninety of the laws of nineteen hundred sixty-nine, is amended to read as follows:

3. The term "conversion," as used in this article, means the change of an insurer of one type into an insurer of another type[, but not including the change of any mutual insurance company into a stock insurance company].

§ 3. Section four hundred eighty-six of such law, as amended by chapter one hundred ninety of the laws of nineteen hundred sixty-nine, is amended to read as follows:

EXPLANATION--Matter in *italics* (underscored) is new; matter in brackets [ ] is old law to be omitted.

LBD1-22-10-Y17

§ 486. Approval by superintendent. Upon the adoption of an agreement of merger or consolidation, or an agreement for the acquisition of assets, the proposed agreement shall be executed by the president and attested by the secretary, or the executive officers corresponding thereto, under the corporate seal of each of the consolidating or contracting companies. A certified copy of such agreement, together with a certificate of its adoption as provided for herein, subscribed by such officers and affirmed by them as true under the penalties of perjury and under the seal of each of said companies, shall be submitted to the superintendent for his approval. The superintendent shall thereupon consider such agreement, and if satisfied that it complies with this article, is fair and equitable, does not tend to substantially lessen competition in any line of insurance or tend to create a monopoly therein, and is not inconsistent with law, he shall approve such agreement. If the superintendent shall refuse to approve such agreement, notification of such refusal, assigning the reasons therefor, shall within thirty days from the date of submission to him of such agreement be given in writing by the superintendent to each of said companies parties thereto. No agreement shall take effect unless the approval of the superintendent has been obtained.

§ 4. Such law is amended by adding a new section four hundred eighty-seven-b to read as follows:

§ 487-b. Conversion of a domestic mutual casualty, surety, fire or marine insurer or advance premium corporation into a domestic stock insurer; insurer not in rehabilitation. 1. As used in this section the following terms shall have the following meanings:

(a) "Affiliate" of a mutual insurer means any other person who controls, is controlled by or is under common control with, the mutual insurer being converted. A corporation is an affiliate of another corporation, regardless of ownership, if substantially the same group of persons manage the two corporations.

(b) "Control" shall have the same meaning assigned to it in paragraph (b) of subdivision one of section sixty-nine-a of this chapter.

2. A domestic mutual insurer which is authorized to issue non-assessable policies only and which is organized under article IV of this chapter and licensed pursuant to article X or XI-A of this chapter and not operating under an order of rehabilitation, or a domestic advance premium corporation which issues non-assessable policies only and is organized and licensed under article XI-B of this chapter and not operating under an order of rehabilitation, may apply to the superintendent for permission to convert into a domestic stock insurer to be organized under article IV and licensed under article X or XI-A of this chapter. As used in this section, the term "domestic mutual insurer" or "mutual insurer" shall include a domestic advance premium corporation. The application to the superintendent shall be in the form of a resolution, adopted by no less than a majority of the entire board of directors. The resolution shall specify the reasons for and the purposes of the proposed conversion, and the manner in which the conversion is expected to benefit policyholders and the public. Upon adoption of the resolution, it shall be duly executed by the president and attested by the secretary, or the executive officers corresponding thereto, under the corporate seal of the mutual insurer. Thereupon, a certified copy of the resolution, together with a certificate of its adoption by the board subscribed by such officers and affirmed by them as true under the penalties of perjury and under the seal of the mutual insurer, shall be

submitted to the superintendent. The superintendent may thereafter request any additional documents and information which he may reasonably require. Unless the superintendent finds that: (a) the resolution is defective upon its face; or (b) the proposed conversion is contrary to law or is not in the best interests of the policyholders or the public; or (c) the mutual insurer does not have a surplus to policyholders at least equal to the minimum capital and surplus required by the superintendent for a newly organized stock insurer doing the same kind or kinds of insurance; or (d) the mutual insurer is impaired, in which cases the proposed conversion shall terminate, the superintendent shall order an examination of the mutual insurer as of the last day of the period covered in its latest filed annual or quarterly statement pursuant to section twenty-nine of this chapter. The superintendent may also examine any affiliate of the mutual insurer.

3. The superintendent shall also appoint one or more qualified disinterested persons to appraise the value of the mutual insurer and, to the extent necessary, its affiliates, on the basis of fair market value as of the last day of the period covered in its latest filed annual or quarterly statement, including any significant developments occurring subsequent to such date. Such persons shall consider the assets and liabilities of the mutual insurer and any factors bearing on the value of the mutual insurer or its affiliates. The appraisal report shall be made to the superintendent. The appraisers shall receive reasonable compensation and shall be reimbursed for reasonable expenses incurred in discharging their duties. They may, as necessary, employ consultants to advise them on any technical matters associated with the appraisal.

4. The superintendent shall make copies of such examination report and appraisal available to the board of directors within fifteen days of his receipt of the report and appraisal. On the basis of such examination report and appraisal, the superintendent may grant permission to the board of directors to prepare a plan of conversion, for adoption by no less than a majority of the entire board, and submission to the superintendent not later than forty-five days after such permission is granted. Such permission to prepare a plan shall not be denied by the superintendent unless such denial is set forth in writing with a statement of his findings; the board shall have the right to a hearing before the superintendent within thirty days of the date of such denial. If such permission is granted, the plan shall include, in addition to any other material requested by the superintendent, the following:

(a) the proposed charter and by-laws of the stock corporation set out in accordance with section forty-eight of this chapter;

(b) the manner and basis of exchanging the equitable share of each mutual policyholder for securities and/or other consideration of the stock corporation into which the mutual insurer is to be converted and the treatment of any unclaimed shares. The plan shall also provide that each person who had a policy of insurance in effect at any time during the three year period preceding the date the resolution described in subdivision two of this section is adopted by the board of directors shall be entitled to receive in exchange for such equitable share, without additional payment, consideration payable in voting common shares of the stock corporation and/or other consideration. The equitable share of the policyholder in the mutual insurer shall be determined by the ratio which the net premiums (gross premiums less return premiums and dividend paid) such policyholder has properly and timely paid to the mutual insurer on insurance policies in effect during the three years

immediately preceding the adoption of the resolution by the board of directors under subdivision two of this section bears to the total net premiums received by the mutual insurer from such eligible policyholders. In computing a policyholder's equitable share, no credit shall be given for any net premiums which result from an endorsement which is effective on or after the date of the adoption of the resolution; except that credit shall be given for any net premiums resulting from an audit or retrospective premium adjustment which is billed within one hundred eighty days after the date the resolution is adopted, provided such premium is paid timely. If the equitable share of the eligible policyholder entitles said policyholder to the purchase of a fractional share of stock, the policyholder shall have the option either to receive the value of the fractional share in cash or to purchase a full share by paying the balance in cash;

(c) the number of voting common shares proposed to be authorized for the new stock corporation, their par value and the price at which they shall be offered, which price may not exceed one-half of the median equitable share of all policyholders under paragraph (b) of this subdivision.

5. No voting common shares shall be subscribed by or issued to persons other than such policyholders until all subscriptions by the policyholders have been filled or other consideration has been provided in accordance with the plan of conversion. Thereafter, any new issue of common stock within three years after the conversion shall first be offered to the persons who have become voting common shareholders, pursuant to paragraph (b) of subdivision four of this section, in accordance with the plan of conversion, in proportion to their interests pursuant to such paragraph (b).

6. The plan of conversion shall be executed by the president and attested by the secretary, or the executive officers corresponding thereto, under the corporate seal of the mutual insurer. A certified copy of the plan together with a certificate of its adoption by the board subscribed by such officers and affirmed by them as true under the penalties of perjury and under the seal of the mutual insurer, shall be submitted to the superintendent for approval.

7. The superintendent shall hold a public hearing, adequate notice of which shall be mailed by the mutual insurer to each person who was a policyholder of the mutual insurer on the day preceding the date the resolution was adopted by the board of directors in compliance with subdivision two of this section. Such notice shall contain a copy of the plan of conversion and any comment the superintendent considers necessary for the adequate information of the policyholders. In addition, the insurer shall give notice of the hearing by publication in a newspaper of general circulation in the county in which the insurer has its principal office and in the two largest cities in each state in which the insurer has underwritten insurance within the five years preceding the date of the adoption of the resolution; such notice shall include a summary approved by the superintendent of the proposed plan for conversion and any comment the superintendent considers necessary for the adequate information of former policyholders and the public.

8. (a) After the hearing the superintendent shall: approve the plan as submitted, refuse to approve the plan, or request modification of the plan before granting approval. If the superintendent finds that the plan does not violate the insurance law, is not inconsistent with law, is fair and equitable and is in the best interests of the policyholders and

the public, he shall approve such plan. If the superintendent finds that the plan does not meet the foregoing standards for approval he shall either refuse to approve the plan and the plan shall become null and void or he shall return the plan to the mutual insurer for modification to meet his objections.

(b) If within ninety days after receipt of the superintendent's request for modifications the insurer submits an amended plan which meets the superintendent's objections and complies with the standards for approval he shall approve such amended plan.

9. After approval by the superintendent the conversion plan shall be submitted to a vote of the persons who were policyholders of the mutual insurer on the day preceding the date the resolution was adopted by the board of directors in compliance with subdivision two of this section. Such plan shall provide for proxy voting in a manner to be prescribed by the superintendent. The board shall submit the question of the plan to such policyholders of the insurer at any special or any regular, annual or periodic meeting thereof, by causing a full, true and correct copy of such plan or a summary thereof approved by the superintendent, together with notice, stating the time, place and purpose of such meeting, to be delivered personally, or deposited in the post office, postage prepaid, at least thirty days (unless a shorter time, not less than ten days, be approved by the superintendent) prior to the time fixed for such meeting, addressed to each such policyholder at his last post office address appearing on the records of the insurer.

10. Each such policyholder eligible to vote pursuant to subdivision nine of this section shall be entitled to such number of votes as may be provided for in the by-laws of the mutual insurer. The votes of two-thirds of all the votes cast by policyholders respresented at the meeting in person or by proxy, shall be necessary for the adoption of the plan of conversion. Upon the conclusion of the vote the insurer shall submit to the superintendent a certified copy of the plan voted on together with a certificate setting forth the results of the vote, both of which shall be subscribed by the president and attested by the secretary, or the executive officers corresponding thereto, and affirmed by them as true under the penalties of perjury and under the corporate seal of the mutual insurer.

11. If the conversion plan is adopted in accordance with the provisions of subdivision ten of this section, the superintendent shall issue a new certificate of authority to the converted corporation, provided that the new stock insurer will have at least the minimum capital and surplus required by the superintendent for a newly organized domestic stock insurer doing the same kind or kinds of insurance. The issuance of the certificate is the act of conversion and the mutual insurer shall immediately become a stock corporation. In connection with the granting of such certificate of authority, the superintendent may issue such license as may be required under section fifty-one of this chapter.

12. Upon conversion the new stock insurer shall give notice of the conversion by publication in a newspaper of general circulation in the county in which the insurer has its principal office and in the two largest cities in each state which the insurer shall be licensed to do business, provided, however, that a full, true and correct copy of the plan of conversion, or a summary thereof approved by the superintendent, shall be included in such notice.

13. Upon the conversion of the mutual insurer in the manner herein provided, all the rights, franchises and interests of the former mutual

insurer, in and to every species of property, real, personal and mixed, and things in action thereunto belonging, shall be deemed as transferred to and vested in the new stock insurer, without any other deed or transfer; and simultaneously therewith such company shall be deemed to have assumed all of the obligations and liabilities of the former mutual insurer.

14. No action or proceeding, pending at the time of the conversion to which the predecessor insurer may be a party shall be abated or discontinued by reason of such conversion, but the same may be prosecuted to final judgment in the same manner as if the conversion had not taken place, or the new corporation may be substituted in place of such predecessor insurer by order of the court in which the action or proceeding may be pending.

15. The directors and officers of the mutual insurer shall serve until new directors and officers have been duly elected and qualified pursuant to the charter and by-laws of the stock insurer.

16. Neither the mutual insurer nor the stock insurer shall pay compensation of any kind to any person other than regular salaries to existing personnel, in connection with the proposed conversion, other than for clerical and mailing expenses, except that, with the superintendent's approval, payment may be made at reasonable rates for printing costs, and for legal and other professional fees for services actually rendered. All expenses of the conversion, including the expenses incurred by the insurance department, shall be borne by the company being converted.

17. Notice shall be given by the mutual insurer to all persons who become policyholders on or after the date of the adoption of the resolution, of the pendency of a proposed conversion and of the effect thereof on such policyholders.

18. No insurer formed as a domestic stock insurer under the provisions of this section shall: for a period of ten years after conversion, redomesticate directly or indirectly or remove its principal offices from within the state; or for a period of five years after conversion (a) enter into any agreement by the terms of which any person, partnership or corporation agrees to pay all or a portion of the expenses of management of such insurance corporation in consideration of an agreement to pay him or it either commissions on premiums due the insurance corporation or any other compensation for his or its services, or (b) enter into any agreement with an officer or director of the insurance corporation or with any firm or corporation in which any officer or director of the insurance corporation is pecuniarily interested, directly or indirectly, under which agreement the insurance corporation agrees to pay, for the acquisition of business, any commissions or other compensation which by the terms of such agreement is increased or diminished by the amount of such business or by the earnings of the insurance corporation on such business.

19. No domestic mutual insurer which is affiliated with other mutual companies may be converted to a stock corporation unless all such affiliated companies are converted at the same time, or the superintendent determines that the interests of the policyholders of the remaining mutual companies can be permanently protected by limitations on the corporate powers of the new stock corporation or on its authority to do business.

20. If at any stage in the process of a conversion under this section the superintendent finds that the mutual insurer is impaired or that the

NOT

CHAPTER 552

LAWS OF 2014

SENATE BILL 6545-A

ASSEMBLY BILL ---

STATE OF NEW YORK

6545--A

Cal. No. 150

IN SENATE

February 4, 2014

Introduced by Sens. SEWARD, LATIMER, MARTINS -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance -- reported favorably from said committee, ordered to first and second report, ordered to a third reading, amended and ordered reprinted, retaining its place in the order of third reading

AN ACT to amend the insurance law, in relation to certificates of insurance

A9590/Morelle

DATE RECEIVED BY GOVERNOR:

12/30/14

ACTION MUST BE TAKEN BY:

1/29/14

DATE GOVERNOR'S ACTION TAKEN:

1/29/14

SENATE VOTE 58 Y 0 N HOME RULE MESSAGE ___Y ___N

DATE 5/19/14

ASSEMBLY VOTE 133 Y 0 N

DATE 6/10/14

06/10/14	S6545-A	Assembly Vote	Yes: 133	No : 0
05/19/14	S6545-A	Senate Vote	Aye: 58	Nay: 0

Go to Top of Page

Floor Votes:

06/10/14 S6545-A Assembly Vote Yes: 133 No : 0

Yes	Abbate	**Yes**	Abinanti	**ER**	Arroyo	**Yes**	Aubry
Yes	Barclay	**Yes**	Barrett	**Yes**	Benedetto	**Yes**	Blankenbush
Yes	Borelli	**Yes**	Braunstein	**Yes**	Brennan	**Yes**	Brindisi
Yes	Bronson	**Yes**	Brook-Krasny	**Yes**	Buchwald	**Yes**	Butler
Yes	Cahill	**Yes**	Camara	**Yes**	Ceretto	**Yes**	Clark
Yes	Colton	**Yes**	Cook	**Yes**	Corwin	**Yes**	Crespo
Yes	Crouch	**Yes**	Curran	**Yes**	Cusick	**Yes**	Cymbrowitz
Yes	Davila	**Yes**	DenDekker	**Yes**	Dinowitz	**Yes**	DiPietro
Yes	Duprey	**Yes**	Englebright	**Yes**	Fahy	**Yes**	Farrell
Yes	Finch	**Yes**	Fitzpatrick	**Yes**	Friend	**Yes**	Galef
Yes	Gantt	**Yes**	Garbarino	**Yes**	Giglio	**Yes**	Gjonaj
Yes	Glick	**Yes**	Goldfeder	**Yes**	Goodell	**Yes**	Gottfried
Yes	Graf	**Yes**	Gunther A	**Yes**	Hawley	**Yes**	Heastie
Yes	Hennessey	**Yes**	Hevesi	**Yes**	Hikind	**Yes**	Hooper
Yes	Jacobs	**Yes**	Jaffee	**Yes**	Johns	**Yes**	Katz
Yes	Kavanagh	**Yes**	Kearns	**AB**	Kellner	**Yes**	Kim
Yes	Kolb	**Yes**	Lalor	**Yes**	Lavine	**Yes**	Lentol
Yes	Lifton	**Yes**	Lopez P	**Yes**	Lupardo	**Yes**	Lupinacci
Yes	Magee	**ER**	Magnarelli	**Yes**	Malliotakis	**Yes**	Markey
Yes	Mayer	**Yes**	McDonald	**Yes**	McDonough	**Yes**	McKevitt
Yes	McLaughlin	**Yes**	Miller	**Yes**	Millman	**Yes**	Montesano
Yes	Morelle	**Yes**	Mosley	**Yes**	Moya	**ER**	Nojay
Yes	Nolan	**Yes**	Oaks	**Yes**	O'Donnell	**Yes**	Ortiz
Yes	Otis	**Yes**	Palmesano	**Yes**	Palumbo	**Yes**	Paulin
Yes	Peoples-Stokes	**Yes**	Perry	**Yes**	Pichardo	**Yes**	Pretlow
Yes	Quart	**Yes**	Ra	**Yes**	Raia	**Yes**	Ramos
Yes	Rivera	**Yes**	Roberts	**Yes**	Robinson	**Yes**	Rodriguez
Yes	Rosa	**Yes**	Rosenthal	**Yes**	Rozic	**Yes**	Russell
ER	Ryan	**Yes**	Saladino	**Yes**	Santabarbara	**Yes**	Scarborough
Yes	Schimel	**Yes**	Schimminger	**Yes**	Sepulveda	**Yes**	Simanowitz
Yes	Simotas	**Yes**	Skartados	**Yes**	Skoufis	**Yes**	Solages
Yes	Stec	**Yes**	Steck	**Yes**	Stirpe	**Yes**	Sweeney
Yes	Tedisco	**ER**	Tenney	**Yes**	Thiele	**Yes**	Titone

Yes	Titus	**Yes**	Walter	**Yes**	Weinstein	**ER**	Weisenberg
Yes	Weprin	**Yes**	Wright	**Yes**	Zebrowski K	**Yes**	Mr. Speaker

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Floor Votes:

05/19/14 S6545-A Senate Vote Aye: 58 Nay: 0

Aye	Addabbo	**Aye**	Avella	**Aye**	Ball	**Aye**	Bonacic
Exc	Boyle	**Aye**	Breslin	**Aye**	Carlucci	**Aye**	DeFrancisco
Exc	Diaz	**Aye**	Dilan	**Aye**	Espaillat	**Aye**	Farley
Aye	Felder	**Aye**	Flanagan	**Aye**	Gallivan	**Aye**	Gianaris
Aye	Gipson	**Aye**	Golden	**Aye**	Griffo	**Aye**	Grisanti
Aye	Hannon	**Aye**	Hassell-Thompson	**Aye**	Hoylman	**Aye**	Kennedy
Aye	Klein	**Aye**	Krueger	**Aye**	Lanza	**Aye**	Larkin
Aye	Latimer	**Aye**	LaValle	**Exc**	Libous	**Aye**	Little
Aye	Marcellino	**Aye**	Marchione	**Aye**	Martins	**Aye**	Maziarz
Aye	Montgomery	**Aye**	Nozzolio	**Aye**	O'Brien	**Aye**	O'Mara
Aye	Parker	**Aye**	Peralta	**Aye**	Perkins	**Aye**	Ranzenhofer
Aye	Ritchie	**Aye**	Rivera	**Aye**	Robach	**Aye**	Sampson
Aye	Sanders	**Aye**	Savino	**Aye**	Serrano	**Aye**	Seward
Aye	Skelos	**Aye**	Smith	**Aye**	Squadron	**Aye**	Stavisky
Aye	Stewart-Cousins	**Aye**	Tkaczyk	**Aye**	Valesky	**Aye**	Young
Aye	Zeldin						

STATE OF NEW YORK
EXECUTIVE CHAMBER
ALBANY 12224

CHAPTER #552
APPROVAL #37

JAN 29 2015

MEMORANDUM filed with Senate Bill 6545-A, entitled:

"AN ACT to amend the insurance law, in relation to certificates of insurance"

APPROVED

This bill would regulate the form and content of certificates of insurance to ensure that such certificates are not misused or abused. As drafted, however, it contains a number of technical flaws and would not provide sufficient oversight authority to the Department of Financial Services. The Legislature has agreed to amend this bill and enact a chapter amendment to correct these deficiencies and on that basis, I am signing this bill.

The bill is approved.

S6545-A

THE ASSEMBLY
STATE OF NEW YORK
ALBANY

KEVIN A. CAHILL
Assemblymember 103rd District

CHAIR
Assembly Insurance Committee

COMMITTEES
Ways and Means

Economic Development, Job Creation, Commerce & Industry

Ethics and Guidance

Health

Higher Education

December 9, 2014

Honorable Andrew Cuomo, Governor
State of New York
New York State Capitol Building
Office of the Governor, Executive Chamber
Albany, New York 12224

Dear Governor Cuomo:

I write regarding Assembly Bill A. 9590 (Morelle), an act to amend the insurance law, in relation to certificates of insurance. A previous version of this bill was vetoed last year due to concerns over a potentially negative impact to state agencies. However, the New York State Assembly firmly believes these issues were directly and adequately addressed through subsequent revisions that will provide some leeway to state agencies to issue their own certificates with approval from the Department of Financial Services. It remains clear that problems continue to persist that demand a legislative solution. As Chair of the Assembly Committee on Insurance, I respectfully request this bill be signed into law.

Certificates of insurance are issued by insurance producers in order to briefly outline and detail basic information about the coverage, terms, and limits of a specific policy. The insurance industry has long had problems regarding the misuse of these documents by bad actors in both the private and public sectors. For years, municipalities, government agencies, property owners, and others have asked contracting parties to provide certificates that attempt to modify the underlying policy's terms by expanding coverage that is not there or skirting liability in some fashion. Insurance producers are often required by their clients to issue a certificate or sign a pre-printed version that does not accurately reflect the policy terms. Thus, agents and brokers are put in an untenable position of being forced to either prepare a false document or lose a client. Assembly Bill A.9590 (Morelle) would stop this situation from arising by ensuring that a certificate of insurance is an accurate and honest portrayal of the underlying policy, while making it illegal for any person or governmental entity to demand their improper issuance.

This bill defines and standardizes the practice by encouraging the use of uniform certificate forms that are developed by the Association for Cooperative Operations Research and Development (ACORD) and the Insurance Services Office (ISO). This legislation would prohibit any person or governmental entity from preparing, issuing, or knowingly requesting a certificate of insurance that contains false or misleading information or otherwise attempts to alter, expand, or modify terms of the policy. Additionally, if enacted, the Department of

ALBANY OFFICE Room 716, Legislative Office Building, Albany, New York 12248, (518) 455-4436

DISTRICT OFFICE Governor Clinton Building, 1 Albany Avenue, Suite G-4, Kingston, New York 12401, (845) 338-9610

Financial Services (DFS) and the State Inspector General would be authorized to investigate and seek disciplinary measures against any violators of the provisions of this bill.

In recognition of your veto message (No. 257 of 2013), the legislature amended last year's bill to provide a limited exemption to state agencies who need the flexibility to request certificates that contain more detailed policy coverage information than what would be found within the generic forms required by this bill. Therefore, Subsection (4) of Section 502 was added in order to allow governmental entities the ability to promulgate certificates that have been approved by the Superintendent of DFS.

Enacting this legislation will assure certainty, as it expresses that it is the will of the legislature and people of New York that these unsavory practices meet a permanent end. This sentiment is underscored by the fact that the bill has found overwhelming support in both the Assembly and Senate – passing nearly unanimously in each house over the last two consecutive sessions. It will assure that departmental actions are supported by the force and effect of statutory authority and that local and out of state governments, which may operate beyond the reach of our regulatory apparatus, are prohibited from engaging in this harmful act. Passage into law will make certain the practice will immediately cease and that insurance producers will no longer be forced into a situation where they must choose between losing important business opportunities or breaking the law.

For the aforementioned reasons, I respectfully urge you to sign the bill, as it is a matter of great priority and public importance to residents of our state. We must take this opportunity to prevent dangerous misrepresentations and suspect practices that can unleash untold harm on our insurance market as well as the safety and financial well-being of New York's laborers and businesses.

Thank you in advance for your consideration. Please do not hesitate to contact me if I can provide anything further.

Sincerely,

Kevin A. Cahill

Kevin A. Cahill
Chair, Assembly Standing Committee on Insurance

cc: Honorable Joseph Morelle, Majority Leader, New York State Assembly
Seth Agata, Esq., Acting Counsel to the Governor, Office of Counsel to the Governor
Niall O'Hegarty, Esq., Counsel, Office of Counsel to the Governor
Mr. George Haggerty, Deputy Secretary for Financial Services, Office of the Secretary to the Governor
Mr. Brendan Fitzgerald, Assistant Secretary for Financial Services, Office of the Secretary to the Governor

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NEW YORK STATE SENATE
INTRODUCER'S MEMORANDUM IN SUPPORT
submitted in accordance with Senate Rule VI. Sec 1

BILL NUMBER: S6545A

SPONSOR: SEWARD

TITLE OF BILL: An act to amend the insurance law, in relation to certificates of insurance

PURPOSE: To establish standards for the proper issuance of certificates of insurance and to authorize the department of financial services and other entities to impose penalties against any person who violates the provisions of this article.

SUMMARY OF PROVISIONS: Section 1 adds a new article five to the insurance law, which sets forth specific standards for the issuance of certificates of insurance.

Section 501 provides for definitions of the terms "certificate", "certificate of insurance", "certificate holder", "insurance producer", "insurer", "person", and "policyholder."

Section 502 sets forth prohibited practices, including, altering or modifying a certificate of insurance form, knowingly requesting the issuance of a certificate of insurance that contains false or misleading information, issuing a certificate of insurance that alters the terms or coverage provided by the insurance policy, issuing an opinion letter or similar document that is inconsistent with this section. However, an accompanying addendum, with clarifying information is permissible.

Section 503 provides for the applicability of the provisions of this section.

Section 504 provides for enforcement powers of the superintendent, the NYS inspector general, and other appropriate entities.

Section 505 provides for rules and regulations to be adopted by the superintendent.

Section 2 of the bill provides for a 90 day effective date.

EXISTING LAW: Under current law, an insurance producer may not add terms or clauses to a certificate of insurance which alter, expand or otherwise modify the terms of the actual policy, unless authorized by the insurer which has filed an appropriate endorsement with the Department of Financial Services. The department may take disciplinary actions against producers that engage in this practice.

However, those parties that make the request for a certificate that alters the terms of the policy are not regulated by the Department of Financial Services and the department has no authority to prohibit them from demanding improper certificates of insurance.

Additionally, existing law does not define certificates of insurance or sets standards for forms.

JUSTIFICATION: Insurance producers are often asked by their commercial insurance clients to provide certificates of insurance to various third parties. A certificate of insurance is commonly used in business transactions as proof that a policy of insurance is in effect. It is a simple document that merely summarizes the essential terms, conditions, and duration of the contract of insurance that is in effect between the insured and the insurer. Usually, the request for a certificate is made by a party the insured has contracted with to provide services, including city, state, and municipal agencies, public authorities, as well as private contractors.

A problem has existed for many years where various government agencies have required, as a condition of doing business, that an insured supply evidence of insurance on preprinted forms supplied by the agency, These forms often times alter, expand or modify the terms of the subject policy. In other cases, government agencies or private contractors may demand that terms be added to the standard ACORD certificate of insurance form which do not appear in the insurance policy. For example, requests are often made for the certificate to include "hold harmless" agreements or other clauses that alter the language of the policy, as well as statements that the wording of the certificate will control in the event of any inconsistency or conflict between the certificate and the policy.

An insurance producer that is asked to provide these types of altered certificates may not legally do. so. The Department of Financial Services has made it clear that an insurance producer may not add terms or clauses to a certificate of insurance which alter, expand or otherwise modify the terms of the actual policy unless authorized by the insurer which has filed an appropriate endorsement with the Superintendent of Financial Services. The department may seek disciplinary measures against producers who do this.

Insurance producers are being placed in an untenable position. If they do not comply with the request to issue an improper certificate, their insurance client will not be allowed to perform work for the party asking for the certificate. Unfortunately, an insurance producer that complies with the law and refuses to issue an improper. Certificate will often lose the client, who will find another insurance producer willing to ignore the law and issue the improper certificate.

The department has recognized this problem over the years and has issued numerous opinions and two circular letters on this topic (Circular Letter 8 (1995) and Circular Letter 15 (1997)). Circular letter 15 was also issued to city, state, and municipal agencies and other public authorities and corporations, as well as to producers. In the circular letter, the department acknowledges that these government agencies were making requests for improper certificates and advised insurance producer that they may not provide them. Despite the department's efforts, government agencies continue to insist upon certificates of insurance that do not merely act as evidence of insurance, but seek to modify the terms and conditions of coverage.

This bill will remedy this problem by making it a violation of law for any person to request the issuance of a certificate of insurance that

contains any false or misleading information.

LEGISLATIVE HISTORY: S.5804 of 2012-13 veto message number 257 of 2013
S.4425-B of 2011-12

FISCAL IMPLICATIONS: None.

EFFECTIVE DATE: 90 days after it shall have become a law.

DIVISION OF THE BUDGET BILL MEMORANDUM

Session Year 2014

SENATE:
No. 6545-A

ASSEMBLY:
No.

Primary Sponsor: Seward

Law: Insurance **Sections: 501, 502, 503, 504, 505**

Division of the Budget recommendation on the above bill

APPROVE: __ VETO: __ NO OBJECTION: _x_

1. Subject and Purpose:

This bill amends the Insurance Law regarding the form and format of certificates of insurance. Certificates of insurance are typically used by governmental and other entities in conjunction with the awarding of third party contracts. To ensure that the contracting entity will incur no unnecessary liabilities, a certificate is provided by the contractor attesting to the level and nature of insurance coverage provided by the contractor. Currently, the State does not prescribe the format and content of certificates of insurance and providing falsified, incomplete or inaccurate information on the certificates is dealt with via a variety of regulatory, criminal, and civil sanctions. This bill would require that contractors and contracting entities use standardized Certificate forms that may not be altered or amended.

A previous bill (A.3107-D) relating to the regulation of certificates of insurance was vetoed in 2013 (Veto Message No. 257) because of its generic and rigid application for standardizing certificate of insurance forms and the undesired unintended consequences that could result from standardizing the form.

2. Summary of Provisions:

The bill requires a person or governmental entity to prepare, issue or request a certificate of insurance form from among the following:

- A form authorized for use by the Association for Cooperative Operations Research and Development (ACORD) or Insurance Services Office (ISO)
- A form promulgated by the insurance company that has underwritten the policy referenced in the certificate of insurance
- A form promulgated by the Mortgage Bankers Association (MBA)
- A form promulgated by a governmental entity provided such form has been approved for use by the Superintendent of the Department of Financial Services (DFS).

The bill also stipulates that no person or government entity may alter, modify, request or require the alteration of a certificate of insurance form if that change will violate this article.

Validation: Document ID: 39481313-0
Robert L. Megna, Director of the Budget
By George Westervelt
Date: 8/14/2014 1:36:00 PM

The bill empowers the Superintendent of the Department of Financial Services (DFS) to assess civil penalties to any violators of the law.

The bill will take effect 90 days after it is signed into law.

3. Legislative History:

2013: A.3107-D Vetoed by Governor (Veto Message No. 257)
2012: S.4425-B Committed to Rules

4. Arguments in Support:

By mandating the use of standardized certificates of insurance forms, some may argue that the bill may discourage improper and dishonest practices associated with the issuance of certificates of insurance.

5. Arguments in Opposition:

While the bill's goal of discouraging improper practices in the issuance of certificates of insurance is laudable, it could contain numerous flaws that would make implementation problematic and increase the cost of delivering State programs. More specifically:

- Certificates of insurance are typically used by State agencies to ensure that contractors provide insurance coverage that meets specific agency and program standards. Therefore, the level of information required on the state agency certificate forms is generally more expansive and detailed compared to the standardized forms mandated by this bill. If this bill is enacted, State agencies will either be forced to frequently perform detailed reviews of contractor insurance policies to ensure adequacy of coverage or develop a new form that the DFS Superintendent deems acceptable.

- The Department of Financial Services has expressed concerns with certain technical aspects of the bill.

6. Other State Agencies Interested:

The Department of Transportation (DOT) and the Department of Financial Services have not yet taken a position on this legislation.

7. Other Interested Groups:

Any contractor or entity that needs to provide proof of policy via certificates of insurance.

8. Budget Implications:

State agencies would continue to require additional insurance coverage information that will not be provided on the standardized forms mandated by this legislation, but this problem is mooted by the fact that the legislation allows for the creation of an alternative form that is subject to the approval of the DFS Superintendent.

9. Recommendation:

No objection. The Department of Financial Services and the Department of Transportation have not yet taken a position on the bill's enactment. The Division of the Budget has no objection to this bill's enactment.

STATE OF NEW YORK
DEPARTMENT OF TRANSPORTATION
ALBANY, N.Y. 12232
www.dot.ny.gov

JOAN McDONALD
COMMISSIONER

ANDREW M. CUOMO
GOVERNOR

January 8, 2015

Seth H. Agata, Esq.
Acting Counsel to the Governor
Governor's Office
NYS State Capitol Building
Albany, NY 12224

Re: S6545-A
TEN-DAY LETTER
Recommendation: Disapproval

Dear Mr. Agata:

The New York State Department of Transportation (NYSDOT) currently administers a capital program valued at an average of $1.4 billion per year involving construction projects that carry considerable risk of claims for injuries, property damage or death relating to contractor work. One of the tools utilized by NYSDOT to effectively administer this large capital program is the requirement for insurance professionals to certify that contractor/consultant insurance complies with the minimum requirements contained in NYSDOT contracts. The proposed bill would eliminate the insurance professionals' certifications mandated by NYSDOT and would instead place the responsibility upon the Department to review insurance policies to determine whether minimum requirements are met. If NYSDOT were to assume this responsibility, additional delays and associated costs would be incurred during the contracting process, resulting in millions of dollars in additional expense to the State of New York.

NYSDOT includes in its contract specifications a requirement that state contractors carry appropriate types of insurance that provide levels of protection up to state minimums and that the contractors document the existence of this insurance using a certificate of insurance prescribed by NYSDOT and designated as the C-218. The certificate is the only documentation that NYSDOT receives to verify that a contractor is insured. Certificates are reviewed and approved before contractors are allowed to begin work. Any failure by a NYSDOT contractor to have the required insurance in place could result in a default by the contractor and, at minimum, the loss of its bid deposit or bond. NYSDOT has observed that some construction contractors have purchased insurance policies that purportedly afford no protection for certain kinds of claims. Measures used in the attempt to vitiate contractor policies include an endorsement to remove or modify the "insured contract" exception to the employer's liability exclusion, removing or restricting the blanket contractual liability located in the "insured contract" definition, or even negating coverage for the additional insured for claims by employees of the contractor and its subcontractors. NYSDOT relies upon the certification in the C-218 to assure that the agent has looked at the NYSDOT insurance requirements and has sold a policy that conforms to these

requirements. The Department does not receive, nor review, contractor insurance policies unless there is a problem. NYSDOT has the authority to take action against an insurance agent who sells a cut-rate policy that does not afford the required coverage and then falsely certifies that the coverage exists. NYSDOT has never taken such action, but it is our belief that the certification requirement helps to ensure the integrity of the insurance agents that produce these policies for NYSDOT contractors and reduces the number of falsely certified insurance policies.

The proposed bill is very similar to a bill passed by the Legislature in 2013 (A.3107-D) that the Governor vetoed (Veto Message #257) on grounds that State agencies frequently require certificates of insurance that provide more detailed insurance information than that provided under ACORD forms. The current bill would effectively eliminate forms such as NYSDOT's C-218 and prescribes the use of Association for Cooperative Operations Research and Development (ACORD) or the Insurance Services Office (ISO) standard certificates of insurance instead. The ACORD certificates of insurance provide no assurance of coverage, warnings about endorsements that serve to negate coverage, or an assurance that the policy complies with NYSDOT requirements. Instead, ACORD certificates provide disclaimers for the benefit of insurance agents. A typical disclaimer reads,

> THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

Without the ability to utilize a certification form, such as the C-218, the Department would have to receive and review an estimated 1,000 insurance policies on an annual basis. The Department is not staffed for this effort and even if it were, the time to review individual insurance polices to ensure minimum requirements would lengthen the time needed to complete the contract approval process.

In the absence of an insurance certificate that provides additional information, the approval of contractor insurance by state agencies will require additional time. In accordance with Section 140 of State Finance Law, NYSDOT has forty-five days in which to award a contract following the receipt of a bid for a project. If the Department fails to award within the forty-five day window, the low bidder is allowed to walk away without penalty. During the prior fiscal year (2013-14), the Department had 30 construction contracts that were awarded within one week of the end of the forty-five day window. If the Department had to review the insurance policies of all contracts prior to award, it is estimated that the majority of these 30 contracts would have exceeded the forty-five day window. The cost differential between the winning bids on these 30 contracts and the next lowest bidder was $7.2 million.

NYSDOT has no office charged with ordering, reviewing and storing the hundreds of insurance policies that would be needed from contractors if NYSDOT were to assume the duty of checking the policies and their endorsements. Proper review of the insurance polices is essential so that NYSDOT can protect the State against claims that arise out of project work; particularly claims by contractor employees. The most common problems involve a failure to have contractor policies endorsed to name NYSDOT as an additional insured. There have also been claims where insurers have relied upon an endorsement in their policies excluding coverage for claims by contractor employees. There was at least one insurer that marketed a liability policy that specifically excluded coverage for claims asserted under NY Labor laws. To properly staff an insurance policy review office to catch these types of endorsements and loopholes, the Department would need to hire three qualified contract management specialists or legal assistants at an annual cost of $300,000, including salaries, fringe benefits, and non-personal expenses such as document storage.

The proposed bill states that some agency-required forms seek to alter, expand or modify the terms of the insurance policy. NYSDOT does not assert that the certification in the C-218 has the effect of expanding or modifying coverage. The coverage is created only by the underlying insurance policy.

NYSDOT enters into 400 to 500 contracts every year with contractors and consultants that provide important services in connection with the construction, repair, maintenance and operation of the state highway system. A key element of the contractual relationship with NYSDOT is that contractors be responsible for any claims that arise out of their work. Because NYSDOT has non-delegable duties to the public, and because New York law imposes upon NYSDOT special responsibility for work locations, it is essential that NYSDOT contractors have in place insurance to protect not only themselves, but also the taxpayers of New York who might otherwise be exposed to liability because of work performed by contractors.

Assuring that contractors all have the required insurance is also an important element of competitive fairness because insurance cost can be a significant proportion of contractor expenses. NYSDOT cannot allow contractors that do not have the required insurance to work on state projects. Most insurance agents find their way clear to sign the C-218, but a small but vocal group of insurance agents have objected to using the C-218 and a small minority of them have refused to sign the certification. NYSDOT has an average of 400 major projects each year and many more smaller projects. NYSDOT has never made an exception for contractors with agents who did not want to or refused to sign and has withheld payments to contractors if their C-218 expired during the contract period. We have had the occasional complaint (one or two per year), but we have not experienced any lack of cooperation.

The fiscal impact of ordering and reviewing contractor insurance policies before contractors are allowed to begin work on NYSDOT projects is estimated to be millions of dollars per year. As outlined above, this is primarily the result of delaying the contracting process beyond the statutorily required forty-five day window to award a project following a successful bid. The loss of just a few low bidders will quickly result in millions of dollars in additional costs for the State. In addition to this cost, NYSDOT would have to properly staff an office to manage the receipt and review of approximately 1,000 insurance policies per year at an estimated expense of $300,000 annually.

The Department recommends the Governor's disapproval of S6545-A

Very truly yours,

DAVID M. CHERUBIN
Chief Counsel and Assistant Commissioner

ANDREW M. CUOMO
GOVERNOR

ROANN M. DESTITO
COMMISSIONER

STATE OF NEW YORK
EXECUTIVE DEPARTMENT
OFFICE OF GENERAL SERVICES
MAYOR ERASTUS CORNING 2ND TOWER
THE GOVERNOR NELSON A. ROCKEFELLER EMPIRE STATE PLAZA
ALBANY, NEW YORK 12242

October 8, 2013

Seth H. Agata, Esq.
Acting Counsel to the Governor
Office of Counsel to the Governor
State Capitol
Albany, NY 12224

Dear Mr. Agata:

Re: S.6545-A—Certificates of Insurance Bill

The Office of General Services ("OGS") thanks you for the opportunity to provide comments on S.6545-A, which amends the Insurance Law to establish standards for proper issuance of insurance certificates and to authorize the Department of Financial Services ("DFS") to impose penalties against persons that violate these requirements. The amendments would no longer permit a public entity or private contractor to require the use of forms other than a certificate of insurance, as defined in the bill, to confirm that a party has the requisite insurance.

A very similar bill was passed by the Legislature last year (A.3107-D) that the Governor vetoed (Veto Message #257) on the grounds that State agencies frequently require contractors and vendors to complete certificates of insurance that convey detailed policy information and that the forms mandated by the bill would not convey the necessary detailed information. The Governor further directed DFS to examine the manner in which certificates of insurance are used by State agencies and to identify any means by which such use may be improved. OGS is not aware of the results of any review that DFS may have undertaken, but we note that this bill is virtually identical to the bill that was vetoed last year. In light of the fact that no substantive changes were made to the bill in response to last year's veto, OGS will restate the comments it made on last year's bill.

OGS continues to have concerns with the new Section 502(d) that the bill would add to the New York State Insurance Law. Section 502(d) prohibits agencies from asking for documents other than a certificate of insurance, as that term is defined in the bill, and may result in uncertainty as to whether OGS, and other agencies, are able to comply with Sections 57 and 220(8) of the New York State Workers' Compensation Law. Those provisions require the head of a State agency to obtain proof of workers' compensation and disability coverage, in a form satisfactory to the Chair of the New York State Workers' Compensation Board (the "Board"), from all entities prior to entering into a contract or permit. The Board indicates that satisfactory proof consists of submission of certain forms drafted by the Board. Passage of the bill would leave OGS, and other agencies, facing the dilemma of having to use the Board's forms in order to comply with Sections 57 and 220(8) of the Workers' Compensation Law while potentially facing penalties, under the bill, for using such forms. In addition, the Office of the State

Comptroller routinely verifies that coverage is provided in accordance with Sections 57 and 220(8) of the Workers' Compensation Law before it approves contracts. Therefore, agencies must use forms approved by the Board in order to enter into contracts and permits.

In addition, OGS believes that proposed Section 502(d) of the New York State Insurance Law could also prohibit agencies from asking for statements or correspondence other than a certificate of insurance, as that term is defined in the bill. This provision could be interpreted to prevent agencies from being able to ask bidders questions about their insurance coverage and the insurance certificates that are submitted during the solicitation process. OGS does require confirmation of insurance in support of many of its business activities. When required, OGS secures proof of insurance using a standard form insurance certificate that would meet the requirements of the bill. But it is sometimes necessary to clarify that the coverage provided meets the requirements set forth in a particular solicitation. For example, OGS's insurance requirements indicate that OGS must approve a bidder's self-insured retention or deductible that exceeds $100,000.00. In order to approve the coverage in those situations, OGS must ensure that the bidder has the financial capacity to meet those obligations. OGS can ascertain this information only by asking the bidder clarifying questions about its insurance program and its financial assets. Limiting communications between agencies and bidders will jeopardize the open and transparent procurement process required by the New York State Finance Law and could potentially subject the State to risk if it contracts with an entity that does not have the necessary financial resources available to support large self-insured retentions or deductibles.

Based on the foregoing comments, OGS respectfully requests that the Governor not approve the bill in its current form. If you have any further questions, please feel free to call me at (518) 474-5988.

Sincerely,

Bradley G. Allen
Deputy Commissioner and Counsel

cc: Meredith Weill
Commissioner Destito
Joseph Rabito
Anne Phillips
Michele Reale

MENSCHIK | INSURANCE SERVICES

NY OFFICE
574 ROUTE 303
BLAUVELT, NY 10913

NJ OFFICE
177 HUDSON STREET
HACKENSACK, NJ 07601

T: 718 365-3000
T: 845 359-0444
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F: 845-359-2572

October 7, 2014

The Honorable Andrew Cuomo
Office of the Governor
State Capital
Albany, NY 12224

RE: A 9590 Morelle/S.6545-A Seward

Gov. Cuomo

The above proposed legislation is one of the most important pieces of legislation affecting agents and brokers to appear on the national scene and I respectfully urge you to sign it signifying New York State's lead in the solution to a longstanding and pressing issue that needs reforming.

I chaired the CPCU Society's Agent and Broker Interest Group from September 2007 to September 2010. This is the national professional society for the insurance industry in the United States and its second largest interest group. Abuses Certificates of Insurance were then, and continue to be now, the number one issue on the mind of my fellow professionals. There was no close second. When we studies the issue we found that abuses of Certificates of Insurance accounted for 40% of Error and Omission claims and created unnecessary litigation by people who attempted to strong arm agents into stating things on the certificate that were false and misleading attempts to create illusory insurance coverage.

Refusing to submit to the unethical pressure has caused me to lose insurance accounts and to refuse to quote on referral business that came to me from very credible referrals. I have been active on a national level in sponsoring education programs that have brought some of these abuses to light through my professional society. This is not a minor issue and is something that New York should take a lead on.

Thank you for your consideration of the above

Joseph F. Menschik, CPCU

CC: Mr. Niall O' Hegarty, Esq.
PIANY
IIABANY

Rest insured.

Lawley

October 1, 2014

The Honorable Andrew Cuomo
Office of the Governor
State Capitol
Albany, NY 12224

Re: Certificates of Insurance Reform Law
A.9590 Morelle/S.6545-A Seward

Dear Governor Cuomo:

We are a large regional independent insurance agency, serving over 8,000 businesses and 20,000 individuals and families. We employ over 350 people in 7 offices across New York State.

One of our practice groups specializes in insurance and risk management for the construction industry. Our team reviews thousands of certificates each year, focusing on compliance with specifications. In addition, we review hundreds of contracts and bid specifications, all of which contain comprehensive insurance demands. We see first-hand the issues our clients face when asked to provide insurance that is either unavailable or so expensive that they cannot justify the expense. We cannot and will not certify coverage that is not reflected on the insurance policy. However, many unsophisticated agents will do so in order to placate their clients, leading to the following issues:

- There is a large and growing problem regarding the improper use of certificates in the state of New York.
- The improper use of certificates creates situations in which proper insurance coverage is not in place, which puts both workers and the general public at risk. Certificate holders (developers, contractors, financial institutions) are led to believe that coverage exists, which the actual policy document does not provide.

This bill (A.9590 Morelle/S.6545-A Seward) directly addresses the problem by regulating the use of certificate forms and requiring that certificates clearly and accurately reflect the coverages in the policy. A similar bill was passed in 2013. You vetoed the bill stating that state agencies objected to the mandated form of the certificate. The 2014 bill was amended and passed to eliminate the concerns you set forth in last year's veto message.

I urge you to pass this bill, as it responds to the needs of the business and insurance communities and overcomes the concerns you brought forth last year.

Very truly yours,

Fred Holender
Dir. of Administration
716.849.8257
fholender@lawleyinsurance.com

000020

Delaware Avenue Buffalo NY 14202 MAIN 716.849.8618 FAX 716.849.8617 www.lawleyinsurance.com

cc: Niall O'Hegarty, Esq.
Counsel
Office of Counsel to the Governor
State Capitol
Albany, NY 12224

George Haggerty
Deputy Secretary for Financial Services
Office of the Secretary to the Governor
State Capitol
Albany, NY 12224

000021

LIFE INSURANCE COUNCIL OF NEW YORK, INC.
111 Washington Avenue – Suite 300
Albany, New York 12210
Tel: (518) 436-8417
Direct: (518) 471-1902
Fax: (518) 436-0226
dstuto@licony.org

In New York:
551 Fifth Avenue, 29th Floor
New York, New York 10176
Tel: (212) 986-6181
Fax: (212) 986-6549

DIANE D. STUTO
Executive Vice President

October 3, 2014

Seth H. Agata, Esq.
Acting Counsel to the Governor
State of New York
Executive Chamber
Albany, New York 12224

Re: A.9590/S.6545A

Dear Mr. Agata:

Thank you for giving us the opportunity to offer our position on the above-referenced legislation that has passed the legislature and will be delivered to the Governor for consideration of enactment. This bill would add a new Article 5 to the insurance law. The new Article defines certificates of insurance, describes permissible certificates of insurance and prohibits certain practices with respect to the issuance of such certificates of insurance. The Life Insurance Council of New York, Inc. (LICONY) supports this legislation.

A certificate of insurance is commonly used in business transactions as proof that a policy of property/casualty insurance is in effect. For life insurers, these types of forms, typically called "evidence of insurance" forms, are used as proof of coverage in commercial lending transactions. Life insurers are lenders in these types of transactions, lending multiple billions of dollars in New York State, particularly New York City, every year. Lenders rely on the forms to provide evidence of the specific coverage in place to insure the commercial buildings for which they are providing the loan. The ability to obtain this type of form is crucial in the commercial lending transaction because lenders do not usually get a copy of the actual policy or even an insurance binder that contains the specific types of coverage that is put in place on large, commercial properties. Without this type of form, lenders would have no recourse for determining the levels of coverage put in place to insure these very large, commercial properties.

This bill will prohibit any person from requesting the issuance of a certificate of insurance unless the certificate is: (1) a standard certificate form promulgated and authorized for use by the Association for Cooperative Operations Research and Development (ACORD) or the Insurance Services Office (ISO); (2) a form promulgated by the insurance company that has underwritten the policy referenced in the certificate; (3) a form prepared, issued, or requested as evidence of insurance in connection with a commercial lending transaction in which the underlying property serves as the primary collateral securing the borrower's repayment of the loan, including, but not limited to a form promulgated by the Mortgage Bankers Association (MBA); or 4) a form promulgated by a governmental entity that is considered a covered agency under §51 of the Executive Law, provided such form has been approved for use by the superintendent.

The third form listed above describes the type of form used by lenders, including life insurers, in commercial lending transactions. By listing this form as one of the permissible types of "certificates of insurance," this bill codifies its use in a commercial lending transaction and provides lenders with a legitimate document that can be used as evidence of insurance coverage in these types of transactions.

For all of the above reasons, LICONY supports this legislation and urges its enactment into law by the Governor. If you or your staff have any questions regarding our position on this legislation, please do not hesitate to contact me.

Sincerely,

Diane Otuto

cc: Niall O'Hegarty, First Assistant Counsel to the Governor
George Haggerty, Deputy Secretary for Financial Services
Kate Powers, Director of Legislative Affairs – Department of Financial Services

000023

MEMORANDUM IN SUPPORT

S.6545-A (Seward) **A.9590 (Morelle)**

AN ACT to amend the insurance law, in relation to the issuance of certificates of insurance

This bill would add a new Article 5 to the insurance law, to set forth specific standards for the issuance of certificates of insurance, to ensure that they do not alter, expand or otherwise modify the terms of the underlying insurance policy.

The **Council of Insurance Brokers of Greater New York, Inc. (CIB)**, the leading professional independent insurance brokers association in the New York metropolitan region, including Long Island and the Lower Hudson Valley, **STRONGLY SUPPORTS** this bill.

The provisions of this legislation would remedy a problem for insurance producers, wherein municipalities, other government agencies, private contractors and others, insist, as a condition of obtaining work that certificates of insurance provided by insured vendors act not merely as evidence of insurance, but seek to modify the terms and conditions of the underlying policy coverage.

For instance, requests are often made for the certificate to include "hold harmless" agreements or other clauses that alter the language of the policy, as well as statements that the wording of the certificate will control in the event of any inconsistency or conflict between the certificate and the policy. Insurance producers are thus unfairly placed in an untenable position. If they do not comply with the request to issue an improper certificate, their insurance client will not be allowed to perform work for the party asking for the certificate. Unfortunately, an insurance producer that complies with the law and refuses to issue an improper certificate will often lose the client.

The instant bill would correct this problem by making it a violation of law for any person to knowingly request the issuance of a certificate of insurance that contains any false or misleading information. The bill would further proscribe any knowing requests in lieu of a certificate of insurance, for an opinion letter, warranty, statement, supplemental certificate or any other document, inconsistent with the terms of the underlying insurance policy. Additionally, no person may require a certificate of insurance unless it is a standard certificate form developed by the Association for Cooperative Operations Research and Development (ACORD) or the

Insurance Services Office (ISO). In the case of commercial mortgage lending transactions, forms promulgated by the Mortgage Bankers Association (MBA) to evidence insurance would be acceptable. Also, insurance carriers underwriting the specific policies in question would be able to promulgate their own certificates of insurance evidencing the same. And, governmental entities that are considered "covered agencies" under Section 51 of the Executive Law, may promulgate their own certificates, provided such forms are approved for use by the Superintendent of Financial Services.

Moreover, the bill contains a provision that unequivocally states that a certificate of insurance shall not confer to any person new or additional rights beyond what the referenced policy of insurance expressly provides.

Finally, the bill would grant the Superintendent of Financial Services specific statutory and regulatory authority to investigate and examine suspected violations of this Act against any person, together with the power to enforce its provisions. In the case of a governmental entity, the State Inspector General or other investigative official or entity are granted similar investigative powers thereunder.

The provisions of this bill are meant to address and satisfy the objections contained in Governor's Veto Message No. 257 (2013), disapproving of a similar certificates of insurance measure.

For these reasons, the **Council of Insurance Brokers of Greater New York, Inc. STRONGLY SUPPORTS** S.6545-A / A.9590, which is one of the Association's Legislative Priority Bills, and **URGES ITS PASSAGE**.

Respectfully submitted,

Joseph Bosnack, Jr.
President

Jeffrey H. Greenfield
Legislative Chair

000025

H.R. KELLER & CO., INC., 1520 SHERIDAN DRIVE, BUFFALO, NY 14217
(716) 874-1644 (800) 424-2202 FAX (716) 874-4920 www.kellerco.com
e-mail: epkeller@kellerandco.com

October 8, 2014

Governor Andrew Cuomo
Office of the Governor
State Capitol
Albany, NY 12224

RE: A.9590 Morelle/S.6545-A Seward
Below is example of why this law is needed!
Businesses are being cheated! Please sign the Bill!

Dear Governor Cuomo:

I am told you are reluctant to sign the above referenced legislation because there is no need for it. The enclosed information is an actual example of an insurance broker defrauding a customer by issuing a phony insurance certificate. It cost the victim over $25,000 in legal fees because the coverage portrayed in the Certificate never existed. My firm's contact with the victim arose when we secured coverage for him after he had been cheated and after he had been sued with no liability insurance to protect him. I will go over the details, but the bottom line is this:

- A licensed insurance broker took a customer's money and issued a phony insurance certificate
- The broker never obtained any insurance policy as he had said he would
- The customer assumed he had insurance despite the fact that he never got a physical policy
- Years afterwards, the customer was sued and there was no coverage for him
- The broker who defrauded the customer is still in business and hasn't lost his license

How can you think this isn't a problem??? At present, although it is a dishonest act, there is no crime the broker can be charged with, even though he took a customer's money and fooled him into thinking there was coverage by issuing a Certificate of Insurance for non-existent policy.

The customer is Somar Enterprises, Inc. a residential insulation contractor in Roslyn Heights, NY, owned by Dave Esposito at (516) 852-6325. In March 2005, Mr. Esposito's company needed proof of insurance for a job the company was doing, and H.M. Beswick Insurance Agency Inc. (NY Insurance Brokers License #BR-681548) issued a Certificate of Insurance, enclosed herewith, dated 03/28/2005 showing coverage for a policy running from 11/26/2004 to 11/26/2005. Beswick had taken money for the insurance coverage, but never obtained the coverage shown in the certificate; the certificate was phony! **Although Beswick was dishonest in issuing the phony Certificate of Insurance, there was and still is no law to prevent it or punish the dishonest broker.** The reason many brokers get away with issuing phony insurance certificates is that they don't get caught if there is no claim against the non-existent policy, because the customer never knows the policy never existed!

Mr. Esposito's company spent more than $25,000 in legal bills to defend itself against a lawsuit, and he shut down his corporation and reincorporated under a new name to protect himself in case the suit was successful. Fortunately, Somar's attorney won the case and the lawsuit was thrown out.

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KELLER & CO.

H.R. KELLER & CO., INC., 1520 SHERIDAN DRIVE, BUFFALO, NY 14217
(716) 874-1644 (800) 424-2202 FAX (716) 874-4920 www.kellerco.com

Governor Andrew Cuomo October 7, 2014

Mr. Esposito asked his attorney how he could recover the expenses his company incurred because there was no insurance policy. His attorney suggested he could sue Beswick Insurance Agency, but Beswick claimed to have sold their insurance business, so the best Mr. Esposito could do was to file a complaint with the Consumer Service Bureau of the NY DFS (formerly the NY Insurance Department.) He hasn't received any conclusion to that complaint and the NY DFS website still shows Beswick's broker's license as active.

NOW do you believe there is a need to sign S.6545-A/A9590 into law? There have to be dozens, if not hundreds of cases where an insurance consumer is cheated out of premium dollars, given a phony Certificate of Insurance, and no real coverage is ever secured in the form of a policy. In the 99% of those cases where there isn't a claim against a non-existent policy, the dishonest broker never gets caught.

I am a proud member of both the Independent Insurance Agents and Brokers Association of New York and the Professional Insurance Agents of New York and the officers, directors and members of both organizations are all in favor of this consumer-protecting legislation. Honest insurance brokers want a law that will weed out the insurance licensees who are cheating the public. You can start that process with a stroke of your pen! Please sign the bill into law.

Very truly yours,

Eric P. Keller
President

EPK/dbm
Encl.: Fraudulent Certificate of Insurance

cc: Mr. Niall O'Hegarty, Esq., Counsel
Office of the Counsel to the Governor
State Capitol, Albany, N.Y. 12224

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ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YY) 03/28/2005

PRODUCER
HM Beswick Ins. Agency Inc.
1597 Grand Ave
Baldwin, NY 11510
(516) 868-4336

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURERS AFFORDING COVERAGE

INSURED
SOMAR ENTERPRISES, INC
SOMAR INSULATION
195 YALE ST.
ROSLYN HEIGHTS, NY 11577

INSURER A: ATLANTIC CASUALTY INS CO.
INSURER B:
INSURER C:
INSURER D:
INSURER E:

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A	GENERAL LIABILITY [X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [ ] POLICY [ ] PRO-JECT [ ] LOC	AC0500025	11/26/04	11/26/05	EACH OCCURRENCE FIRE DAMAGE (Any one fire) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$1,000,000 $100,000 $5,000 $500,000 $1,000,000 $500,000
	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS [ ] HIRED AUTOS [ ] NON-OWNED AUTOS	THE COVERAGE SHOWN HERE NEVER EXISTED			COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $
	GARAGE LIABILITY [ ] ANY AUTO				AUTO ONLY - EA ACCIDENT OTHER THAN AUTO ONLY: EA ACC AGG	$ $ $
	EXCESS LIABILITY [ ] OCCUR [ ] CLAIMS MADE [ ] DEDUCTIBLE [ ] RETENTION $				EACH OCCURRENCE AGGREGATE	$ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				WC STATU-TORY LIMITS / OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $
	OTHER					

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS

INSULATION CONTRACTOR

CERTIFICATE HOLDER

474 LEONARD ST, LLC
TAHOE DEVELOPMENT CORP.
96-20 ATLANTIC AVE
OZONE PARK, NY 11416

ADDITIONAL INSURED; INSURER LETTER: A

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL ____ DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

ACORD 25-S (7/97)

SAMPLE OF

CORRESPONDENCE

ONLY

October 23, 2014

The Honorable Andrew Cuomo
Office of the Governor
State Capitol
Albany, NY 12224

RE: A.9590 Morelle/S.6545-A Seward

Gov. Cuomo:

As a licensed insurance producer in the state of New York and a PIANY member, I write to you to ask for your help. There is a large and growing problem regarding the improper use of certificates of insurance in New York. Many times, the improper use of certificates creates situations in which proper insurance coverage is not in place. This puts both workers and the general public at risk. Legislation headed to your desk (A.9590 Morelle/S.6545-A Seward) directly addresses the problem by regulating the use of certificate forms and requiring that certificates clearly and accurately reflect the coverages in the policy. Please give this bill your favorable consideration. This bill was amended this year to eliminate the concerns you set forth in last year's veto message to allow state agencies to use their own forms once approved by the DFS.

Sincerely,

Jay True

Jay True
President
J.B. True Company, Inc.
DBA: True Insurance

COPY Jay True

Cc: Mr. Niall O'Hegarty, Esq., Counsel, Office of the Counsel to the Governor, State Capitol, Albany, NY 12224

TRUE INSURANCE
124 SENECA WAY • ITHACA, N.Y. 14850 • (607) 273-7511

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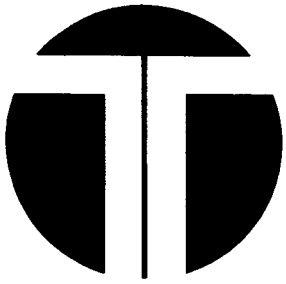

COPY

Taylor & Taylor Associates, Inc.
Taylor & Taylor, Ltd.
www.taylorinsurance.com

October 23, 2014

The Honorable Andrew Cuomo
Office of the Governor
State Capitol
Albany, NY 12224

Dear Governor Cuomo:

RE: A.9590 Morelle/S.6545-A Seward

As a licensed insurance producer in the state of New York and a PIANY member, I write to you to ask for your help. There is a large and growing problem regarding the improper use of certificates of insurance in New York.
Many times, the improper use of certificates creates situations in which proper insurance coverage is not in place. This puts both workers and the general public at risk.

Legislation headed to your desk (A.9590Morelle/S.6545-A Seward) directly addresses the problem by regulating the use of certificate forms and requiring that certificates clearly and accurately reflect the coverages in the policy.

Please give this bill your favorable consideration. This bill was amended this year to eliminate the concerns you set forth in last year's veto message to allow state agencies to use their own forms once approved by the DFS.

Sincerely,

Raymond Taylor

Raymond Taylor, C.L.U.
Chairman of the Board

RT:mb

CC: Mr. Nial O'Hegarty, Esq.
Office of the Counsel to the Governor

000031

16 East 40th Street, New York, NY 10016 • Tel (212) 490-8511 • Fax (212) 490-7236 • Lic. No. BR653360
15060 Ventura Boulevard, Sherman Oaks, CA 91403 • Tel (818) 981-9700 • Fax (818) 981-9703 • Lic. No. 0731414

Ryan&Ryan
INSURANCE BROKERS INC

CUSTOMERS FIRST

The Honorable Andrew Cuomo
Office of the Governor
State Capitol
Albany, NY 12224

RE: A.9590 Morelle/S.6545-A Seward

Gov. Cuomo:

As a licensed insurance producer in the state of New York and a PIANY member, I write to you to ask for your help. There is a large and growing problem regarding the improper use of certificates of insurance in New York. Many times, the improper use of certificates creates situations in which proper insurance coverage is not in place. This puts both workers and the general public at risk. Legislation headed to your desk (A.9590 Morelle/S.6545-A Seward) directly addresses the problem by regulating the use of certificate forms and requiring that certificates clearly and accurately reflect the coverages in the policy. Please give this bill your favorable consideration. This bill was amended this year to eliminate the concerns you set forth in last year's veto message to allow state agencies to use their own forms once approved by the Department of Financial Services.

Sincerely,

Robert J. Ryan, Jr. CIC
Ryan & Ryan Insurance Brokers Inc.

cc: Mr. Niall O'Hegarty, Esq., Counsel, Office of the Counsel to the Governor, State Capitol, Albany, N.Y. 12224

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400 Stockade Drive Kingston, NY 12401-3874 845.340.0001 fax 845.340.0002
www.RyanandRyanInsurance.com

1152 State Route 23
Catskill, NY 12414

VALENTINE
INSURANCE AGENCY, LLC
Keith W. Valentine Certified Insurance Counselor
www.myvalentineinsurance.com

Phone: 518-943-3489
Fax: 518-943-7364

October 7, 2014

Mr. Niall O'Hegarty, Esq., Counsel
Office of the Counsel to the Governor
State Capitol
Albany, N.Y. 12224

RE: A.9590 Morelle/S.6545-A Seward

Gov. Cuomo:

As a licensed insurance producer in the state of New York and a PIANY member, I write to you to ask for your help. There is a large and growing problem regarding the improper use of certificates of insurance in New York. Many times, the improper use of certificates creates situations in which proper insurance coverage is not in place. This puts both workers and the general public at risk. Legislation headed to your desk (A.9590 Morelle/S.6545-A Seward) directly addresses the problem by regulating the use of certificate forms and requiring that certificates clearly and accurately reflect the coverages in the policy. Please give this bill your favorable consideration. This bill was amended this year to eliminate the concerns you set forth in last year's veto message to allow state agencies to use their own forms once approved by the Department of Financial Services.

Sincerely,

Keith W. Valentine, CIC, LUTCF
President
Valentine Insurance Agency, LLC

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cc: The Honorable Andrew Cuomo, Office of the Governor, State Capitol
Albany, NY 12224

000033

GEORGE BURKLE, INC. *Insurance*

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October 10, 2014

The Honorable Andrew Cuomo
Office of the Governor
State Capitol
Albany, NY 12224

RE: A.9590 MORELLE/S.6545-A SEWARD

Gov. Cuomo:

As a licensed insurance producer in the state of New York and a PIANY member, I write to you to ask for your help. There is a large and growing problem regarding the improper use of certificates of insurance in New York. Many times, the improper use of certificates creates situation in which proper insurance coverage is not in place. This puts both workers and the general public at risk. Legislation headed to your desk (A.9590 Morelle/S.6545-A Seward) directly addresses the problem by regulating the use of certificate forms and requiring that certificates clearly and accurately reflect the coverage in the policy. Please give this bill your favorable consideration. The bill was amended this year to eliminate the concerns you set forth in last year's veto message to allow state agencies to use their own forms once approved by the DFS.

Sincerely,

CRAIG BURKLE

CC: Mr. Niall O'Hegarty, Esq.

PROFESSIONAL INSURANCE AGENTS

000034

STATE OF NEW YORK

6545--A

Cal. No. 150

IN SENATE

February 4, 2014

Introduced by Sens. SEWARD, LATIMER, MARTINS -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance -- reported favorably from said committee, ordered to first and second report, ordered to a third reading, amended and ordered reprinted, retaining its place in the order of third reading

AN ACT to amend the insurance law, in relation to certificates of insurance

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. The insurance law is amended by adding a new article 5 to read as follows:

ARTICLE 5
CERTIFICATES OF INSURANCE

Section 501. Definitions.
502. Prohibitions.
503. Applicability.
504. Enforcement.
505. Rules and regulations.

§ 501. Definitions. For purposes of this section:

(a) "Certificate" or "certificate of insurance" means any document or instrument, no matter how titled or described, which is prepared or issued by an insurer or insurance producer as evidence of property or casualty insurance coverage. "Certificate" or "certificate of insurance" shall not include a policy of insurance or insurance binder, and does not amend, extend or alter the coverage provided by the policy of insurance to which the certificate makes reference, and is subject to all the terms, exclusions and conditions of such policy. A certificate of insurance shall not confer to any person new or additional rights beyond what the referenced policy of insurance expressly provides.

(b) "Certificate holder" means any person, other than a policyholder, that is identified on the certificate as a certificate holder.

(c) "Insurance producer" has the meaning ascribed to it by subsection (k) of section two thousand one hundred one of this chapter.

EXPLANATION--Matter in *italics* (underscored) is new; matter in brackets [-] is old law to be omitted.

LBD13740-03-4

(d) "Insurer" means any person "doing an insurance business" as such phrase is defined in section one thousand one hundred one of this chapter.

(e) "Person" means any individual, partnership, corporation, association, or other legal entity, but shall not include any governmental entity, as that term is defined in this section.

(f) "Governmental entity" means any public entity as defined in paragraph fifty-one of subsection (a) of section one hundred seven of this chapter, any state authority as defined in subdivision one of section two of the public authorities law, any local authority as defined in subdivision two of section two of the public authorities law, and any interstate or international authority as defined in subdivision three of section two of the public authorities law.

(g) "Policyholder" means a person who has contracted with a property or casualty insurer for insurance coverage.

§ 502. Prohibitions. (a) No person or governmental entity shall prepare, issue, request, or require the issuance of a certificate if such person or governmental entity knows that such certificate does not comply with the following provisions:

(1) The certificate is a standard certificate of insurance form promulgated and authorized for use by the Association for Cooperative Operations Research and Development (ACORD) or the Insurance Services Office (ISO);

(2) The certificate is a form promulgated by the insurance company that has underwritten the policy referenced in the certificate of insurance; or

(3) The certificate is a form prepared, issued, or requested as evidence of insurance in connection with a commercial lending transaction in which the underlying property serves as the primary collateral securing the borrower's repayment of the loan, including, but not limited to a form promulgated by the Mortgage Bankers Association (MBA).

(4) The certificate is a form promulgated by a governmental entity that is considered a covered agency under section fifty-one of the executive law, provided such form has been approved for use by the superintendent.

(b) No person or governmental entity shall alter, modify, request, or require the alteration of a certificate of insurance form when such person or governmental entity knows that such alteration, modification, request or requirement is in violation of this article.

(c) No person or governmental entity shall request or require that a certificate of insurance form contain additional terms, conditions, or language of any kind not found in the insurance policy to which the certificate makes reference or to an endorsement to such policy when such person or governmental entity knows such request or requirement is in violation of this article.

(d) No person or governmental entity shall request or require either in addition to or in lieu of a certificate of insurance, an opinion letter, warranty, statement, supplemental certificate or any other document or correspondence that such person or governmental entity knows to be inconsistent with the prohibitions of this section. However, an insurer or insurance producer may prepare or issue an addendum to a certificate that clarifies and explains the coverage provided by a policy of insurance and otherwise complies with the requirements of this section, provided such authority is granted to the producer by the insurer.

(e) No person or governmental entity shall request or require a certificate of insurance that such person or governmental entity knows contains references to a contract other than the insurance policy, or warrants that the insurance policies referenced in the certificate comply with the requirements of a particular contract provided however a certificate may include a contract title or description for the sole purpose of identifying the project for which the certificate was issued, but such inclusion shall not be interpreted as warranting that the insurance policies referenced in the certificate comply with the requirements of such contract.

(f) No person or governmental entity shall request or require, prepare or issue a certificate of insurance that such person or governmental entity knows: (i) does not accurately state the terms of coverage provided by the policy or policies of insurance to which the certificate makes reference; (ii) purports to alter, amend, extend, or misrepresent the terms of coverage to which the certificate makes reference; or (iii) purports to confer to any person new or additional rights beyond what the referenced policy of insurance expressly provides.

§ 503. Applicability. The provisions of this section shall apply to all certificate holders, policyholders, insurers, insurance producers, or any other person and to certificate of insurance forms issued as evidence of insurance coverages on property, operations, or risks located in this state, regardless of where the certificate holder, policyholder, insurer, or insurance producer is located.

§ 504. Enforcement. (a) The superintendent shall have the power under section four hundred four of the financial services law to examine and investigate the activities of any person that the superintendent reasonably believes has been or is engaged in an act or practice prohibited by this article. The superintendent shall have the power to enforce the provisions of this section and impose any authorized penalty or remedy as provided under section four hundred eight of the financial services law against any person who violates this article.

(b) The office of the state inspector general shall have the power pursuant to section fifty-three of the executive law to investigate any governmental entity that is considered a covered agency under section fifty-one of the executive law that has been or is engaged in an act or practice prohibited by this article. If a governmental entity not considered a covered agency under section fifty-one of the executive law has been or is engaged in an act or practice prohibited by this article, that entity's inspector general, other compliance or internal investigative unit or other official or entity with proper authority shall have the power to investigate such entity.

§ 505. Rules and regulations. The superintendent may adopt rules or regulations as he or she considers appropriate to carry out the provisions of this article.

§ 2. This act shall take effect on the ninetieth day after it shall have become a law.