Appellate Division Docket No. 2019-09157

New York Supreme Court
Appellate Division – Second Department

MAPLE MEDICAL LLP,

Plaintiff-Respondent,

- against -

JOSEPH SCOTT, D.O.,

Defendant-Appellant,

- and –

MEDICAL LIABILITY MUTUAL INSURANCE COMPANY,

Defendant.

APPELLANT'S REPLY BRIEF

NOLAN HELLER KAUFFMAN LLP
Justin A. Heller, Esq.
Brendan J. Carosi, Esq.
Attorneys for Defendant-Appellant
Joseph Scott, D.O.
80 State Street, 11th Floor
Albany, New York 12207
(518) 449-3300

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PRELIMINARY STATEMENT[1]

Plaintiff-Respondent's Brief ("Resp. Brief") rests entirely on its specious argument that, as the then-sole Appellate Division decision concerning a dispute over MLMIC Cash Consideration, *Matter of Schaffer, Schonholz & Drossman, LLP v. Title* (171 A.D.3d 465 [1st Dep't 2019] ["*Schaffer*"]) was binding on the court below and obviates this Court's *de novo* consideration of whether Defendant was entitled to the Consideration under the Insurance Law, Plan of Conversion and DFS Decision. While Defendant maintains that the court below was not bound by *Schaffer*, it is beyond cavil that this Court is not so bound.

Contrary to Plaintiff's spurious claims, *Schaffer* did not (a) hold that an employer's payment of its employee's premiums made the employer the MLMIC "Policyholder," (b) support Plaintiff's argument that Insurance Law § 7307(e)(3) requires that the payor of the premiums receive the Cash Consideration, or (c) confirm the DFS Decision wrongly approved the Plan of Conversion's definition of the Policyholder as the Insured. Indeed, the *Schaffer* decision did not even reference--let alone discuss--the Insurance Law, Plan or DFS Decision.

Moreover, on April 24, 2020, the Fourth Department held that, notwithstanding *Schaffer* and the plaintiff-employer's payment of its employees'

[1] Capitalized terms have the meanings ascribed thereto in Defendant-Appellant's opening Brief unless otherwise defined herein.

MLMIC premiums on their behalf (as policy administrator), "as a matter of law [the employer/policy administrator] had no legal or equitable right of ownership to the demutualization payments." *Maple-Gate Anesthesiologists, P.C. v. Nasrin*, 2020 NY Slip Op 02389, ¶¶1-2 (4th Dep't Apr. 24, 2020) ("*Maple-Gate*").[2] Not only does *Maple-Gate*'s holding comport with Defendant's arguments to the lower court and herein, it is consistent with four recent Orange County Supreme Court decisions denying an employer's unjust enrichment claims to its employees' MLMIC Cash Consideration.[3]

In those Orange County cases, the court held in pertinent part that (a) upon careful scrutiny, *Schaffer*'s conclusory decision was not binding, and the plaintiff-employer could not sustain an unjust enrichment claim under established New York law (*Cornell*); (ii) the employers had already received the benefit of the bargains from the employment agreements and policy administrator arrangements and therefore could not sustain an unjust enrichment claim (*Allegro-Skinner*; *Sidorski-Nutt*); and (iii) the employer already bargained to pay the premiums without regard to demutualization proceeds, thus the "enrichment is not at [employer's] expense,

[2] The Fourth Department affirmed the Erie County Supreme Court's decision (96 N.Y.S.3d 837 [Sup. Ct. Erie County 2019]).

[3] *GHVHS Med. Group, P.C. v. Allegro-Skinner*, No. EF001608-2019 (Sup. Ct. Orange County Jan. 6, 2020) ("*Allegro-Skinner*"); *GHVHS Med. Group, P.C. v. Sidorski-Nutt*, No. EF001620-2019 (Sup. Ct. Orange County Jan. 6, 2020) ("*Sidorski-Nutt*"); *GHVHS Med. Group, P.C. v. Cornell*, No. EF001610/2019 (Sup. Ct. Orange County Jan. 6, 2020) ("*Cornell*"); and *GHVHS Med. Group, P.C. v. Arthurs*, No. EF001609/2019 (Sup. Ct. Orange County Oct. 7, 2019) ("*Arthurs*") (collectively, "GHVHS Decisions").

but rather an unforeseen benefit [to the policyholder] of the bargain . . . ." (*Arthurs*).

In sum, neither *Schaffer*, nor Plaintiff's contrived arguments as to its alleged entitlement to the Cash Consideration, alter the fact that under the Insurance Law, Plan of Conversion and DFS Decision, it is the Defendant, as the Eligible Policyholder, that is entitled to the Consideration. *See Maple-Gate*, 2020 NY Slip Op 02389, ¶¶1-2 (holding that under the Insurance Law and Plan of Conversion, payment of the Consideration was "required to be made to those policyholders who had coverage during the relevant period," and not to the employer, which "as a matter of law . . . had no legal or equitable right of ownership to the demutualization payments"). *See also Shoback v. Broome Obstetrics and Gynecology, P.C.*, No. EFCA2018003334, at 4 (Sup. Ct. Broome County Sept. 12, 2019) ("*Shoback*") ("The language of the Plan is clear and unambiguous, and as such must be accorded the plain meaning of its terms. According to those terms, [employee-Policyholder] is entitled to the money." [citation omitted]); *Maple-Gate*, 96 N.Y.S.3d at 841-42 ("Insurance Law § 7307 does not confer an ownership interest . . . to the cash consideration to anyone other than the policyholder"; "The DFS Decision reiterated that it was the policyholder who was entitled to the cash consideration.").

For the reasons set forth on this appeal, Defendant respectfully requests that this Court (a) reverse the Decision of the lower court, (b) grant Defendant's motion for summary judgment, and (c) deny Plaintiff's cross-motion for summary judgment.

ARGUMENT

I. PLAINTIFF'S CLAIM THAT THE ISSUES PRESENTED TO THE *SCHAFFER* COURT WERE "THE EXACT ISSUES" PRESENTED TO THE COURT BELOW IS FALSE AND, ULTIMATELY, NUGATORY.

As noted in Defendant's opening Brief (at Point II[D]), a case is precedent only as to the legal issues "'presented, considered and squarely decided.'" *Wellbilt Equip. Corp. v. Fireman*, 275 A.D.2d 162, 168 (1st Dep't 2000). In a contrived attempt to support its argument that *Schaffer* was binding precedent on the lower court, Plaintiff posits in conclusory fashion that the *Schaffer* court was presented with, considered and resolved "the *exact* issues now before the Court" (Resp. Brief, 9 [emphasis in original]; *see also id.*, at 10 ["the *Schaffer* court considered and resolved the very issues before this Court"]).

As discussed herein, Plaintiff's spurious claim entirely ignores that the *Schaffer* submissions did not include or discuss, among other things, (a) the controlling provision of the Insurance Law, § 7307, which is fundamental to understanding demutualization and the operation of the Plan of Conversion, (b) the DFS Decision approving the Plan, which explained the limited circumstances under which a Policy Administrator could have a legal right to the Cash Consideration (i.e., designation by the consent form or an assignment), or (c) controlling New York unjust enrichment law, which precludes an unjust enrichment claim where, *inter alia*, (i) plaintiff already received the bargained-for consideration for the benefit

conferred on defendant, or (ii) plaintiff's claim is based on a benefit conferred in accordance with the parties' written agreement. Having been presented with none of these authorities, it is not surprising that the *Schaffer* court failed to reference any of them.

In short, Plaintiff's argument that the legal issues presented to, and considered and resolved by, the *Schaffer* court are identical to those raised to the court below is pure fiction, proffered in a hollow attempt to convince the Court that *Schaffer* obviates a *de novo* consideration of the legal issues presented herein. In any event, Plaintiff's argument is ultimately rendered nugatory by the fact that this Court is not bound by the *Schaffer* decision. Accordingly, Defendant respectfully submits that the Court should decline to follow *Schaffer* and instead follow the Fourth Department's *Maple-Gate* decision and the Orange County GHVHS Decisions (discussed *infra*).

A. The Deficient Briefing in *Schaffer* Excluded the Critical Concept That the Doctor Bargained for Her MLMIC Policy and Received Her Membership Interest (and the Related Membership Rights) by Virtue of Becoming a Policyholder.

It is axiomatic that, like Plaintiff, the employer in *Schaffer* did not bargain for the Cash Consideration.[4] Yet, the *Schaffer* court based its finding of unjust

[4] As Policy Administrator, the employers agreed to act as agent with respect to their employees' policies, and in so doing, expressly acknowledged that they were only entitled to receive dividends/premium refunds--which the Cash Consideration is not. (Opening Brief, Point I[C]).

enrichment on its presupposition—parroted by Plaintiff (Resp. Brief, 2-3 & 19)—that the employee did not "bargain for the benefit of the demutualization proceeds." 171 A.D.3d at 465. Significantly, the *Schaffer* court was not presented with the basic structure and operation of a mutual insurance company—namely that "when the [employees], at the [employer's] behest, signed up for professional liability policies issued by MLMIC, they acquired certain rights and benefits, including membership in MLMIC." *Maple-Gate*, 96 N.Y.S.3d at 841 (emphasis added). *See also Shoback*, at 4 ("Policyholders in a mutual insurance company acquire two separate types of rights – contractual rights and membership rights. The contractual rights are paid for by the premiums . . ."; the membership rights "are intrinsic to the owner of the policy, the policyholder." [Citing *Dorrance v. U.S.*, 809 F.3d 479 (9th Cir. 2015)]).

The parties' arguments in *Schaffer* (and in turn the *Schaffer* decision) notably ignored these basic concepts by disconnecting the Membership Interest from the MLMIC policy and positing that the employee did not bargain for the inherent ownership rights attendant to becoming a Policyholder. But in so doing, the *Schaffer* court (and the lower court here) disregarded (a) that under the Insurance Law, the employee obtained a Membership Interest by virtue of becoming—and when s/he became—a MLMIC Policyholder, and (b) that when a mutual insurance company like MLMIC converts to a stock insurance company, the Policyholders are entitled to the cash consideration paid for the extinguishment of their membership interests.

As noted in Defendant's opening Brief (at n.11), the controlling provisions of the Insurance Law (§§ 1211 and 7307) were enacted in 1984, and were in force at the time of the *Schaffer* parties', and the within parties', employment agreements. As such, the employers cannot claim ignorance as to the fact that their employees obtained Membership Interests as an incident to becoming MLMIC Policyholders; and that upon a demutualization, the Policyholders would be entitled to the Cash Consideration under the Insurance Law. This statutory framework cannot be read out of the employment agreements simply because the employers ignored the import of their employees becoming MLMIC Policyholders and now want to claim a legal or equitable ownership interest in their policies. *See Burns v. Burns*, 163 A.D.3d 210, 213 (4th Dep't 2018) ("'[u]nless a contract provides otherwise, the law in force at the time the agreement is entered into becomes as much a part of the agreement as though it were expressed or referred to therein . . .'" [quoting *Dolman v. United States Tr. Co.*, 2 N.Y.2d 110, 116 (1956)]). *See also Kasen v. Morrell*, 6 A.D.2d 816, 817 (2d Dep't 1958) (same).

Simply put, the *Schaffer* court's (and Plaintiff's) claim that the employee did not "bargain" for the Cash Consideration misses the point. The malpractice policy and premium payments were part of the bargained-for exchange of consideration under the parties' employment agreements. When, at their employers' direction, the employees obtained MLMIC policies (rather than non-mutual insurance policies)

and became Policyholders, they received Membership Interests, which included the statutory right (under Insurance Law § 7307[e][3]) to receive Consideration for the extinguishment of those Interests.

B. The *Schaffer* Court Was Not Advised as to the Import of the Employer Signing the Policy Administrator Designation Form.

The employer in *Schaffer* (R. 314, ¶9)—like Plaintiff herein (R. 207, ¶4)—was designated as its employee's Policy Administrator pursuant to a Policy Administrator Designation Form. That form stated that the employer would be the "agent" of the insured/policyholder "for the paying of Premium[s], requesting changes in the policy, . . . and for receiving dividends and any return Premiums when due" (R. 222 [emphasis added]). By executing this Form, both the employer in *Schaffer* and Plaintiff expressly acknowledged that their rights as to remuneration relating to employees' policies were limited to dividends/refunded premiums.

As discussed in Defendant's opening Brief (at Point I[C]), mutual insurance company dividends are partial returns of premiums. *Towne Bus Corp. v. Ins. Co. of Greater N.Y.*, 2008 NY Slip Op 50149(U), ¶ 4 (Sup. Ct. N.Y. County Jan. 18, 2008). The Cash Consideration, however, is not a dividend/premium refund. *See Columbia Mem'l Hosp. v. Hinds*, 2019 NY Slip Op 51508(U), ¶5 (Sup. Ct. Columbia County Sept. 3, 2019) ("*Columbia Mem'l Hosp.*") ("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.").

Accordingly, neither the *Schaffer* employer's nor Plaintiff's status as Policy Administrator, including the right to receive dividends/premium refunds, entitled it to receive the Cash Consideration. *See Maple Gate*, 2020 NY Slip Op 02389, *2 ("[A]lthough defendants had assigned some of their rights as policyholders to plaintiff as Policy Administrator, they had not designated plaintiff to receive demutualization payments. . . . The mere fact that plaintiff paid the annual premiums on the policies on defendants' behalf does not entitle it to the demutualization payments.").

C. The *Schaffer* Court Was Not Presented with the Controlling Unjust Enrichment Law Submitted to the Court Below.

The *Schaffer* court was not presented with the controlling unjust enrichment law set forth in Defendant's opening Brief (at Point II[C]) and *infra* (at Points II[C]-[D]). While unjust enrichment was raised (improperly) for the first time in the *Schaffer* employer's reply brief, it was done so with only a conclusory statement that the doctor would be unjustly enriched by receiving the Cash Consideration and a citation to a distinguishable motion to dismiss case, *Castellotti v. Free* (138 A.D.3d 198 [1st Dep't 2016]). *Castellotti* is a prototypical unjust enrichment case where plaintiff conferred a benefit on defendant under an alleged oral agreement for which

defendant provided nothing in exchange.

In stark contrast to *Castellotti*, the *Schaffer* employer and the Plaintiff herein each paid their employees' MLMIC premiums pursuant to their employment agreements and Policy Administrator Designation Forms and, in return, received the agreed-upon consideration: the employees' services and dividends/refunded premiums. As discussed in the opening Brief and *infra*, Plaintiff cannot as a matter of law sustain an unjust enrichment claim because (i) its claim is based on a benefit (premium payments) conferred on Defendant in accordance with their Employment Agreement, and (ii) Plaintiff already received the bargained-for consideration for such benefit (revenue from Defendant's services, and dividends/refunded premiums). Had the *Schaffer* court been presented with, *inter alia*, this controlling unjust enrichment law, the First Department would have ruled in favor of the employee-physician.

D. In Lieu of Controlling Unjust Enrichment Law, the *Schaffer* Court Was Presented With—and Relied On—Inapposite ERISA Case Law.

In *Schaffer*, the First Department was presented with and relied exclusively on two inapposite ERISA cases: *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* (No. 02-cv-3115, 2005 U.S. Dist. LEXIS 42877 [N.D.

Ill. Mar. 4, 2005]) ("*Chi. Truck Drivers*"). Plaintiff disingenuously claims that the issues decided in, and the "principle enunciated by," those two ERISA cases are the same as those in *Schaffer* and the instant case (Resp. Brief, 13-15). As discussed in Defendant's opening Brief (at Point II[E]), *Ruocco* and *Chi. Truck Drivers* concerned whether demutualization proceeds were ERISA "plan assets"—a question which turned on ERISA law, had nothing to do with a common law unjust enrichment claim, and is clearly not an issue raised in *Schaffer* or herein.

Moreover, as noted in Defendant's opening Brief, neither *Ruocco* nor *Chi. Truck Drivers* referenced any plan-related documentation that provided guidance as to the distribution of demutualization proceeds. By contrast, the Plan of Conversion and 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 Cash 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.").[5]

Plaintiff's reliance on *Mell v. Anthem, Inc.* (688 F.3d 280 [6th Cir. 2012] and 2010 U.S. Dist. LEXIS 19056 [S.D. Ohio Mar. 3, 2010]) is similarly misplaced. *Mell* involved a dispute between (a) the City of Cincinnati, the holder of a group health insurance policy (rather than the individual policy at issue herein), and (b) its employees, the holders of certificates of benefits under the policy (rather than policyholders/members/owners of the MLMIC policy 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 employees' claim that they were the statutory "policyholders." Nevertheless, the District Court sought to

[5] Similarly, Plaintiff's reference to *Wright v. Nimmons* (641 F. Supp. 1391 [S.D. Tex. 1986]) being cited in *Ruocco* is unavailing. The *Wright* court held that the employer could recapture excess ERISA plan contributions under 29 U.S.C. § 1344(d) where either (a) the "trust plan is silent regarding the distribution of excess assets" and the employer exclusively funded the plan, or (b) "excess assets have accumulated as a consequence of actuarial error." *Id.* at 1406-07. Here, by contrast, the Insurance Law, Plan of Conversion and DFS Decision are not "silent" as to the distribution of Cash Consideration—it is to be paid to Policyholders. And, the Consideration is not "excess [ERISA plan] assets"; it is proceeds from the extinguishment of Policyholders' Membership Interests.

determine who the "owner" was, and thus the party entitled to the demutualization proceeds under the statute. To determine the meaning of the word "owner," the District Court applied the maxim of statutory construction that the undefined term should be given its plain meaning. The court held that the employees could not be the "owners" of the policy because they "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, *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 policy to "policyholders" was unavailing. *Id.* at 287.

Unlike the Ohio statute, New York Insurance Law § 7307(e)(3) does not use the undefined term "owner." Rather, Insurance Law §§ 1211 and 7307(e)(3) establish that a mutual insurance 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 interests. Pursuant to those provisions, the Plan of Conversion and

DFS Decision require that the Cash Consideration be paid to the Policyholders (such as Defendant). *Mell*, *Ruocco* and *Chi. Truck Drivers* are therefore wholly inapposite.

II. PLAINTIFF'S SUBSTANTIVE CLAIMS TO THE CASH CONSIDERATION FAIL BASED ON DOCUMENTARY EVIDENCE AND CONTROLLING NEW YORK LAW

As noted above, Plaintiff's claims that *Schaffer* confirmed (a) its payment of Defendant's premiums rendered Plaintiff the "Policyholder," (b) Insurance Law § 7307(e)(3) mandates that the payor of the premiums receive the Consideration, and (c) the DFS Decision wrongly approved the Plan of Conversion's definition of the Policyholder as the Insured, are patently spurious. The *Schaffer* decision did not even reference--let alone discuss--the Insurance Law, Plan or DFS Decision. Moreover, as discussed below, Plaintiff's above claims—as well as its related unjust enrichment arguments—fail based on documentary evidence, the Insurance Law, and black letter New York unjust enrichment law.

A. Contrary to Plaintiff's Claim, *Defendant* Was the MLMIC Policyholder.

Contrary to Plaintiff's claim that its payment of Defendant's premiums rendered it the MLMIC "Policyholder" entitled to receive the Consideration under Insurance Law § 7307(e)(3), the Plan of Conversion defines "Policyholder" as the person "identified on the declarations page of such Policy as the insured" (R. 70). 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.*,

Bertalos Rest., Inc. v. Exchange Ins. Co., 240 A.D.2d 452 (2d Dep't 1997); *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 (4th Dep't 1993); *Rhine v. N.Y. Life Ins. Co.*, 248 A.D. 120, 123 (1st Dep't 1936).

Here, documentary evidence establishes that Defendant was the sole insured—and thus the sole Policyholder—under his MLMIC malpractice policy (R. 207, ¶4; R. 226). Plaintiff, on the other hand, has failed to provide *any* documentation (nor could it) showing that it was the Policyholder. As held by the Fourth Department in *Maple-Gate*, which relied upon similar documentary evidence as Defendant presented to the court below, the named Policyholders (here, Defendant) are entitled under the Insurance Law and Plan of Conversion to the Cash Consideration. 2020 NY Slip Op 02389, **2.

To the extent Plaintiff is arguing that it should be *deemed* the Policyholder because it paid the premiums and performed other duties of a Policy Administrator, that argument entirely lacks merit. As explained in Plaintiff's opening Brief (at Point I[B]), a Policy Administrator is merely the Policyholder's agent, tasked with performing the same administrative duties and granted the same limited rights respecting its principal's policy on which Plaintiff bases its argument: paying premiums, requesting changes in the policy and receiving premium refunds (R.222).

Clearly, if an employer were entitled to the Cash Consideration by reason of being Policy Administrator, the Plan of Conversion would have provided so. It did not. *See Maple-Gate*, 96 N.Y.S.3d at 841-42 ("Being designated as the policy administrator did not make the plaintiff a policyholder, did not make the plaintiff a member of MLMIC and did not entitle the plaintiff to the cash consideration."). *See also Maple-Gate*, 2020 NY Slip Op 02389, *2 ("[A]lthough defendants had assigned some of their rights as policyholders to plaintiff as Policy Administrator, they had not designated plaintiff to receive demutualization payments. . . . The mere fact that plaintiff paid the annual premiums on the policies on defendants' behalf does not entitle it to the demutualization payments.").

B. Plaintiff Mischaracterizes the Insurance Law in an Unavailing Effort to Support a Claim to the Cash Consideration.

Lacking any support for its above "policyholder" argument, Plaintiff contends that under Insurance Law § 7307, the party who paid the premiums is entitled to the Cash Consideration. That contention is squarely based on Plaintiff's mischaracterization of § 7307(e)(3)'s formula for calculating Policyholders' shares of Consideration:

> "The plan [of conversion] shall include: . . . (3) The manner and basis of exchanging the equitable share of each eligible mutual policyholder for . . . consideration . . . . The plan shall also provide that **each person who had a policy of insurance in effect at any time during the three year period . . . shall be entitled to receive in exchange for such equitable share, . . . consideration** payable in voting common shares of the insurer

> or other consideration, or both. 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 . . . .*" (Emphasis added).

Those italicized and underlined provisions on which Plaintiff relies merely address how the amount of consideration is to be determined, not to whom it is payable. The first portion of § 7307(e)(3) (in bold) clearly describes to whom the Consideration is to be paid: "each person who had a policy of insurance in effect" (i.e., the Policyholder). At no point does the statute provide that the Consideration is to be paid to the payor of the premiums. Simply put, Plaintiff's argument conflates the statutory language governing *how* the Consideration is to be calculated (by reference to premiums paid on the policy) with the provision governing *who* is to receive it (the Policyholder).

In a desperate attempt to support its strained position as to § 7307(e)(3), Plaintiff proffers a MLMIC email and newsletter from 2016—*two years b*efore the Plan of Conversion was adopted—positing that in most cases, the payor of the premiums will be considered the "owner" of policies (R. 289, 297). As Plaintiff concedes, MLMIC ultimately rejected that notion in its Plan of Conversion. Specifically, the Plan (a) defined the "Members" (*i.e.*, the owners of the Policy under

Insurance Law § 1211[a]) as the Policyholders, and the Policyholders as the "insured" listed on the Policy (R. 69-70); and (b) defined "Eligible Premium" (the premiums on which the amount of Cash Consideration would be determined) as "with respect to *each Eligible Policyholder*, the sum of net premiums . . . properly and timely *paid on each Eligible Policy*." (R. 68, 78 [emphasis added]). In short, MLMIC recognized that under the Insurance Law, the Policyholder/Insured was entitled to the Consideration.

Significantly, as discussed in Defendant's opening Brief (at Point I[D]), Plaintiff twice made the same flawed argument regarding § 7307(e)(3)'s formula language—(i) at the DFS Hearing, and (ii) in its Article 78 proceeding challenging the DFS Decision[6]—and each time it was flatly rejected. Plaintiff's renewal of those arguments below (and herein) to contest the Plan of Conversion and the DFS Decision are improper and unavailing.

DFS Hearing: In its Decision, DFS dismissed Plaintiff's above argument made at the DFS Hearing:

> "One commenter [Plaintiff] 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 . . . . ' The commenter suggested that this means that the person that paid the premium is automatically entitled to the proceeds of the sale.

[6] *See Maple Medical LLP v. N.Y. State Dep't of Fin. Servs.*, No. 65929/2018 (Sup. Ct. Westchester County Dec. 28, 2018).

> The Superintendent finds that this [i.e., *the above § 7307(e)(3) formula language*] is not determinative because the same provision [i.e., *governing who gets paid*] refers to the 'policyholder,' which might or might not be the person who paid the premiums." (R. 184, para. 3 [emphasis added]).

In other words, the DFS (a) clarified that § 7307(e)(3)'s formula for calculating the amount of the Cash Consideration is not determinative of who receives the Consideration, and (b) confirmed that the Consideration is to be paid *to the Policyholders* under § 7307(e)(3).

Article 78 Proceeding: Plaintiff subsequently commenced an Article 78 proceeding (*Maple Medical LLP v. N.Y. State Dep't of Fin. Servs.*) to challenge the DFS Decision's approval of the Plan of Conversion's definition of "Policyholder." The Westchester County Supreme Court rejected Plaintiff's argument that § 7307(e)(3) required the Plan to define policyholders "as the parties who actually paid the premiums and not the doctors who are insured under the policies," holding that DFS had a rational basis for approving the Plan, including its definition of Policyholder (and the Policyholders' entitlement to the Consideration) (R. 203-04).

Quite simply, there is no basis on which Plaintiff could have asked the court below (or on which to ask this Court) to ignore the plain language of § 7307(e)(3), disregard the Plan, and overrule the DFS Decision. It bears emphasis that in reviewing an agency determination, such as the DFS Decision, a court must defer to the agency's interpretation of its own governing statutes and regulations when the

agency acts within its particular area of expertise. *See Rodriguez v. Perales*, 86 N.Y.2d 361, 367 (1995) ("An agency's interpretation of the statutes it administers generally should be upheld if not unreasonable or irrational."); *New Surfside Nursing Home, LLC v. Daines*, 103 A.D.3d 637, 639 (2d Dep't 2013) ("courts must defer to an administrative agency's rational interpretation of its own regulations in its area of expertise"). Here, DFS' interpretation of the Insurance Law and approval of the Plan was rational, as confirmed by the Westchester County Supreme Court (*supra*), and is therefore entitled to judicial deference.

In sum, Insurance Law § 7307(e)(3)'s "formula regarding <u>how</u> to calculate the amount of consideration the policyholder would receive"[7] is not relevant to <u>who</u> is to receive it. Indeed, § 7307(e)(3) is clear on that latter point: "each person who had a policy of insurance in effect" (i.e., the <u>Policyholder</u>) is to receive the Consideration. As recognized by the *Maple-Gate* trial court, the statute makes "<u>[n]o distinction</u> . . . between a policyholder who pays the premium out of his own pocket versus a policyholder whose employer pays the premium as part of an employee compensation package." 96 N.Y.S.3d at 841 (emphasis added). *See also Columbia Mem'l Hosp.*, 2019 NY Slip Op 51508(U), ¶4 (quoting *Maple-Gate* trial court). As such, the Fourth Department in *Maple-Gate* aptly concluded—as this Court should--that under the Insurance Law and Plan of Conversion, payment of the Cash

[7] *Maple-Gate*, 96 N.Y.S.3d at 841 (emphasis added).

Consideration was "required to be made to those policyholders who had coverage during the relevant period," and not to the employer, which "as a matter of law . . . had no legal or equitable right of ownership to the demutualization payments." 2020 NY Slip Op 02389, ¶¶1-2 (emphasis added).

C. Plaintiff Cannot Sustain an Unjust Enrichment Claim Based on Its Payment of Defendant's Premiums Pursuant to the Employment Agreement

As discussed in Defendant's opening Brief (at Point II[C]), it is black letter New York law that an unjust enrichment claim is precluded where the plaintiff has already received consideration for the benefit conferred on the defendant (*Smith v. Chase Manhattan Bank, USA, N.A.*, 293 A.D.2d 598, 600 [2d Dep't 2002]), or where the claim arises out of the subject matter of a written agreement. *IDT Corp. v. Morgan Stanley Dean Witter & Co.*, 12 N.Y.3d 132, 142 (2009); *ISS Action, Inc. v. Tutor Perini Corp.*, 170 A.D.3d 686, 690 (2d Dep't 2019). In an unavailing effort to avoid this controlling unjust enrichment law, Plaintiff avers that the Employment Agreement "does not address, much less even mention," the Cash Consideration (Resp. Brief, 19).[8] Plaintiff misses the point.

[8] Plaintiff's cited cases are patently distinguishable, as they concerned whether alleged uncompensated services were performed outside of the parties' written agreements. *See Ashwood Capital, Inc. v OTG Mgt., Inc.*, 99 A.D.3d 1, 10-11 (1st Dep't 2012) (*motion to dismiss* denied because plaintiff adequately pled that unpaid services were performed outside of the agreement); *Baker v. Robert I. Lappin Charitable Found.*, 415 F. Supp. 2d 473, 484-485 (S.D.N.Y. 2006) (denying summary judgment because there were questions of fact as to whether alleged uncompensated services were performed under an enforceable agreement). By contrast, Plaintiff's

By its own admission, Plaintiff's claim to the Consideration is predicated on its payment of Defendant's MLMIC premiums. But Plaintiff's payment of those premiums was an express obligation under the parties' Employment Agreement (Resp. Brief, 2-3 [admitting that Plaintiff paid Defendant's premiums "[p]ursuant to Dr. Scott's employment agreement"] & 19 ["Dr. Scott's employment agreement covers . . . the premiums for which Maple was required to pay."). And in return for, *inter alia*, payment of his malpractice insurance, Defendant agreed to provide medical services to Plaintiff's patients and generate revenue for Plaintiff. *See Shoback*, at 4:

> "Here, the defendant paid the premiums as part of its obligation under the Employment Agreement with plaintiff. She provided services and in return defendant was confident that she was covered (and hence it was covered) in terms of malpractice insurance. This arrangement benefitted both parties."

See also Arthurs (*infra*), at 5 (Employee would not be unjustly enriched at employer's expense because employer "fully expected to pay all the insurance premiums, without repayment, as part of the compensation to [the employee], when the employment contract was signed."). Quite simply, Plaintiff agreed to pay Defendant's premiums as part of the bargained-for exchange of consideration under

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unjust enrichment claim is squarely based on its payment of Defendant's MLMIC premiums and administration of his policy—which Plaintiff expressly agreed to do under the Employment Agreement and Policy Administrator Designation Form, and for which Plaintiff received the agreed-upon compensation (i.e., revenue from Defendant's services, and refunded premiums).

the Employment Agreement, and received the benefits of its bargain.[9]

Based on the foregoing, Plaintiff's unjust enrichment claim premised on its payment of Defendant's premiums fails as a matter of law. *See IDT Corp.*, 12 N.Y.3d at 142 (Plaintiff could not sustain an unjust enrichment claim on the basis of the fee it paid to defendant in accordance with the signed engagement letter.); *ISS Action, Inc*, 170 A.D.3d at 690 (Summary judgment dismissing unjust enrichment claim was proper because "payment of applicable taxes was expressly provided for in the parties' agreements"); *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).

D. Plaintiff's Attempt to Base its Unjust Enrichment Claim on a Non-Existent Ownership Interest in Defendant's Policy Fails

Plaintiff also attempts to sustain its unjust enrichment claim on the erroneous contention that it was the "owner and policyholder" of Defendant's policy."[10] (Resp. Brief, 18). As set forth in Defendant's opening Brief (at Point I), MLMIC is owned

[9] Moreover, by the Policy Administrator Designation Form, Plaintiff further agreed that in exchange for its payment of Defendant's premiums and administration of his policy, it would receive dividends/refunded premiums (which the Cash Consideration is not [Opening Brief, Point I(C)]). As held in *Sidorski-Nutt* (*infra*), the employer—like the Plaintiff herein—"already received the benefit of the bargain from the dividends which reduced the premiums the [employer] paid before MLMIC converted," and thus could not sustain a claim for unjust enrichment. *Id.* at 3.

[10] Plaintiff's citation to *Alan B. Greenfield, M.D., P.C. v. Long Beach Imaging Holdings* (114 A.D.3d 888 [2d Dep't 2014]) is misplaced. *Greenfield* is a motion to dismiss case where defendant allegedly enriched itself at plaintiff's expense by wrongfully withholding plaintiff's files/records. Here, there are no allegations of wrongful conduct on Defendant's part.

by its Members, the Policyholders, who hold "Policyholder Membership Interests" (R. 69-70). *See* Insurance Law § 1211(a). The Plan of Conversion defines "Policyholder" as the person listed as the "Insured" on the policy (R. 70)—which, here, was Defendant (R. 207, ¶4; R. 226).

The statutory scheme under the Insurance Law is clear: Defendant obtained a Policyholder Membership Interest when he became, and by virtue of his becoming, a MLMIC Policyholder. Consistent with the foregoing, and as aptly held by the Fourth Department in *Maple-Gate*, the documentary evidence establishes "that defendants [employees] were the policyholders of the relevant MLMIC policies" and that "as a matter of law, plaintiff [employer] had no legal or equitable right of ownership to the demutualization payments." 2020 NY Slip Op 02389, *1-2.

Based on the foregoing, Plaintiff's attempt to base its unjust enrichment claim on a non-existent ownership interest in Defendant's policy fails as a matter of law. *A & A Assocs. v. Olympic Plumbing & Heating Corp.*, 306 A.D.2d 296, 297 (2d Dep't 2003) ("no issue of fact was raised as to whether respondents derived a benefit that belonged to plaintiff, which is necessary to sustain a cause of action based upon unjust enrichment"). *See also Clifford R. Gray, Inc. v. LeChase Constr. Servs., LLC*, 31 A.D.3d 983, 988 (3d Dep't 2006) ("[P]laintiff asserts no facts suggesting that defendant is in possession of money or property belonging to plaintiff.").

III. RECENT APPELLATE AND SUPREME COURT DECISIONS CORRECTLY DECLINED TO FOLLOW *SCHAFFER* AND RULED IN FAVOR OF THE POLICYHOLDERS/EMPLOYEES

Contrary to the rote adherence of the court below and certain other trial courts[11] to *Schaffer*, the Fourth Department and the Orange County Supreme Court have declined to follow *Schaffer*, and ruled in favor of the employees/Policyholders.

Maple-Gate. On April 24, 2020, the Fourth Department affirmed the decision of the Erie County Supreme Court holding that the employees/Policyholders would not be unjustly enriched by receiving the Cash Consideration. In holding that "as a matter of law . . . [employer] had no legal or equitable right of ownership to the demutualization payments," the Fourth Department (a) emphasized the employer's agreement to pay the premiums pursuant to the defendant-employees' employment agreements, (b) recognized that the Insurance Law, the Plan and other documentary evidence required that the employees/Policyholders receive the Consideration, and (c) relied upon established New York unjust enrichment precedent. 2020 NY Slip Op 02389, ¶¶1-2. By way of emphasis, *Schaffer* (i) did *not* cite to the Insurance

[11] Plaintiff highlights two non-binding cases in which trial courts held that they are bound to follow *Schaffer*: (i) *Schoch v. Lake Champlain OB-GYN, P.C.* (64 Misc. 3d 1215(A) [Sup. Ct. Saratoga County 2019]); and (ii) *Long Island Radiology Assocs., P.C. v. Koshy* (No. 600195/19 [Sup. Ct. Nassau County Oct. 7, 2019]). (Resp. Brief, 16). Neither case is persuasive because, as discussed above, *Schaffer* was not binding on the lower court and is not binding on this Court. Moreover, both cases are being appealed on similar grounds to the within appeal. Plaintiff also cites *Urgent Med. Care, PLLC v. Amedure* (117 N.Y.S.3d 459 [Sup. Ct. Greene County 2019]. *Amedure* was a motion to dismiss case (*not* a summary judgment case, as Plaintiff contends), and did not hold that the employer was entitled to the MLMIC Cash Consideration on the basis of unjust enrichment. Rather, the court denied the motion to dismiss because the employer had adequately pled unjust enrichment.

Law, (ii) did *not* reference the parties' employment agreement, the MLMIC Plan of Conversion or the DFS Decision, and (iii) did *not* rely upon *any* New York unjust enrichment law. Indeed, citing *Schaffer*, the Fourth Department stressed that "[t]he mere fact that plaintiff paid the annual premiums on the policies on defendants' behalf does not entitle it to the demutualization payments." *Maple-Gate*, 2020 NY Slip Op 02389, ¶2.

Arthurs. On October 7, 2019, the court issued its Decision and Order in *GHVHS Medical Group, P.C. v. Arthurs* (No. EF001609/2019) awarding the employee/Policyholder the Cash Consideration. Specifically addressing the employer's contention that awarding the employee the Consideration would constitute unjust enrichment, the court held:

> While Dr. Arthurs may be enriched by receiving this profit, she is not being enriched at the expense of the [employer]. [The employer] fully expected to pay all the insurance premiums, without repayment, as part of the compensation to [Dr. Arthurs], when the employment contract was signed. No one anticipated that MLMIC would be demutualized with a profit paid to the policyholders. Therefore [Dr. Arthurs'] enrichment is not at [the employer's] expense, but rather an unforeseen benefit of the bargain . . ."

Arthurs at 5.

Allegro-Skinner* and *Sidorski-Nutt. On January 6 and January 8, 2020, respectively, the Orange County Supreme Court issued its Decisions and Orders in the cases *GHVHS Medical Group, P.C. v. Allegro-Skinner* (No. EF001608-2019)

and *GHVHS Medical Group, P.C. v. Sidorski-Nutt* (No. EF001620-2019). The court correctly held that as the MLMIC Policyholders, the employees were entitled to the Cash Consideration from the extinguishment of their Membership Interests. Like the case at bar, the employer was the Policy Administrator and paid the premiums on behalf of its employees.

The court emphasized that notwithstanding the employer's payment of the premiums, the employees/Policyholders would not be unjustly enriched by receiving the Consideration. In short, the court recognized that the employer's payment of premiums was part of the parties' exchange of consideration and that in return, the employer received, among other things, dividends/refunded premiums. Simply put, the employer had "already received the benefit of the bargain" and therefore could not sustain a claim for unjust enrichment. *Sidorski-Nutt*, at 3.

Cornell. On January 16, 2020, the court issued its Amended Decision and Order in *GHVHS Medical Group, P.C. v. Cornell* (No. EF001610/2019). While the employer argued that the court was bound to follow *Schaffer*, the court disagreed:

> "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 Appeals, caution must be applied in some cases. (See *People v Hobson*, 39 NY2d 479, 489-90 [1976], which recognized that conclusory assertions should be carefully scrutinized.)." (*Id.* at 5-6 [citations omitted]).

Declining to find that the employee would be unjustly enriched if awarded the Consideration, the *Cornell* court reasoned, "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." *Id.* at 7.

Ultimately, the court ruled that the employee/Policyholder was entitled to the Consideration, emphasizing that "[t]he Plan approved by the Department of Insurance allowed for the Policy Holder to assign the benefits if they chose to do so, further illustrating that the rightful owner of the proceeds would be the Policy Holder, Dr. Cornell, and no one else." *Id.* at 9.

Although the foregoing decisions, like *Schaffer*, are not binding on this Court, they support the Court's departure from *Schaffer*, reversal of the lower court's Decision, and grant of summary judgment in Defendant's favor.

CONCLUSION

Based upon the foregoing, his opening Brief, and the Record herein, Defendant-Appellant respectfully requests that the Court reverse the Decision of the court below in its entirety and grant Defendant's motion for summary judgment.

Dated: May 7, 2020
Albany, New York

NOLAN HELLER KAUFFMAN LLP

By: _____

Justin A. Heller, Esq.
Brendan J. Carosi, Esq.
Attorneys for Defendant-Appellant
Joseph Scott, D.O.
80 State Street, 11th Floor
Albany, New York 12207
(518) 449-3300

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A & A Assocs. v. Olympic Plumbing & Heating Corp.

Supreme Court of New York, Appellate Division, Second Department

May 15, 2003, Argued ; June 9, 2003, Decided

2002-05380

Reporter
306 A.D.2d 296 *; 760 N.Y.S.2d 652 **; 2003 N.Y. App. Div. LEXIS 6460 ***

A & A Associates, Inc., Appellant, v. Olympic Plumbing & Heating Corp. et al., Respondents, et al., Defendant. (Index No. 20275/98)

Subsequent History: [*1]**

Appeal denied by *A & A Assocs. v. Olympic Plumbing & Heating Corp., 1 N.Y.3d 503, 2003 N.Y. LEXIS 4097 (N.Y., Dec. 18, 2003)*

Counsel: Agovino & Asselta, LLP, Mineola, N.Y. (Steven R. Miller, Joseph P. Asselta, and Eric Su of counsel), for appellant.

Sonnenschein Nath & Rosenthal, New York, N.Y. (Allen G. Reiter and Stephen L. Brodsky of counsel), for respondents Olympic Plumbing & Heating Corp. and Albert Rocco.

Dewey, Pegno & Kramarsky, LLP, New York, N.Y. (David S. Pegno of counsel), for respondents A. J. Pegno Construction Corp. and Timothy S. Rexon.

Judges: FRED T. SANTUCCI, J.P., GLORIA GOLDSTEIN, HOWARD MILLER, ROBERT W. SCHMIDT, JJ. SANTUCCI, J.P., GOLDSTEIN, H. MILLER and SCHMIDT, JJ., concur.

Opinion

[*296] **[**652]** In an action, inter alia, to recover damages for unfair competition, the plaintiff appeals from an order of the Supreme Court, Queens County (Weiss, J.), dated May 3, 2002, which granted the motion of the defendants Olympic Plumbing & Heating Corp. and Albert Rocco, and the separate motion of **[*297]** the defendants A. J. Pegno Construction Corp. and Timothy S. Rexon, for summary judgment dismissing the amended complaint insofar as asserted against them.

Ordered that the order is affirmed, **[***2]** with one bill of costs.

The respondents demonstrated their prima facie entitlement to judgment as a matter of law. In opposition, the plaintiff failed to raise a triable issue of fact relating to its cause of action alleging unfair competition (*see* *Allied Maintenance Corp. v Allied Mech. Trades, 42 N.Y.2d 538, 399 N.Y.S.2d 628, 369 N.E.2d 1162 [1977]*; **[**653]** *Camelot Assoc. Corp. v Camelot Design & Dev., 298 A.D.2d 799, 750 N.Y.S.2d 155 [2002]*). In addition, no issue of fact was raised as to whether the respondents derived a benefit that belonged to the plaintiff, which is necessary to sustain a cause of action based upon unjust enrichment (*see* *Smith v Chase Manhattan Bank, USA, 293 A.D.2d 598, 741 N.Y.S.2d 100 [2002]*; *Fandy Corp. v Chang, 272 A.D.2d 369, 707 N.Y.S.2d 361 [2000]*; *Bugarsky v Marcantonio, 254 A.D.2d 384, 678 N.Y.S.2d 737 [1998]*). Moreover, the plaintiff failed to establish the existence of a triable issue of fact with respect to whether the respondents made misrepresentations which deprived the plaintiff of payment for a service which it performed, which was necessary to sustain the plaintiff's cause of action alleging fraud (*see Cohen v Houseconnect Realty Corp., 289 A.D.2d 277, 734 N.Y.S.2d 205 [2001]*; **[***3]** *Buxton Mfg. Co. v Valiant Moving & Stor., 239 A.D.2d 452, 657 N.Y.S.2d 450 [1997]*; *Garelick v Carmel, 141 A.D.2d 501, 529 N.Y.S.2d 126 [1988]*). Accordingly, the Supreme Court properly granted the respondents' motions to dismiss the amended complaint.

The plaintiff's remaining contention is without merit.

Santucci, J.P., Goldstein, H. Miller and Schmidt, JJ., concur.

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Alan B. Greenfield M.D., P.C. v. Long Beach Imaging Holdings, LLC

Supreme Court of New York, Appellate Division, Second Department

February 26, 2014, Decided

2013-02104

Reporter
114 A.D.3d 888 *; 981 N.Y.S.2d 135 **; 2014 N.Y. App. Div. LEXIS 1253 ***; 2014 NY Slip Op 1285 ****; 2014 WL 715131

[**1]** Alan B. Greenfield, M.D., P.C., Appellant, v Long Beach Imaging Holdings, LLC, Defendant, and Lenox Hill Radiology & Medical Imaging Associates, P.C., Respondent. (Index No. 636/12)

Prior History: *Greenfield v. Long Beach Imaging Holdings, LLC, 2012 N.Y. Misc. LEXIS 6781 (N.Y. Sup. Ct., Dec. 17, 2012)*

Core Terms

unjust enrichment, amended complaint, cause of action, Radiology, good conscience, recover damages, enriched, records, motion to dismiss, grant a motion, Restitution, wrongfully, recovered, files

Headnotes/Summary

Headnotes

Equity—Unjust Enrichment

Counsel: **[***1]** Eisenberg & Carton, Port Jefferson, N.Y. (Lloyd M. Eisenberg of counsel), for appellant.

Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Einiger, LLP, Lake Success, N.Y. (Sarah C. Lichtenstein of counsel), for respondent.

Judges: PETER B. SKELOS, J.P., CHERYL E. CHAMBERS, L. PRISCILLA HALL, ROBERT J. MILLER, JJ. SKELOS, J.P., CHAMBERS, HALL and MILLER, JJ., concur.

Opinion

[*888] **[**136]** In an action, inter alia, to recover damages for breach of contract and unjust enrichment, the plaintiff appeals from an order of the Supreme Court, Nassau County (Bucaria, J.), dated December 17, 2012, which granted the motion of the defendant Lenox Hill Radiology & Medical Imaging Associates, P.C., pursuant to *CPLR 3211 (a) (7)* to dismiss the amended complaint insofar as asserted against it.

Ordered that the order is reversed, on the law, with costs, and the motion of the defendant Lenox Hill Radiology & Medical Imaging Associates, P.C., pursuant to *CPLR 3211 (a) (7)* to dismiss the amended complaint insofar as asserted against it is denied.

The plaintiff, Alan B. Greenfield, M.D., P.C. (hereinafter the P.C.), is a professional services corporation specializing in diagnostic radiology. It commenced this action **[***2]** against the defendants Long Beach Imaging Holdings, LLC (hereinafter Long Beach, LLC), and Lenox Hill Radiology & Medical Imaging Associates, P.C. (hereinafter Lenox Hill). In the amended complaint, the plaintiff asserted one cause of action against Lenox Hill, which sought to recover damages for unjust enrichment. Lenox Hill moved pursuant to *CPLR 3211 (a) (7)* to dismiss the amended complaint insofar as

asserted against it, and the Supreme Court granted the motion.

"On a motion to dismiss the complaint pursuant to CPLR 3211 (a) (7) for failure to state a cause of action, the court must afford the pleading a liberal construction, accept all facts as alleged in the pleading to be true, accord the plaintiff the benefit of every possible inference, and determine only whether the facts as alleged fit within any cognizable legal theory" (*Breytman v Olinville Realty, LLC, 54 AD3d 703, 703-704, 864 NYS2d 70 [2008]*; *see* **[*889]** *Leon v Martinez, 84 NY2d 83, 87, 638 NE2d 511, 614 NYS2d 972 [1994]*). "Whether the complaint will later survive a motion for summary judgment, or whether the plaintiff will ultimately be able to prove its claims, of course, plays no part in the determination of a prediscovery CPLR 3211 motion to dismiss" (*Shaya B. Pac., LLC v Wilson, Elser, Moskowitz, Edelman & Dicker, LLP, 38 AD3d 34, 38, 827 NYS2d 231 [2006]*; **[***3]** *see EBC I, Inc. v Goldman, Sachs & Co., 5 NY3d 11, 19, 832 NE2d 26, 799 NYS2d 170 [2005]*).

[137]** "The essential inquiry in any action for unjust enrichment or restitution is whether **[****2]** it is against equity and good conscience to permit the defendant to retain what is sought to be recovered" (*Paramount Film Distrib. Corp. v State of New York, 30 NY2d 415, 421, 285 NE2d 695, 334 NYS2d 388 [1972]*). A plaintiff must show that (1) the other party was enriched, (2) at the plaintiff'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 (*see Mandarin Trading Ltd. v Wildenstein, 16 NY3d 173, 182, 944 NE2d 1104, 919 NYS2d 465 [2011]*).

"Unjust enrichment . . . does not require the performance of any wrongful act by the one enriched" (*Simonds v Simonds, 45 NY2d 233, 242, 380 NE2d 189, 408 NYS2d 359 [1978]*). "Innocent parties may frequently be unjustly enriched" (*id.*). "What is required, generally, is that a party hold property 'under such circumstances that in equity and good conscience he ought not to retain it' " (*id. at 242*, quoting *Miller v Schloss, 218 NY 400, 407, 113 NE 337 [1916]*; *see Paramount Film Distrib. Corp. v State, 30 NY2d at 421*).

Here, the amended complaint alleged that Long Beach, LLC, wrongfully withheld, or otherwise wrongfully barred access to, the plaintiff's files and **[***4]** records (*see Thyroff v Nationwide Mut. Ins. Co., 8 NY3d 283, 864 NE2d 1272, 832 NYS2d 873 [2007]*; *Sporn v MCA Records, 58 NY2d 482, 489, 448 NE2d 1324, 462 NYS2d 413 [1983]*). The complaint further alleged that Lenox Hill used the plaintiff's files and records to enrich itself at the plaintiff's expense. These allegations were adequate to state a cause of action against Lenox Hill to recover damages for unjust enrichment (*see generally Levin v Kitsis, 82 AD3d 1051, 1053, 920 NYS2d 131 [2011]*; *Restatement [Third] of Restitution § 40*). Lenox Hill's contention that the nexus between the plaintiff and Lenox Hill was, as a matter of law, too attenuated to support a cause of action for unjust enrichment is without merit (*cf. Georgia Malone & Co., Inc. v Rieder, 19 NY3d 511, 519, 973 NE2d 743, 950 NYS2d 333 [2012]*; *Mandarin Trading Ltd. v Wildenstein, 16 NY3d 173, 182, 944 NE2d 1104, 919 NYS2d 465 [2011]*). Accordingly, the Supreme Court should have denied Lenox Hill's motion pursuant to CPLR 3211 (a) (7) to dismiss the amended complaint insofar as asserted against it. Skelos, J.P., Chambers, Hall and Miller, JJ., concur.

End of Document

Allstate Ins. Co. v. Sullivan

Supreme Court of New York, Appellate Division, Second Department

May 14, 1996, Submitted ; August 5, 1996, Decided

95-07170

Reporter
230 A.D.2d 732 *; 646 N.Y.S.2d 359 **; 1996 N.Y. App. Div. LEXIS 8271 ***

In the Matter of Allstate Insurance Company, Respondent, v. Eugene Sullivan, Appellant.

Prior History: [*1]** In a proceeding pursuant to CPLR article 75 to stay arbitration of an underinsured motorist claim, the appeal is from an order of the Supreme Court, Orange County (Peter C. Patsalos, J.), dated June 27, 1995, which granted the petition and permanently stayed arbitration.

Disposition: ORDERED that the order is reversed, on the law, with costs, the petition is denied, the proceeding is dismissed, and the parties are directed to proceed to arbitration.

Core Terms

policyholder, tortfeasor's, stay of arbitration, arbitration, permanent, carrier, settle

Case Summary

Procedural Posture
In a proceeding pursuant to N.Y.C.P.L.R. 75 to stay arbitration of an underinsured motorist claim, appellant policyholder sought review of an order by the Supreme Court, Orange County (New York), which granted the petition and permanently stayed arbitration.

Overview
The court stated that the supreme court had improperly granted the petition of the carrier to permanently stay arbitration. The insurance carrier contended that the policyholder had settled his claim against a third-party tortfeasor for the maximum limit of the tortfeasor's insurance without first obtaining the insurance carrier's consent, and that the failure to obtain the insurance carrier's consent constituted a violation of the insurance policy and was a proper basis for a permanent stay of arbitration. The court disagreed. The policyholder made several efforts to obtain the insurance carrier's consent. The insurance carrier never responded. The policyholder's attorney then wrote to the insurance carrier advising the insurance carrier that the tortfeasor's carrier had tendered its entire $ 10,000 policy, that the insurance carrier's written consent to settle was requested, and that if the insurance carrier did not respond within 30 days, the policyholder would settle the case and proceed with underinsurance arbitration. The insurance carrier ignored that letter as well. Under such circumstances, the insurance carrier was estopped from denying coverage.

Outcome
The court reversed the decision of the supreme court in favor of the carrier, denied the petition, dismissed the proceeding, and directed the parties to proceed to arbitration.

Counsel: Dienst & Serrins, New York, N.Y. (Jonny Kool of counsel), for appellant.

Kornfeld, Rew, Newman & Ellsworth, Suffern, N.Y. (Robert J. Ellsworth of counsel), for respondent.

Judges: Rosenblatt, J. P., Ritter, Pizzuto and Altman, JJ., concur.

Opinion

[*732] [360]** Ordered that the order is reversed, on the law, with costs, the petition is denied, the proceeding is dismissed, and the parties are directed to proceed to arbitration.

The court improperly granted the petition of the carrier (hereinafter Allstate) to permanently stay arbitration. Allstate contends that the insured (hereinafter the policyholder) settled his claim against a third-party tortfeasor for the maximum limit of the tortfeasor's insurance without first obtaining **[***2]** Allstate's consent, and that the failure to obtain Allstate's consent constitutes a violation of the insurance policy and is a proper basis for a permanent stay of arbitration. We disagree.

The policyholder made several efforts to obtain Allstate's consent. Allstate never responded. The policyholder's attorney then wrote to Allstate advising Allstate that the tortfeasor's **[*733]** carrier had tendered its entire $ 10,000 policy, that Allstate's written consent to settle was respectfully requested, and that if Allstate did not respond within 30 days, the policyholder would settle the case and proceed with underinsurance arbitration. Allstate ignored this letter as well. Under such circumstances, Allstate is estopped from denying coverage *(see, Matter of State Farm Mut. Auto. Ins. Co. v Del Pizzo, 185 AD2d 352*; *see also, Matter of Aetna Cas. & Sur. Co. v Crown, 181 AD2d 883*; *Matter of Tri-State Consumer Ins. Co. v Hundley, 208 AD2d 754*).

We have considered Allstate's remaining contentions and find them to be without merit.

Rosenblatt, J. P., Ritter, Pizzuto and Altman, JJ., concur.

Ashwood Capital, Inc. v OTG Mgt., Inc.

Supreme Court of New York, Appellate Division, First Department

July 10, 2012, Decided; July 10, 2012, Entered

7011-7012-, 652087/10, 7014

Reporter

99 A.D.3d 1 *; 948 N.Y.S.2d 292 **; 2012 N.Y. App. Div. LEXIS 5389 ***; 2012 NY Slip Op 5483 ****; 2012 WL 2741860

[**1]** Ashwood Capital, Inc., Appellant, v OTG Management, Inc., et al., Respondents, et al., Defendants.

Prior History: Appeal from two orders of the Supreme Court, New York County (Charles E. Ramos, J.), entered July 29, 2011 and two orders of that court, entered August 1, 2011. The orders granted defendants' motion to dismiss the complaint pursuant to *CPLR 3211 (a) (1)*, *(7)*.

Core Terms

Terminal, parties, unjust enrichment, ambiguity, negotiating, gross sales, relocation, words, motion to dismiss, cause of action, unambiguously, facilities, quotation, marks, terms

Case Summary

Procedural Posture

Plaintiff merchant bank filed an action against defendants, a management company and the company's president, alleging breach of contract and unjust enrichment. The company and president moved to dismiss the bank's claims pursuant to *CPLR 3211(a)(1)* and *(7)*. The bank challenged orders of the Supreme Court, New York County (New York), which granted the motions.

Overview

The bank assigned to the company its rights under a concessionaire agreement with an airline. The bank contended that the supreme court erroneously interpreted the phrase "Terminal 6." The appellate court held that there was no ambiguity either in the term itself or when it was read in the context of the agreement as a whole. The phrase "Terminal 6" unambiguously limited the scope of the parties' agreement to concessions at an airport's Terminal 6. Dismissal of the bank's unjust enrichment claim in its entirety was premature. That claim could arguably extend beyond a claim for services that were owed pursuant to the agreement. However, the statute of frauds barred any unjust enrichment claim based on the assertion that the bank's chairman acted as an intermediary between the airline and the company during negotiations over the company's right to operate the airline's concessions at Terminal 5, *General Obligations Law § 5-701(a)(10)*. Yet, the bank's unjust enrichment claim did not fall entirely within the scope of *§ 5-701(a)(10)* because the bank also sought compensation for the chairman's' advice to the company regarding financing and raising the quality of its concessions.

Outcome

The appellate court modified the orders to deny the motion to dismiss as to the bank's cause of action for unjust enrichment to the extent it claimed to have provided services beyond those mentioned in the

parties' contract and those having to do with brokering or negotiating a deal between the company and the airline for the company's operation of the airline's concessions at Terminal 5. It otherwise affirmed the orders.

LexisNexis® Headnotes

Contracts Law > Contract Interpretation > Intent

HN1[] **Contract Interpretation, Intent**

In order to determine the contracting parties' intent, a court looks to the objective meaning of contractual language, not to the parties' individual subjective understanding of it.

Contracts Law > Contract Interpretation > Intent

HN2[] **Contract Interpretation, Intent**

A contract has, strictly speaking, nothing to do with the personal, or individual, intent of the parties. A contract is an obligation attached by the mere force of law to certain acts of the parties, usually words, which ordinarily accompany and represent a known intent. If, however, it were proved by twenty bishops that either party, when he used the words, intended something else than the usual meaning which the law imposes upon them, he would still be held, unless there were some mutual mistake, or something else of the sort. If it appear by other words, or acts, of the parties, that they attribute a peculiar meaning to such words as they use in the contract, that meaning will prevail, but only by virtue of the other words, and not because of their unexpressed intent.

Contracts Law > Contract Interpretation > Intent

HN3[] **Contract Interpretation, Intent**

When parties set down their agreement in a clear, complete document, their writing should as a rule be enforced according to its terms. The courts apply this rule with even greater force in commercial contracts negotiated at arm's length by sophisticated, counseled businesspeople. In such cases, courts should be extremely reluctant to interpret an agreement as impliedly stating something which the parties have neglected to specifically include. 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. The courts instead concern themselves with what the parties intended, but only to the extent that they evidenced what they intended by what they wrote. Accordingly, before assessing evidence regarding what was in the parties' minds at the time of the agreement, the courts must first look to the agreement itself.

Contracts Law > Contract Interpretation > Ambiguities & Contra Proferentem > General Overview

HN4[] **Contract Interpretation, Ambiguities & Contra Proferentem**

Whether a contractual term is ambiguous must be determined by the court as a matter of law, looking solely to the plain language used by the parties within the four corners of the contract to discern its meaning and not to extrinsic sources.

Contracts Law > Contract Interpretation > General Overview

HN5[] **Contracts Law, Contract Interpretation**

It is not for the court to imply a term where the circumstances surrounding the formation of the contract indicate that the parties, when the contract was made, must have foreseen the contingency at issue and the agreement can be enforced according to its terms.

Business & Corporate Compliance > ... > Contracts Law > Contract Conditions & Provisions > Integration Clauses

Business & Corporate Compliance > ... > Contracts Law > Contract Modifications > Oral Modifications

HN6[] **Contract Conditions & Provisions,**

Integration Clauses

A no-oral-modification clause and a broad merger clause as a matter of law bar any claim based on an alleged intent that the parties failed to express in writing.

Business & Corporate Compliance > ... > Contracts Law > Types of Contracts > Quasi Contracts

Contracts Law > Remedies > Equitable Relief > Quantum Meruit

HN7[] **Types of Contracts, Quasi Contracts**

Where the parties executed a valid and enforceable written contract governing a particular subject matter, recovery on a theory of unjust enrichment for events arising out of that subject matter is ordinarily precluded. Only where the contract does not cover the dispute in issue may a plaintiff proceed upon a quasi-contract theory of unjust enrichment.

Civil Procedure > ... > Responses > Defenses, Demurrers & Objections > Motions to Dismiss

Civil Procedure > Pleading & Practice > Motion Practice > Opposing Memoranda

HN8[] **Defenses, Demurrers & Objections, Motions to Dismiss**

On a motion to dismiss the court must read the complaint liberally, accept as true the facts alleged, and accord the plaintiff the benefit of every possible inference. Further, the court must consider the factual assertions of an affidavit submitted in opposition to the dismissal motion in order to preserve inartfully pleaded, but potentially meritorious, claims.

Contracts Law > Statute of Frauds > Requirements > Writings

HN9[] **Requirements, Writings**

Without a writing, an alleged agreement, promise or undertaking is unenforceable under General Construction Law § 5-701(a)(10), if it is a contract to pay compensation for services rendered in negotiating a business opportunity. Negotiating includes procuring an introduction to a party to the transaction or assisting in the negotiation or consummation of the transaction. The statute of frauds applies where the intermediary's activity is that of providing know-who, in bringing about between principals an enterprise of some complexity.

Headnotes/Summary

Headnotes

Contracts — Construction — Enforcement of Unambiguous Term

1. In an action for, among other things, breach of a written contract regarding the right to operate concessions within an airline's terminal at a major airport, the contract's repeated use of the term "Terminal 6" unambiguously limited the scope of the contract exclusively to the operation of concessions at that terminal, notwithstanding plaintiff's contention that the parties intended for their rights and obligations under the agreement to endure after the airline relocated to another terminal at that airport. Contract terms that are unambiguous must be enforced as written and are not interpreted in some other way based on one party's assertion that when it used the words, it intended something other than the usual meaning. Throughout the parties' agreement, the phrase "Terminal 6" was repeated a total of five times and consistently referred to the airline's facilities at the specified airport. The parties' use of the phrase "Terminal 6" was susceptible to no interpretation **[*2]** other than one that limited the scope of the parties' agreement to concessions at Terminal 6. Although both parties were aware of the airline's upcoming relocation, their agreement neither mentioned the terminal to which it relocated, nor referred to any unspecified terminal of the airline at the airport. That the agreement did not address the contingency of the airline's move to another terminal did not, by itself, create an ambiguity. Nor was there anything in the agreement to support plaintiff's contention that the parties intended for plaintiff to receive a permanent ownership interest in defendant, and thus there was no basis to find an implicit long-term contractual relationship between the parties. Moreover, the agreement contained both a no-oral-modification clause and a broad merger clause, which as a matter of law barred any claim based on an alleged intent that the

parties failed to express in writing.

Disclosure — Discovery and Inspection — Breach of Contract Action — Parol Evidence

2. In an action for breach of contract, plaintiff was not entitled to discovery regarding the parties' intent pursuant to *CPLR 3211 (d)*. Because the parties' agreement was clear and complete on its face, any such discovery would simply be an opportunity for plaintiff to uncover parol evidence in an attempt to create an ambiguity in an otherwise clear and unambiguous agreement. Absent a finding of ambiguity in the agreement, discovery was unnecessary, as any parol evidence would be inadmissible.

Contracts — Breach or Performance of Contract — Effect of Dismissal of Contract Claim on Related Causes of Action

3. In an action for breach of contract arising from the parties' agreement regarding the right to operate concessions at an airport, plaintiff's claim against defendant's president for breach of his personal guaranty of the agreement fell with the dismissal of its breach of contract claim against the corporate defendant since its president's liability under the agreement accrued only after default on the part of the principal obligor. Similarly, the declaratory judgment plaintiff sought, that it was entitled to 1.5% of the gross sales from defendant's concessions, also fell with its breach of contract claim.

Equity — Unjust Enrichment — Cause of Action Barred Where Subject Matter of Claim Covered by Contract

4. In an action arising out of an alleged breach of a contract to operate concessions at an airport, plaintiff's cause of action for unjust enrichment was barred to the extent that it was based on the consulting services plaintiff was required to provide under the parties' agreement because plaintiff's contractual claims were found to be without merit. Recovery on a theory of unjust enrichment was precluded since the parties executed a valid and enforceable written contract governing the subject matter in question; only where the contract does not cover the dispute in issue might plaintiff proceed upon a quasi-contract theory of unjust enrichment.

Equity — Unjust Enrichment — Cause of Action Not Barred Where Subject Matter of Claim Not Covered by Contract

5. In an action arising out of an alleged breach of a contract to operate concessions at an airport, plaintiff's cause of action for unjust enrichment was not barred to the extent that it was based on claims for services it allegedly provided defendant that fell outside of the parties' agreement, which was found not to have given rise to a valid claim for breach of contract. Inasmuch as the factual assertions in plaintiff's affidavit submitted in opposition to defendants' **[*3]** dismissal motion must be accepted as true and accorded the benefit of every possible inference, the allegations that certain services plaintiff rendered to defendants extended beyond the scope of their written agreement supported the cause of action for unjust enrichment since they fell outside the scope of the agreement.

Frauds, Statute of — Agreement to Pay for Services in Negotiating Contract

6. In an action arising out of the right to operate concessions at an airline's terminal at a major airport, the statute of frauds barred any unjust enrichment claim based on the assertion that plaintiff's chairman and sole stockholder acted as an intermediary between the airline and defendant management company during negotiations over defendant's right to operate the airline's concessions (*see* *General Obligations Law §5-701 [a] [10]*). Without a writing, an alleged agreement, promise or undertaking is unenforceable under the statute, which applies where the intermediary's activity is that of providing "know-who" in bringing about between principals an enterprise of some complexity. However, plaintiff's unjust enrichment claim did not fall entirely within the scope of the statute, as plaintiff also sought compensation for the advice rendered by its principal to defendant regarding financing, replacing two of its chief financial officers, and raising the quality of its concessions. Therefore, dismissal of plaintiff's unjust enrichment claim in its entirety on defendants' motion to dismiss was premature.

Counsel: **[***1]** *K&L Gates LLP*, New York City (*Michael R. Gordon* and *Brian D. Koosed* of counsel), for appellant.

Morrison & Foerster LLP, New York City (*David J.*

Fioccola, *Dennis P. Orr* and *Shiri Bilik Wolf* of counsel), for respondents.

Judges: David B. Saxe, J.P., John W. Sweeny, Jr., Dianne T. Renwick, Leland G. DeGrasse, Rosalyn H. Richter, JJ. Opinion by Saxe, J.P. All concur.

Opinion by: David B. Saxe

Opinion

[*4] **[**295]** Saxe, J.P.

[1] The central issue in this appeal from the dismissal of an action for breach of contract, unjust enrichment and a declaratory judgment is the scope of the parties' 2003 written agreement regarding the right to operate concessions within the JetBlue terminal at John F. Kennedy Airport (JFK). We are asked to determine whether the agreement's repeated use of the term "Terminal 6" unambiguously limited the scope of the contract exclusively to the operation of concessions at Terminal 6, or whether, as plaintiff contends, the parties intended for their rights and obligations under the agreement to endure **[***2]** after JetBlue relocated to another JFK terminal. Because contract terms that are unambiguous must be enforced as written (*W.W.W. Assoc. v Giancontieri, 77 NY2d 157, 162, 566 NE2d 639, 565 NYS2d 440 [1990]*), and not interpreted in some other way based on one party's assertion that "when [it] used the words, [it] intended something [other] than the usual meaning" (*Hotchkiss v National City Bank of N.Y., 200 F 287, 293 [SD NY 1911]*), we affirm the dismissal of the claim for breach of contract.

Plaintiff Ashwood Capital, Inc. is a merchant bank, founded in 1991; Ashwood's chairman and sole stockholder, Lawrence J. Twill, Sr., is an investment banker and a businessman with more than 40 years of experience. According to Ashwood, from 1998 to 2002, Twill personally worked with nonparty JetBlue Airways Corporation (JetBlue), then a fledgling airline, to help "develop its overall customer experience" and "facilitate JetBlue's entry into JFK in 2000." In late 2002, JetBlue Chief Executive Officer David Barger approached Twill to seek his assistance with attracting new, higher-quality restaurants and concessionnaires to JetBlue's facilities at JFK, then located in JFK Terminal 6.

According to the complaint, finding interested concessionaires **[***3]** proved challenging because the Port Authority of New York and New Jersey, which operated JFK, had announced its plans to renovate and reorganize all JFK terminals over the next decade. With JetBlue's lease for Terminal 6 set to expire in November 2006, and the airlines' plans to relocate to Terminal 5 shortly thereafter, any newly-created concessions at Terminal 6 would be short-term and therefore were considered unattractive as an investment.

[*5] Twill ultimately committed his own company, Ashwood, to opening new concessions at Terminal 6. In mid-2003, Ashwood alleges, it entered into a Concessionaire Agreement with JetBlue, whereby Ashwood secured the rights to open three restaurants in JetBlue's Terminal 6 facilities: a Papaya King franchise, a New York-themed sports bar and grill, and a Mexican restaurant. Ashwood, however, had little interest in the day-to-day operations and wished to acquire a business partner to assume these responsibilities. On the recommendation of JetBlue's vice-president of real estate, Twill contacted defendant Eric Blatstein, then president of defendant OTG Management, Inc. (OTG), [*] which had been operating JetBlue's concessions in **[****3]** Philadelphia. Blatstein was **[***4]** undeterred by JetBlue's planned relocation and was eager to gain a foothold into JetBlue's concessions at JFK.

On December 18, 2003, Ashwood and OTG entered into a written agreement, **[**296]** assigning to OTG Ashwood's rights under the Concessionaire Agreement with JetBlue, namely "the right to use, for the purposes set forth therein, certain premises located at JFK International Airport, Terminal 6." Ashwood additionally agreed to provide up to twenty hours of consulting services per year to OTG "concerning the prospects for procurement and operation of additional food or liquor concessions" at "Kennedy Airport (Terminal 6)." As consideration for these rights and services, OTG agreed to pay Ashwood 1.5% of all gross sales from OTG's

[*] "OTG" refers to defendants OTG Management, Inc.; OTG Consolidated Holdings, Inc.; OTG Management JFK, LLC, a New York limited liability company; OTG Management JFK, LLC, a Pennsylvania limited liability company; OTG Management JFK, Inc.; OTG JFK T5 Venture, LLC; and various John Doe Entities (collectively OTG or defendants). "Defendants" also includes defendant Eric Blatstein.

concessions "at Kennedy Airport, (Terminal 6)." The agreement is in the form of a letter, **[***5]** drafted by Ashwood, countersigned by Blatstein as president of OTG, and personally guaranteed by Blatstein as well.

Beginning in December 2003, OTG paid Ashwood 1.5% of gross sales from OTG's concessions at Terminal 6 on a monthly basis, as required under the agreement. In September 2008, however, JetBlue began operating out of its new facilities at JFK Terminal 5, having contracted with OTG to be the sole food concessionaire at the new terminal. After the closure of Terminal 6, in October 2008, OTG discontinued its monthly payments to Ashwood.

[*6] Ashwood commenced this action against OTG in November 2010, seeking money damages based on allegations that (1) OTG breached the parties' agreement by failing to pay 1.5% of gross sales since November 2008; (2) Blatstein breached his guaranty; and (3) OTG is liable under the quasi-contract theory of unjust enrichment by failing to compensate Ashwood for the consulting services it provided OTG. Ashwood additionally brought a cause of action for a declaratory judgment, seeking a judicial determination of the parties' respective rights and obligations under the agreement.

Defendants moved to dismiss these claims pursuant to CPLR 3211 (a) (1) and (7). **[***6]** In four separate orders, two entered on July 29, 2011 and two on August 1, 2011, Supreme Court granted defendants' motion to dismiss the complaint, observing that the agreement "unambiguously limits Ashwood's rights to a percentage of Defendants' gross sales at Terminal 6."

Ashwood appeals the dismissal of its claims and, pursuant to CPLR 3211 (d), requests discovery on the issue of the parties' intent.

Discussion

This case serves as a reminder that **HN1**[↑] in order to determine the contracting parties' intent, a court looks to the objective meaning of contractual language, not to the parties' individual subjective understanding of it. As Judge Learned Hand stated:

> **HN2**[↑] "A contract has, strictly speaking, nothing to do with the personal, or individual, intent of the parties. A contract is an obligation attached by the mere force of law to certain acts of the parties, usually words, which ordinarily accompany and represent a known intent. If, however, it were proved by twenty bishops that **[****4]** either party, when he used the words, intended something else than the usual meaning which the law imposes upon them, he would still be held, unless there were some mutual mistake, or something else of the sort. Of **[***7]** course, if it appear by other words, or acts, of the parties, that they attribute a peculiar meaning to such words as they use in the contract, that meaning will prevail, but only by virtue of the other words, and not because of their unexpressed intent" (Hotchkiss, 200 F at 293).

Ashwood contends that the motion court erroneously dismissed its breach of contract claim based on an overly literal **[*7]** and formalistic interpretation of the phrase **[**297]** "Terminal 6." According to Ashwood, the parties intended to establish a long-term business relationship, the principal goal of which was to grant Ashwood a meaningful and effective equity interest in OTG, and thereby bind the parties to the terms of their agreement well after JetBlue's relocation to Terminal 5. To accurately reflect the parties' intent, Ashwood argues, the phrase "Terminal 6" should be read to mean "any JetBlue terminal at JFK."

According to well-established rules of contract interpretation, **HN3**[↑] "when parties set down their agreement in a clear, complete document, their writing should as a rule be enforced according to its terms" (W.W.W. Assoc., 77 NY2d at 162). We apply this rule with even greater force in commercial contracts negotiated **[***8]** at arm's length by sophisticated, counseled businesspeople (*see* Vermont Teddy Bear Co. v 538 Madison Realty Co., 1 NY3d 470, 475, 807 NE2d 876, 775 NYS2d 765 [2004]; R/S Assoc. v New York Job Dev. Auth., 98 NY2d 29, 32, 771 NE2d 240, 744 NYS2d 358 [2002]; Riverside S. Planning Corp. v CRP/Extell Riverside, L.P., 60 AD3d 61, 67, 869 NYS2d 511 [2008], *affd* 13 NY3d 398, 920 NE2d 359, 892 NYS2d 303 [2009]). In such cases, " 'courts should be extremely reluctant to interpret an agreement as impliedly stating something which the parties have neglected to specifically include' " (Vermont Teddy Bear Co., 1 NY3d at 475, quoting Rowe v Great Atl. & Pac. Tea Co., 46 NY2d 62, 72, 385 NE2d 566, 412 NYS2d 827 [1978]). "[C]ourts 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" (Reiss v Financial Performance Corp., 97 NY2d 195, 199, 764 NE2d 958, 738 NYS2d 658 [2001] [internal quotation marks omitted]). We instead concern ourselves "with what the parties intended, but only to the extent that they evidenced what they intended by what they wrote"

(*Rodolitz v Neptune Paper Prods., 22 NY2d 383, 387, 239 NE2d 628, 292 NYS2d 878 [1968]* [internal quotation marks omitted]). Accordingly, before assessing evidence regarding what was in the parties' minds at the time of the **[***9]** agreement, we must first look to the agreement itself.

The primary question here is whether the parties' agreement is ambiguous; specifically, whether the phrase "Terminal 6" is "reasonably or fairly susceptible of different interpretations or may have two or more different meanings" (*New York City Off-Track Betting Corp. v Safe Factory Outlet, Inc., 28 AD3d 175, 177, 809 NYS2d 70 [2006]* [internal quotation marks omitted]). ***HN4***[↑] Whether a contractual term is ambiguous must be determined by the court as a matter of law, looking solely to the plain language used by the parties within the four corners of the contract to discern its **[*8]** meaning and not to extrinsic sources (*see Kass v Kass, 91 NY2d 554, 566, 696 NE2d 174, 673 NYS2d 350 [1998]*). Throughout the parties' agreement, the phrase "Terminal 6" is repeated a total of five times and consistently refers to JetBlue's facilities at JFK. In particular, the agreement specifies that OTG must pay **[****5]** Ashwood 1.5% "of all gross sales from concessions or food service businesses operated by OTG at Kennedy Airport, (Terminal 6)." The agreement neither mentions "Terminal 5," nor does it refer to any unspecified JetBlue terminal at JFK. We therefore agree with the IAS court that the phrase "Terminal **[***10]** 6" unambiguously limits the scope of the parties' agreement to concessions at JFK Terminal **[**298]** 6. The parties' use of the phrase "Terminal 6" is susceptible to no other interpretation.

Nor is the phrase rendered ambiguous, as Ashwood contends, by other language in the contract. Ashwood points to "future-oriented provisions" in the agreement to demonstrate an implicit long-term business relationship intended by the parties, which ostensibly would continue after JetBlue's relocation to Terminal 5. Although the agreement does give OTG the first option to acquire or operate Papaya King franchises outside of Terminal 6, OTG never exercised this option; indeed, Ashwood does not claim that it ever acquired the rights to operate Papaya King franchises either at Terminal 5 or anywhere besides Terminal 6. Ashwood's "mere assertion . . . that contract language means something other than what is clear when read in conjunction with the whole contract is not enough to create an ambiguity" (*New York City Off-Track Betting Corp., 28 AD3d at 177*). As there is no reasonable alternative meaning for the phrase "Terminal 6," we find no ambiguity either in the term itself or when it is read in the context of **[***11]** the agreement as a whole.

If these commercially sophisticated and counseled parties had intended their agreement to apply to any JetBlue terminal at JFK, they could easily have expressed this intent in the language of the agreement. Indeed, both Ashwood and OTG were aware of JetBlue's upcoming relocation, yet their agreement neither mentions "Terminal 5" nor refers to any unspecified JetBlue terminal at JFK. That the agreement does not address the contingency of JetBlue's move to Terminal 5 does not, by itself, create an ambiguity. The parties omitted this contingency from their agreement, and ***HN5***[↑] it is not for the court to "imply a term where the circumstances surrounding the formation of the contract indicate that the parties, when the contract was **[*9]** made, must have foreseen the contingency at issue and the agreement can be enforced according to its terms" (*Reiss, 97 NY2d at 199*).

Similarly absent from the agreement is any mention or implication that the parties intended to grant Ashwood an equity stake in OTG. With nothing in the written agreement to support Ashwood's contention that the parties intended for Ashwood to receive a permanent ownership interest in OTG, there is simply no basis **[***12]** for this Court to find an implicit long-term contractual relationship between the parties.

Furthermore, the agreement contains both ***HN6***[↑] a no-oral-modification clause and a broad merger clause, which as a matter of law bars any claim based on an alleged intent that the parties failed to express in writing (*see Cornhusker Farms v Hunts Point Coop. Mkt., 2 AD3d 201, 203-204, 769 NYS2d 228 [2003]*; *see also Torres v D'Alesso, 80 AD3d 46, 56-57, 910 NYS2d 1 [2010]*). The merger clause specifies that the agreement "constitute[s] the full and entire understanding and agreement among the Parties," and that "no Party shall be liable or bound to any other in any manner by any representations, warranties, covenants and agreements except as specifically set forth herein and therein." Accordingly, even if Ashwood, when drafting the agreement, had understood **[****6]** "Terminal 6" to be an implicit reference to any JetBlue terminal at JFK, the moment the written contract became fully executed by both parties, Ashwood could not rely on that understanding, as it was not included in the mutually executed written document. Moreover, in the years since entering into the agreement, Ashwood made no attempts to amend the terms of the contract **[**299]** pursuant **[***13]** to the no-oral-modification clause.

We therefore affirm Supreme Court's dismissal of Ashwood's claim for breach of contract.

[2] Nor is Ashwood entitled to discovery regarding the parties' intent pursuant to CPLR 3211 (d). Because the agreement is clear and complete on its face, "[a]ny such discovery would simply be an opportunity for plaintiff to uncover parol evidence to attempt to *create* an ambiguity in an otherwise clear and unambiguous agreement" (RM Realty Holdings Corp. v Moore, 64 AD3d 434, 437, 884 NYS2d 344 [2009]). Absent a finding of ambiguity in the agreement, discovery would be unnecessary, as any parol evidence would be inadmissible (*id.*).

[3] Ashwood's claim against Blatstein for breach of his guaranty falls with its breach of contract claim against OTG, since Blatstein's liability under the agreement "accrues only after **[*10]** default on the part of the principal obligor" (Madison Ave. Leasehold, LLC v Madison Bentley Assoc. LLC, 30 AD3d 1, 10, 811 NYS2d 47 [2006] [internal quotation marks omitted], *affd* 8 NY3d 59, 861 NE2d 69, 828 NYS2d 254 [2006]). Similarly, the declaratory judgment Ashwood seeks, that Ashwood is entitled to 1.5% of the gross sales from OTG's concessions in the JetBlue's Terminal 5 facilities going forward, falls with **[***14]** its breach of contract claim.

[4] As to Ashwood's cause of action for unjust enrichment, to the extent the claim is based on the consulting services it was required to provide under the agreement "from time to time as requested with OTG . . . for procurement and operation of additional food liquor concessions at [Terminal 6]," its claim is barred. HN7[] "Where the parties executed a valid and enforceable written contract governing a particular subject matter, recovery on a theory of unjust enrichment for events arising out of that subject matter is ordinarily precluded" (IDT Corp. v Morgan Stanley Dean Witter & Co., 12 NY3d 132, 142, 907 NE2d 268, 879 NYS2d 355 [2009]; *see also* Goldman v Metropolitan Life Ins. Co., 5 NY3d 561, 572, 841 NE2d 742, 807 NYS2d 583 [2005]). Only where the contract does not cover the dispute in issue may a plaintiff proceed upon a quasi-contract theory of unjust enrichment (*IIG Capital LLC v Archipelago, L.L.C., 36 AD3d 401, 405, 829 NYS2d 10 [2007]*).

[5] However, the unjust enrichment claim may arguably extend beyond a claim for services that were owed pursuant to the agreement. Since we have concluded that the parties' rights and obligations under the agreement are limited to activities at Terminal 6, Ashwood's claims relating to Terminal 5 **[***15]** may fall outside the scope of the agreement. HN8[] On a motion to dismiss we must read the complaint liberally, accept as true the facts alleged, and accord plaintiff the benefit of every possible inference (*see* 511 W. 232nd Owners Corp. v Jennifer Realty Co., 98 NY2d 144, 151-152, 773 NE2d 496, 746 NYS2d 131 [2002]). Further, we must consider the factual assertions of an affidavit submitted in opposition to the dismissal motion in order to preserve "inartfully pleaded, but potentially meritorious, claims" (Rovello v Orofino Realty Co., 40 NY2d 633, 635, 357 NE2d 970, 389 NYS2d 314 [1976]). Twill's affidavit elaborated on the consulting services that he, as Ashwood's principal, provided to OTG—namely, that he advised OTG to "(a) obtain financing, rather than have Mr. Blatstein continue to **[****7]** give away equity in the company in exchange for funding; (b) replace its first two Chief Financial Officers; and (c) raise the quality of its concessions in order to attract **[**300]** more—and more lucrative—customers." Twill also claims that he "regularly encouraged George Sauer, JetBlue's **[*11]** Vice-President of Real Estate, to give OTG more concession space and to grow OTG's business at both Terminal 5 and Terminal 6. I also devised the business strategy for OTG." As **[***16]** these services fall outside the scope of the agreement, the contract does not completely bar Ashwood's cause of action for unjust enrichment.

[6] However, the statute of frauds bars any unjust enrichment claim based on the assertion that Twill acted as an intermediary between JetBlue and OTG during negotiations over OTG's right to operate JetBlue's concessions at Terminal 5 (*see* General Obligations Law § 5-701 [a] [10]). HN9[] Without a writing, an alleged agreement, promise or undertaking is unenforceable under § 5-701 (a) (10), if it "[i]s a contract to pay compensation for services rendered in negotiating . . . a business opportunity . . . 'Negotiating' includes procuring an introduction to a party to the transaction or assisting in the negotiation or consummation of the transaction." The statute of frauds applies "where . . . the intermediary's activity is . . . that of providing . . . 'know-who', in bringing about between principals an enterprise of some complexity" (Snyder v Bronfman, 13 NY3d 504, 510, 921 NE2d 567, 893 NYS2d 800 [2009] [internal quotation marks omitted]).

Yet, Ashwood's unjust enrichment claim does not fall entirely within the scope of § 5-701 (a) (10), as Ashwood also seeks compensation for Twill's advice to **[***17]** OTG regarding financing, its chief executive officers, and raising the quality of its concessions.

Therefore, dismissal of Ashwood's unjust enrichment claim in its entirety at this juncture was premature.

We have considered plaintiff's remaining arguments and find them to be without merit.

Accordingly, the orders of the Supreme Court, New York County (Charles E. Ramos, J.), entered July 29, 2011 and August 1, 2011, which granted defendants' motion to dismiss the complaint pursuant to *CPLR 3211 (a) (1)* and *(7)*, should be modified, on the law, to deny the motion as to the cause of action for unjust enrichment to the extent plaintiff claims to have provided services beyond those mentioned in the parties' contract and those having to do with brokering or negotiating a deal between OTG and nonparty JetBlue for OTG's operation of JetBlue's concessions at Terminal 5, and otherwise affirmed, without costs.

Sweeny, Renwick, DeGrasse and Richter, JJ., concur.

[*12] Orders, Supreme Court, New York County, entered July 29, 2010 and August 1, 2010, modified, on the law, to deny the motion as to the cause of action for unjust enrichment to the extent plaintiff claims to have provided services beyond those mentioned in the parties' contract and **[***18]** those having to do with brokering or negotiating a deal between OTG and nonparty JetBlue for OTG's operation of JetBlue's concessions at Terminal 5, and otherwise affirmed, without costs.

End of Document

Baker v. Robert I. Lappin Charitable Found.

United States District Court for the Southern District of New York

February 22, 2006, Decided ; February 22, 2006, Filed

04 Civ. 426 (DC)

Reporter
415 F. Supp. 2d 473 *; 2006 U.S. Dist. LEXIS 7113 **

GIL BAKER, Plaintiff, - against - THE ROBERT I. LAPPIN CHARITABLE FOUNDATION and ROBERT I. LAPPIN, in his individual capacity and as a trustee of THE ROBERT I. LAPPIN CHARITABLE FOUNDATION, Defendants.

Core Terms

film, script, counterclaim, e-mail, funding, parties, terms, distributed, expenses, reasonable jury, defendants', suggestions, contends, hire, conversation, creative, summary judgment, Producer, contributions, documentary, authors, purported agreement, indefiniteness, purportedly, deposition, proposals, finance, website, breach of warranty, satisfaction

Case Summary

Procedural Posture
Plaintiff film producer sued defendants, a foundation and the foundation's trustee, alleging breach of contract, contending that he was entitled to damages of at least $ 500,000. The producer also asserted claims for unjust enrichment, quantum meruit, and copyright infringement. Defendants asserted counterclaims. Before the court were the parties' cross-motions for partial summary judgment.

Overview
The producer contended that the consideration for his agreement to produce a film for defendants was the trustee's promise to invest in an unrelated feature-length film that the producer was planning to make in the future. That funding was not provided. The principal issue presented was whether the purported agreement obligating the trustee to provide funding for the future film was sufficiently certain in its material terms as to be enforceable. The court determined that no reasonable jury could find that the parties reached a meeting of the minds on the essential elements of a financing agreement for the future film. Next, the court rejected defendants' argument--that the producer's quasi-contractual claims for additional compensation for work on the first film were barred because an express contract existed--as it was not clear what the agreement was. The claims for compensation against the trustee individually were dismissed because the producer was hired by the foundation. The copyright claim failed because a reasonable jury could only have found that the trustee and another person were joint authors. The court's opinion ended with a discussion of the producer's motion.

Outcome
The parties' cross-motions were granted in part and denied in part.

LexisNexis® Headnotes

Business & Corporate Compliance > ... > Contract

Formation > Offers > Definite Terms

HN1[] Offers, Definite Terms

Under New York law, contracts are unenforceable unless the parties reach a meeting of the minds on all material terms. As the New York State Court of Appeals has held: Few principles are better settled in the law of contracts than the requirement of definiteness. If an agreement is not reasonably certain in its material terms, there can be no legally enforceable contract.

Business & Corporate Compliance > ... > Contract Formation > Offers > Definite Terms

HN2[] Offers, Definite Terms

Courts are loath to refuse enforcement of agreements on indefiniteness grounds, but they will do so if the terms of the agreement are so vague and indefinite that there is no basis or standard for deciding whether the agreement had been kept or broken, or to fashion a remedy, and no means by which such terms may be made certain. Where essential terms are missing, a court may not rewrite a contract for the parties to impose obligations not bargained for, but the court must consider whether the missing terms can be supplied in a reasonable fashion consistent with the intent of the parties. Terms that may be essential include, for example: the price to be paid, the work to be done, and the time of performance.

Copyright Law > Scope of Copyright Protection > Ownership Interests > Joint Authors & Works

Copyright Law > Scope of Copyright Protection > Ownership Interests > Works Made for Hire

HN3[] Ownership Interests, Joint Authors & Works

If a work is prepared by an independent contractor on commission, no written instrument exists between the parties, and the commissioning party also materially contributed as an author to the creation of the work, he may be held to be a joint author together with the independent contractor.

Copyright Law > Scope of Copyright Protection > Ownership Interests > Joint Authors & Works

HN4[] Ownership Interests, Joint Authors & Works

Under the Copyright Act, a joint work is one prepared by two or more authors with the intention that their contributions be merged into inseparable or interdependent parts of a unitary whole. 17 U.S.C.S. § 101. Co-authors of a joint work are each entitled to distribute a joint work, for in a joint work each author automatically acquires an undivided ownership in the entire work. Each joint author has the right to license or otherwise use the work as he or she wishes, subject only to an obligation to account to the other joint authors for any profits.

Copyright Law > Scope of Copyright Protection > Ownership Interests > Joint Authors & Works

HN5[] Ownership Interests, Joint Authors & Works

To prove co-authorship status, a co-authorship claimant must show that each putative co-author to the work (1) made independently copyrightable contributions and (2) fully intended to be a co-author. The key is the intent of the parties at the time the work is done. There is no requirement that the several authors must necessarily work in physical propinquity, or in concert, nor that the respective contributions made by each joint author must be equal either in quantity or quality. Each author's contribution, however, must be more than de minimis. The contribution must be one of authorship, and merely contributing financing does not suffice.

Counsel: [1]** THE SHAPIRO FIRM, LLP, Attorneys for Plaintiff, By: Robert J. Shapiro, Esq., Natalia Porcelli Good, Esq., New York, NY.

BINGHAM McCUTCHEN LLP, Attorneys for Defendants, By: Kenneth I. Schacter, Esq., Philip L. Blum, Esq., New York, NY.

Judges: DENNY CHIN, United States District Judge.

Opinion by: DENNY CHIN

Opinion

[*475] CHIN, D.J.

In 2001, defendants Robert I. Lappin and The Robert I. Lappin Charitable Foundation (the "Foundation") hired plaintiff Gil Baker to write and produce an educational film entitled *Great Jewish Achievers* ("*GJA*"). *GJA* highlighted the accomplishments of notable Jewish figures, and when it was completed in November 2002, the Foundation distributed it free of charge to more than 2,000 educational and **[*476]** religious institutions throughout the United States.

In this case, Baker contends that he agreed to produce *GJA* -- purportedly on financial terms favorable to defendants -- in return for Lappin's promise to fund an unrelated feature-length film, *Bungalow 6,* that Baker was planning to make in the future. In other words, Baker contends that the consideration for his agreement to produce *GJA* was Lappin's promise to invest in *Bungalow 6.* Lappin **[**2]** has not provided that funding, and Baker has sued defendants for breach of contract, contending that he is entitled to damages of at least $ 500,000. Baker also asserts claims for unjust enrichment, quantum meruit, and copyright infringement.

Before the Court are the parties' cross-motions for partial summary judgment. The principal issue presented is whether, even under Baker's version of the facts, the purported agreement obligating Lappin to provide funding for *Bungalow 6* was sufficiently certain in its material terms as to be enforceable. Other issues include whether Baker's quasi-contractual claims are barred because an express contract governs; whether the claims against Lappin in his individual capacity fail because the Foundation, and not Lappin, hired Baker; and whether Baker's copyright infringement claim is precluded because Baker was not the sole author of *GJA* and the Foundation was, at a minimum, a co-author.

For the reasons that follow, both motions are granted in part and denied in part.

STATEMENT OF THE CASE

A. *The Facts*

Construed in the light most favorable to Baker, the facts are as follows:

1. *The Parties*

Baker, a **[**3]** resident of New York, is a filmmaker whose work has been broadcast on networks throughout the world. (Compl. P6).

The Foundation is a charitable not-for-profit organization with its principal place of business in Massachusetts. (Lappin 6/9/05 Decl. P2). It exists "to serve the interests of the Jewish community" and seeks to provide, among other things, support for Jewish educational programs. (*Id.*). Lappin, a resident of Massachusetts, is a trustee and the sole benefactor of the Foundation. (*Id.* P1; Answer P8).

2. *GJA*

In or before 1999, Lappin conceived the idea of producing a film about great Jewish achievers to be distributed free to Jewish organizations to enhance Jewish pride in young people. The film was to be produced and distributed with funding provided by the Foundation. (Lappin 6/9/05 Decl. PP3, 4).

In early 2001, the Foundation began exploring options for producing *GJA.* (*Id.* P6). In November 2000, Lappin attempted to interest a prominent film director and producer in the project, advising that he was prepared to spend "up to one million dollars" on the film. (Good 7/8/05 Aff. Ex. D). In April 2001, the Foundation developed a specification sheet **[**4]** and statement of explanation that it distributed to solicit proposals. (Lappin 6/9/05 Decl. P7). Defendants apparently eventually received two proposals from filmmakers; one quoted a price of more than $ 700,000 and the other a price of more than $ 1 million. (Baker Dep. 13-14).

3. *Baker Works on GJA*

Baker and Lappin had known each other for many years, as Baker was close friends **[*477]** with Lappin's son, Peter. (Baker Dep. 14; P. Lappin Dep. 13). Lappin had asked Peter to look at the two proposals. (P. Lappin Dep. 17, 20-21). Peter forwarded them to Baker to get

his "objective professional opinion" on "whether these were legitimate proposals or whether they were blown-up figures, exorbitant prices." (Baker Dep. 14; *see* P. Lappin Dep. 17-21).

Baker reviewed the proposals and eventually he and Lappin spoke about the project. (Baker 7/8/05 Aff. P4). Baker told Lappin that the two proposals were asking for "a lot of money." (Baker Dep. 18). Baker then provided some initial assistance, making some creative suggestions by drafting ten sample pages of a script and creating a name montage for the film, for which he received $ 2,500. (Baker 7/8/05 Aff. P4).

On April 30, 2001, Lappin **[**5]** sent Baker an e-mail, on behalf of the Foundation, inviting him to respond to the Foundation's solicitation for proposals for a script for *GJA.* The e-mail included a description of and specifications for the proposed documentary. The format was to be four fifteen-minute segments. (Schacter 7/11/05 Decl. Ex. E). Although the e-mail was from Lappin, it was clearly on behalf of the Foundation and the project clearly was intended to be a Foundation project. (*Id.*).

Baker responded by e-mail on May 7, 2001. He stated that although he was busy working on another film,

> I may have the time to write at least [] one or two of the segments you need. My fee for research, writing and a re-write, wouldn't exceed $ 2,500 per fifteen minute script. A writer who wanted much more than that, might be asking too much.

(*Id.* Ex. F).

Baker began working on *GJA* in the spring of 2001. (Baker 6/9/05 Aff. P6). On June 22, 2001, Baker sent Lappin an e-mail with a proposed budget for making *GJA.* The budget was for $ 70,000, covering four scripts, hosts and studio, interviews, archival footage, and $ 15,000 for "contingency." (Schachter 6/9/05 Decl. Ex. D). The proposal noted **[**6]** that "the actual budget could be CONSIDERABLY LESS." (*Id.*).

Over the course of the next twelve months, as he worked on the project, Baker sent Lappin numerous revised budgets, ranging from $ 120,000 to a high of $ 155,500. (*Id.* Exs. E-J). The increase was due, at least in part, to an increase in the number of segments from four to five. (Baker 7/8/05 Aff. P7). The budgets included amounts for items such as research, scripting, archival research, editing, and contingency. (*See, e.g.,* Schacter 6/9/05 Decl. Exs. E, G, I). The earlier budgets noted a "-" or "N/C" -- meaning no charge -- for items such as "Directorial Fees" and "Production Design." (*Id.* Exs. E, F, G). Near the conclusion of the project, Baker sent the Foundation an "accounting of production expenses," covering the period from September 2001 through June 2002. It showed "total production expenses" of $ 155,500, payment of the same amount, and a balance of zero. (*Id.* Ex. K). It included items such as research and scripting ($ 30,500), editorial and production services ($ 40,500), and film archive and photo research ($ 25,000). (*Id.*).

Although Baker now contends that he "waived all of his creative **[**7]** fees" and was paid only for out-of-pocket expenses (Pl. Opp. Mem. at 5), the documentary evidence shows otherwise. In a fax dated April 15, 2002, Baker acknowledged having been paid for at least some of his "time," as he wrote: "I've seen less than $ 9,000 for my time to date . . . ." (Schacter 6/9/05 Decl. Ex. O). Moreover, he undoubtedly **[*478]** received some portion of the $ 30,500 paid for "research and scripting." (*Id.* Ex. K). In addition, Baker's check register shows that he used monies received from the Foundation for *GJA* to pay for personal bills, including: his mortgage ($ 4,876), his co-op maintenance fees ($ 7,251), home telephone and internet service ($ 3,396) and home utilities ($ 800). (Lappin 6/9/05 Decl. PP23-24 & Ex. A; Schacter 6/9/05 Decl. Ex. M). [1]

[8] 4. *The Completion of GJA***

GJA was completed in November 2002, and it was distributed free of charge, at the Foundation's expense, to some 2,000 Jewish religious and educational organizations. (Lappin 6/9/05 Decl. PP4, 5). Baker assisted in the distribution effort by making

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[1] Baker concedes that these mortgage and maintenance payments were for his Manhattan apartment, but contends that he was living in Queens and kept the Manhattan apartment "in part because I needed office space to complete [*GJA*]." (Baker 7/8/05 Aff. P30). Similarly, he contends that his "cell phone, long distance and Internet bills" were properly *GJA* expenses because he had to communicate with his staff and with the Foundation in Boston regarding GJA's progress and he did "extensive research" for *GJA* through his "internet connection." (*Id.* P31). A reasonable jury could only be troubled by these assertions. Baker does not and cannot contend that the Manhattan apartment and his cell phone, land phone, and Internet service were used *solely* for *GJA,* and it is difficult to understand how he could justify charging the entirety of these expenses to *GJA.* Moreover, the commingling of *GJA* expenses with personal expenses and of *GJA* funds with funds received from other sources, as shown by the check register, is questionable.

arrangements with third-party vendors for duplication bulk mailing of the film. (Baker Dep. 274; Lappin 7/8/05 Decl. PP9-11). Unfortunately, after *GJA* was distributed, the Foundation learned that two of the individuals included in *GJA* were not Jewish and were included by mistake. (Baker 6/9/05 Aff. PP18-21).

Baker's name does not appear in the credits or anywhere else in the DVD of *GJA* provided to the Court. (CX 1). [2] He is not identified as a writer or a director or at all. (*Id.* at 55:33-56:08; Baker Dep. 225). The closing credits start by stating that the film was "made possible by the Robert I. Lappin Charitable Foundation." (CX 1 at 55:33). They list Lappin as the Executive Producer and Coltin as the Associate Producer. (*Id.* at 55:40, 55:47). The credits end with the legend: "This tape may not be broadcast without written consent from the Robert I. Lappin Charitable Foundation. **[**9]** " (*Id.* at 56:05). No copyright notice is provided on the DVD, either on the label or in the film. (CX 1). Nor does Baker's name appear in the teaching guide that accompanies *GJA.* (Baker Dep. 228). In the end, Baker did not want his name associated with *GJA* and he was "happy to let Bob take credit for it." (*Id.*). When *GJA* was distributed, a cover letter on Foundation letterhead identified the Foundation as the film's source. (Lappin 7/8/05 Decl. P10).

At the Foundation's request, Baker also created a website, gjainfo.com, as a supplement to *GJA.* The website became operational as of November 1, 2002 and continues to operate today. (Baker 6/9/05 Aff. P10). Baker also created, at the Foundation's request, a five-minute promotional video and a three-dimensional "Nobel Montage" to be used in conjunction with *GJA*.(*Id.* P9; Baker 7/8/05 Aff. P10). Baker also helped with a teaching guide that was to accompany the film, which Lappin and Coltin **[**10]** wrote. (Baker 7/8/05 Aff. P10; *see also* Lappin 6/9/05 Decl. P21).

[*479] 5. *Lappin's Purported Agreement To Fund Bungalow 6*

Baker contends that Lappin agreed, in return for Baker's work on *GJA,* to fund *Bungalow 6.* Although Baker and Lappin exchanged e-mails and other documents, Baker acknowledges that no documents make any reference to *Bungalow 6* or any agreement by Lappin to provide Baker with funding for *Bungalow 6.* (Baker Dep. 48; *see* Lappin 6/9/05 Decl. P13). Baker "never once" put in writing, in an e-mail or otherwise, anything about the alleged agreement with Lappin. (Baker Dep. 48-49). Indeed, Baker conceded at his deposition that "there is no writing and [there] has never been any writing which embodies the essential terms" of Lappin's purported agreement to finance *Bungalow 6. (Id.* 49).

Baker contends that Lappin made a binding agreement to invest at least $ 500,000 in *Bungalow 6* based on a conversation the two had on September 9, 2001. (Baker 7/8/05 Aff. P5; Baker Dep. 12). At his deposition Baker described the conversation as follows:

> . . . This was his dream, [Lappin] said, for over 20 years, to make a documentary about great **[**11]** Jewish achievers.
> So I said to him, Bob, I'll make your dream come true if you'll make my dream come true.
> He said, What's your dream?
> And I said, A little independent feature called Bungalow 6.
> He said, What's that going to cost to make?
> And I said, Approximately $ 500,000. And I may have just said $ 500,000.
> And Bob nodded. He said, Who wrote the script?
> I said, I did. I said, You want to see it?
> He said, I wouldn't know a good script from a bad script. That was Bob talking.
> And I said, You're welcome to a copy of the script. I can send it to you.
> And he said, I don't really think I need to see it.
> . . .
>
> And he nodded his head and he was thinking this over. And he said, If you can bring in -- his response to me was, If you can bring in [*GJA*] to my satisfaction for the $ 150,000 in out-of-pocket expenses, you can make your movie.
> And I -- that knocked a little breath out of my lungs. I said, Wow. I knew that Bob could back up -- or I believed that Bob could back up what he was saying.
>
> And so because of that, I said -- and what was the next thing that he said? He said that. And I might have said, Are you sure you don't want to see the script? Or something like **[**12]** that, because now this is moving ahead.
> And he said, No. And that was -- that was pretty much it.
> . . .
> And the last thing that was -- that I said to Bob was -- because -- so it might have been something like, So we have a deal? Or, We have an arrangement?

[2] The DVD has been marked Court Exhibit ("CX") 1.

> And he might have said, So we have an arrangement? Or, We have an agreement?
> And I said, We do. And I remember that we shook hands. We stood up. . . .
> And I said, so -- when he said, You'll be able to make your movie, I said, Have I got your word on that, Bob?
>
> **[*480]** And he said, You do.

(*Id.* 24-25, 28-29). [3]

[13]** Baker acknowledges that he and Lapin never discussed, and thus never agreed on, the following terms:

> . Whether the investment was to be in the form of equity, a loan, or something else (*id.* 32);
>
> . Whether the $ 500,000 would be provided by Lappin in a lump sum or over time or when it would be paid, e.g., at the beginning or the end of the project or throughout (*id.* 54);
>
> . The terms under which Lappin would be repaid (*id.* 42);
>
> . Whether and how Lappin would share in any profits from *Bungalow 6 (id.* 45);
>
> . Whether any share of profits would be of net profits or gross profits (*id.* 46);
>
> . Who would be in control of *Bungalow 6 (id.* 42-43);
>
> . Who would own the copyrights to *Bungalow 6 (id.* 45); and
>
> . Whether Lappin would have approval rights over casting, content, dailies, and the like (*id.* 46).

In describing a conversation he had with Deborah Coltin, the Executive Director of the Foundation, during which she asked him about his plans after he completed *GJA,* Baker testified: "And I said, Well, I think Bob and I are going to be *possibly* making an actual -- an actual movie together . . . ." (Baker Dep. **[**14]** 50-51) (emphasis added).

6. ***The Foundation's Involvement in the Production of GJA***

A reasonable jury could only find that Lappin and Coltin provided substantial creative input into *GJA.* The "idea" and the "concept" of *GJA* was Lappin's -- "it was Bob's brainchild," as Baker acknowledged at his deposition. (Baker Dep. 195). Baker agrees that Lappin and Coltin "made a lot of changes" to the script. (*Id.* 199). They suggested individuals to include in the film and they made suggestions such as shortening or lengthening segments or eliminating music. They also commented on the script along the way. (*Id.* 201-02). Baker incorporated their suggestions. (*Id.* 202). Lappin and Coltin both played a role in writing parts of the script, including the parts dealing with "Israel and Jewish survival and the Torah." (Lappin Dep. 127; *see also* Coltin Dep. 63, 95-99, 102-04). As alleged in the complaint, Lappin and Coltin requested thirty-four text revisions to video-taped dialogue and recorded narration, which required "considerable alterations to the documentary." (Compl. P24).

The documentary evidence shows that Lappin and Coltin provided extensive creative input. **[**15]** (*See, e.g.,* Schacter 7/11/05 Decl. Exs. D (Baker e-mail responding to specific suggestions and comments by Lappin and Coltin), H (dozens of e-mails, letters, and notes showing extensive input from Lappin and Coltin), I (e-mail from Lappin making suggestions), J (long e-mail from Lappin with numerous suggestions and comments), L (Baker tells Lappin in e-mail: "You would have made a phenomenal studio boss . . . or producer. The points you made were on mark."), N (several **[*481]** long e-mails from Lappin to Baker with numerous detailed suggestions and comments); Schacter 6/9/05 Decl. Ex. Q (long letter from Baker responding to specific comments and questions of Lappin). For example, in an e-mail sent by Lappin to Baker on August 31, 2001, Lappin provided feedback on a draft of the script:

> Generally, I feel you are on the right track, but I have a strong feeling that the tone is not sufficiently sophisticated for ten to fourteen year olds. . . . Perhaps we are doing what we said we should not do -- talking down to the youngsters.

(*Id.* Ex. H at 01056). Baker's response, dated September 1, 2001, shows his reaction to Lappin's

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[3] Lappin denies that he or the Foundation ever agreed to finance *Bungalow 6* and denies that the subject was ever discussed until the dispute that led to this lawsuit arose. (Lappin 6/9/05 Decl. P14). Baker testified to other conversations he purportedly had with Lappin, after the initial conversation on September 9, 2001, about funding for *Bungalow 6. (See, e.g.,* Baker Dep. 39-41). For purposes of these motions, I assume the conversations occurred as Baker describes them.

suggestions:

> as usual, your perceptions **[**16]** are on target . . . the youngest is too young . . . it won't take long to smarten up this first draft . . . as we had discussed, each show can end with a teaser on the next.

(*Id.* Ex. H at 01077).

Another long e-mail from Lappin to Baker shows that Lappin and Coltin contributed not just general ideas but specific suggestions for the expression of ideas:

> Gil,
> Debbie and I have gone over the script carefully, and here are out thoughts:
> 1) Rather than starting with an intellectual discussion, that falls short of being exciting, consider opening with actual film clips of some of our great Jewish achievers. Possibly include Mark Twain. Then have someone ask the group if they know what all these people have in common. Answer: all Jewish, except one. Then go from there with Mark Twain as on pages 11 & 12 of the script.
> . . .
> 3) When you get in the script to the smallness of our numbers, you might help make the point visually by illustrating that there are approximately 1000 people in the world to every two Jews. . . .
> 4) Similarly on Israel, show a world map, highlighting tiny Israel with bright color, so its tinyness stands out.
>
> 5) Assuming **[**17]** you like 1) above, pages 1 & 2 as written would be out. . . . On page 3, The Girl -- "he's cuter than all . . . together." We feel this stereotypes and trivializes girls. The boys talk numbers and facts. All girls care about is how cute boys are.
> . . .
> 13) We suggest opening the second Episode with Adam Sandler's Hanukah Song. You could then pick out the great Jewish achievers, he mentions.
> 14) Generally, and I repeat your own mantra, that we must avoid talking down. We fear much of the script falls into this trap, and will be considered "lame" by youngsters.

(*Id.* Ex. H at 01098-99).

Baker testified at his deposition in this respect as follows:

> Q. So would it be fair to say that this film is the product of your work and Bob and Debbie's work together?
>
> A. Well, you could say it that way. And the person could walk away thinking Gil did half and Bob and Debbie did half or Gil did a third, Bob did a third, and Debbie did a third. That would be I think a misrepresentation.
>
> Q. I'm not asking for quantities now. . . . But without getting into quantities, would it be fair to say that the work, this film, was the product of joint work by yourself and Bob and **[**18]** Debbie together in some quantity?
>
> **[*482]** A. Yeah, that you could say.

(Baker Dep. 202-03).

Although Baker and Lappin never discussed ownership of the copyright to *GJA,* he understood that the "owner of the rights to the film" was "probably Bob" or "Bob's foundation." (*Id.* 230).

7. *The Thanksgiving Day Dispute*

On Thanksgiving Day 2002, at a family gathering at Peter Lappin's home in Massachusetts, Baker and Lappin had a discussion about *Bungalow 6.* The two differ in their descriptions of the conversation, but they agree that Lappin declined to provide any funding for *Bungalow 6.* (Baker 7/8/05 Aff. P23; Lappin 6/9/05 Decl. PP17-18). [4] The two also agree that Lappin suggested that the Foundation was prepared to make additional payments to Baker, although Baker describes this as an offer by Lappin to pay "'bills' for the work I had done and any additional expenses related to GJA" (Baker 7/8/05 Aff. P24), while Lappin states that he agreed only that the Foundation would "compensate [Baker] fairly" for "any extra work on non-film matters" performed at the Foundation's request (Lappin 6/9/05 Decl. 19).

[19]** Baker sent Lappin seven bills in late December 2002, totaling more than $ 80,000. (Schacter 6/9/05 Decl. Ex. B). They covered services such as compiling, verifying, and editing the Foundation's mailing list and preparing a "duplication master" of *GJA,* as well as services in connection with a *GJA* trailer, documentary guide, and website. (*Id.*). After receiving these bills the Foundation paid Baker only an additional $ 22,000. (Baker 7/8/05 Aff. PP26-27; *see* Schacter 6/9/05 Decl.

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[4] Baker contends that Lappin "reneged" on his prior agreement to finance *Bungalow 6,* while Lappin contends that Baker made an "overture" for funding for *Bungalow 6,* to which Lappin purportedly responded that neither he nor the Foundation had any interest in funding a commercial movie. (Baker 7/8/05 Aff. P23; Lappin 6/9/05 Decl. PP17-18).

Ex. C (Lappin letter to Baker complaining of "shockingly and shamelessly inflated" bills)). Although the invoices were sent to Lappin, they were all addressed to the Foundation and not to Lappin personally. (Schacter 6/9/05 Decl. Ex. B). By the end, with the additional payments, the Foundation had paid Baker a total of some $ 177,500. (Baker 7/8/05 Aff. P26; Lappin 6/9/05 Decl. P16).

B. *Prior Proceedings*

This suit was commenced on January 20, 2004. The Court has subject matter jurisdiction over the action because of the diversity of citizenship of the parties and the existence of a claim under the Copyright Act of 1976. (Compl. P9 (citing *28 U.S.C. §§ 1332* **[**20]** and *1338*)).

The complaint asserts eight causes of action: (1) breach of contract for Lappin's failure to honor his purported contractual obligation to fund *Bungalow 6* (Compl. PP34-35); (2) unjust enrichment as defendants purportedly received Baker's services in creating and producing *GJA* "without fully paying for the same" (*id.* PP37-38); (3) in the alternative, quantum meruit for the reasonable value of Baker's time and services making *GJA* (*id.* P41); (4) breach of contract for Lappin's failure to honor his obligations under a purported marketing and distribution agreement (*id.* PP43-44); (5) unjust enrichment as defendants purportedly received benefits from Baker's work with respect to the website, teaching guide, marketing materials, etc., for which they have not paid Baker (*id.* PP46-48); (6) in the alternative, quantum meruit for the reasonable value of Baker's work with respect **[*483]** to the latter (*id.* P50); (7) copyright infringement (for which declaratory relief is sought) (*id.* P52); and (8) conversion as defendants purportedly converted the *GJA* materials and teaching guides that are the property of Baker (*id.* P54).

Defendants filed an answer **[**21]** denying the principal allegations of the complaint and asserting counterclaims for (1) breach of warranty because two non-Jewish individuals were mistakenly included in *GJA* (Answer Countercls. PP41-45); (2) declaratory relief with respect to the ownership to the copyrights (*id.* PP47-54); and (3) replevin for the return of the "master" copy of *GJA*(*id.* PP56-60).

The parties engaged in discovery and these motions followed. Defendants seek partial summary judgment on the grounds that: (1) the breach of contract claim for funding for *Bungalow 6* fails as a matter of law because the agreement is not sufficiently definite and certain to be enforceable; (2) the breach of contract claim for funding for *Bungalow 6* is barred by the statute of frauds; (3) the quasi-contractual claims relating to the production of *GJA* fail because the parties' rights are governed by an express contract; (4) the claims against Lappin for compensation for additional work fail because any agreement concerning any such additional work was with the Foundation and not Lappin individually; and (5) the copyright claim fails as a matter of law because *GJA* was a "joint work" of Baker and the **[**22]** Foundation. Baker moves for partial summary judgment in his favor on his copyright claim and dismissing defendants' counterclaims.

DISCUSSION

I address defendants' motion first and Baker's motion second.

A. *Defendant's Motion*

I address each prong of defendants' summary judgment motion, with the exception that I do not reach the statute of frauds issue.

1. *Indefiniteness*

The first issue presented by defendants' motion is whether Lappin's purported agreement to provide funding for *Bungalow 6* is barred by the doctrine of indefiniteness.

a. *Applicable Law*

HN1[↑] Under New York law, [5] contracts are unenforceable unless the parties reach a meeting of the minds on all material terms. *See* *Shann v. Dunk, 84 F.3d 73, 78 (2d Cir. 1996)* (under New York law, "contracts are unenforceable unless they cover all essential terms"). As the New York State Court of Appeals has held:

> Few principles are better settled in the law of contracts than the requirement of definiteness. If an agreement is not reasonably certain in its material terms, there can be no legally enforceable contract.

Cobble Hill Nursing Home, Inc. v. Henry & Warren

[5] Both sides apply New York law. (*See* Def. Supp. Mem. at 9-10; Pl. Opp. Mem. at 10). Moreover, here there clearly is a significant connection to New York, as Baker performed much if not most of his work on *GJA* in New York. (*See* Baker 7/8/05 Aff. P30).

Corp., 74 N.Y.2d 475, 482, 548 N.E.2d 203, 548 N.Y.S.2d 920 (1989). **[**23]**

HN2[] Courts are "loath to refuse enforcement of agreements on indefiniteness grounds," Best Brands Beverage v. Falstaff Brewing Corp., 842 F.2d 578, 588 (2d Cir. 1987) (citation omitted), but they will do so "'if the terms of the agreement are so vague and indefinite that there is no basis or standard for deciding whether the agreement had been kept or broken, or to **[*484]** fashion a remedy, and no means by which such terms may be made certain.,'" *id.* (quoting Candid Prods., Inc. v. Int'l Skating Union, 530 F. Supp. 1330, 1333-34 (S.D.N.Y. 1982)). Where essential terms are missing, a court may not rewrite a contract for the parties to impose obligations not bargained for, but the court must consider whether the missing terms **[**24]** can be supplied in a reasonable fashion consistent with the intent of the parties. B. Lewis Prods., Inc. v. Angelou, No. 01 Civ. 0530 (MBM), 2005 U.S. Dist. LEXIS 9032, at *14-15 (S.D.N.Y. May 12, 2005). Terms that may be essential include, for example: "the price to be paid, the work to be done, and the time of performance." Id. at *17.

b. *Application*

On the record before the Court, even accepting as true Baker's version of his conversations with Lappin, no reasonable jury could find that the parties reached a meeting of the minds on the essential elements of a financing agreement for *Bungalow 6.* As Baker conceded at his deposition, there was no discussion, much less any agreement, on critical items such as the nature of the investment (whether loan or equity or otherwise); the time of performance (when Lappin was to provide the $ 500,000); the manner of performance (whether the funds would be paid in a lump sum or installments); the terms of repayment (if the monies were to be repaid at all); whether interest would be paid and if so at what rate; whether Lappin would share in profits and if so in what manner and to what extent; whether and to **[**25]** what extent Lappin would have any control over content, casting, or other creative issues; and who would own the copyrights.

These are matters that "seriously affect[] the rights and obligations of the parties." Ginsberg Mach. Co. v. J&H Label Processing Corp., 341 F.2d 825, 828 (2d Cir. 1965). The absence of any agreement or discussion of these critical matters is fatal to Baker's assertion that the parties intended to be bound, and makes it impossible for any court or jury to fashion "a proper remedy." Cobble Hill Nursing Home, 74 N.Y.2d at 482. Nor are there any reasonable means for filling in the missing terms; the intent of the parties simply cannot be ascertained. Hence, because of its indefiniteness, the purported agreement is unenforceable.

In this respect, Baker relies heavily on the testimony of Stephen Mortell, who testified that Baker told him that Lappin had agreed to finance *Bungalow 6.* (Mortell Dep. 62). This reliance is misplaced. First, what Baker told Mortell is clearly hearsay; Mortell was simply repeating what he heard from Baker. To the extent Baker was describing to Mortell what Lappin purportedly said to Baker, the description **[**26]** is still hearsay. Second, even if it is admissible, Mortell's testimony does not help Baker, for the purported agreement is still fatally indefinite.

Accordingly, defendants' motion for summary judgment is granted to the extent that Baker's claim that Lappin is contractually bound to finance *Bungalow 6* is dismissed. [6]

2. *The Contract as a Bar*

Defendants argue that Baker's quasi-contractual claims for additional compensation for work on *GJA* are barred **[*485]** because an express contract exists between the parties, citing cases that hold that where a valid, express agreement governs the relationship between the parties, no implied contractual claims are viable. (Def. Supp. Mem. at 11-12 (citing, *e.g.*, Data-Stream AS/RS Techs., LLC v. China Int'l Marine Containers, Ltd., No. 02 Civ. 6530 (JFK), 2004 U.S. Dist. LEXIS 6594, at *20-21 (S.D.N.Y. **[**27]** Apr. 13, 2004), and Leber Assocs., LLC v. Entm't Group Fund, Inc., No. 00 Civ. 3759 (LTS), 2003 U.S. Dist. LEXIS 13009, at *62 (S.D.N.Y. July 29, 2003)).

The argument is rejected. While I have no quarrel with the legal proposition, it does not apply here. First, I have held that there was no enforceable agreement by Lappin to provide funding for *Bungalow 6.* Hence, there is no valid, express agreement in this respect. Second, although there is a valid agreement between the parties to the extent that Baker agreed to provide services to the Foundation and the Foundation agreed to accept and pay for those services, it is not clear what the agreement was. Factual issues exist as to the terms of

[6] In light of my ruling on the issue of the indefiniteness of the purported agreement, I do not reach defendants' statute of frauds argument.

the parties' agreement -- if they agreed at all -- on the compensation to be paid to Baker for his creative services.

Baker contends that he essentially agreed to work on an expenses-only basis in return for Lappin's promise to fund *Bungalow 6.* There is some evidence in the record to support that contention. Although I conclude that Lappin's promise (even assuming it was made) was unenforceable, a reasonable factfinder could conclude that Baker was entitled to be paid something **[**28]** to reasonably compensate him for his creative services. In other words, a reasonable jury could conclude that under all the circumstances, in the absence of a clear, express, enforceable agreement as to his compensation, Baker is entitled to be paid on a quantum meruit basis.

Defendants argue that Baker was paid for his creative services, and it is true that the record contains evidence to show, for example, that Baker was paid something "less than $ 9,000" for his time as of April 15, 2002, and that Foundation funds were applied to seemingly personal expenses such as the mortgage and co-op maintenance fees on Baker's Manhattan apartment. Genuine issues of fact exist, however, as to what he was paid and whether he received fair value for his services. Even though Baker is not entitled to be paid damages for the failure of Lappin to provide funding for *Bungalow 6,* he arguably would be entitled to additional compensation from the Foundation for the fair value of his services if indeed he waived his fees with the expectation that he would receive that funding. At trial, defendants are free to argue that Lappin never made a promise, enforceable or otherwise, to provide funding for **[**29]** *Bungalow 6;* even assuming such a promise was made, it was wholly unconnected to *GJA;* Baker was paid all that he was entitled to be paid; and he was paid the reasonable value of his services in any event. These are issues for the jury to decide.

Accordingly, this prong of defendants' summary judgment motion is denied.

3. *The Claims Against Lappin*

Defendants next argue that Baker's claims for compensation for the additional work he did with respect to marketing and distribution, the teaching guide for *GJA,* and the website must be dismissed as to Lappin individually, for Baker was hired by and the work was done for the Foundation. I agree.

On the record before the Court, a reasonable jury could only find that Baker **[*486]** was hired to provide services to the Foundation and that Lappin was acting merely as a representative of the Foundation. Baker was in privity not with Lappin but with the Foundation.

The initial April 30, 2001, e-mail soliciting Baker's involvement was sent on behalf of the Foundation, and it clearly contemplated that the work was to be done for the Foundation and not for Lappin individually. (Schacter 7/11/05 Decl. Ex. E). The seven bills sent by **[**30]** Baker in December 2002 for the additional work were all addressed to the Foundation. (Schacter 6/9/05 Decl. Ex. B). Baker was seeking payment from the Foundation. From the outset, the concept was that this was a documentary to be funded and distributed by the Foundation to further its goals and mission. The additional work for which Baker seeks compensation was performed for the Foundation to assist it in its efforts to market and distribute *GJA.*

Although Lappin negotiated the arrangement with Baker, a reasonable jury could only find that he was acting not in his individual capacity but in his representative capacity on behalf of the Foundation.

Baker argues that Lappin was the trustee and sole benefactor of the Foundation and that the Foundation bears Lappin's name. (Pl. Opp. Mem. at 19-20). While these assertions are correct, they do not change the indisputable fact that Baker was engaged by the Foundation to provide services on behalf of the Foundation. Baker's conclusory assertion that the work was performed for Lappin as an individual and not for the Foundation is simply belied by the documentary invoices, including seven invoices prepared by Baker himself seeking payment **[**31]** not from Lappin but from the Foundation.

Moreover, to the extent Baker seems to be proceeding on an "alter ego" theory, the claim is rejected. First, the complaint does not assert an "alter ego" or "veil-piercing" claim. Hence, no such claim is in the case. Second, the complaint alleges only that the Foundation is a charitable organization with its principal place of business in Massachusetts. It does not specify whether the Foundation is a not-for-profit corporation or a partnership or a trust or some other entity. The Court is unable to consider whether there is a basis for disregarding the form or shell of the entity to reach the assets of the principal, without knowing what the form of the entity is. This prong of defendants' motion is granted.

4. *The Copyright Claim*

Finally, defendants argue that Baker's copyright infringement claim must be dismissed because the indisputable facts show, as a matter of law, that Lappin and Coltin, working on behalf of the Foundation, were joint authors of *GJA* and that *GJA* was a joint work. [7]

[32] [*487] a. *Applicable Law***

HN4[] Under the Copyright Act, a joint work is one "prepared by two or more authors with the intention that their contributions be merged into inseparable or interdependent parts of a unitary whole." *17 U.S.C. § 101*. Co-authors of a joint work are each entitled to distribute a joint work, for "in a joint work each author automatically acquires an undivided ownership in the entire work." *Weissmann v. Freeman, 868 F.2d 1313, 1318 (2d Cir. 1989)* (citation and quotation marks omitted); *see* *17 U.S.C. § 201(a)* ("The authors of a joint work are co-owners of copyright in the work."). Each joint author has the right to license or otherwise use the work as he or she wishes, subject only to an obligation to account to the other joint authors for any profits. *Thomson v. Larson, 147 F.3d 195, 199 (2d Cir. 1998)*.

HN5[] To prove co-authorship status, a co-authorship claimant must show that each putative co-author to the work (1) made independently copyrightable contributions and (2) fully intended to be a co-author. *Thomson, 147 F.3d at 200*; *see* *Robinson v. Buy-Rite Costume Jewelry, Inc., No. 03 Civ. 3619 (DC), 2004 U.S. Dist. LEXIS 16675, **7-8 (S.D.N.Y. Aug. 23, 2004)*. **[**33]** *But see* Nimmer on Copyright § 6.07[A][3][a], at 22 (suggesting that each author's contribution need not be copyrightable). The key is the intent of the parties at the time the work is done. *Thomson, 147 F.3d at 199*. There is no requirement that "the several authors must necessarily work in physical propinquity, or in concert, nor that the respective contributions made by each joint author must be equal either in quantity or quality." Nimmer on Copyright § 6.03, at 7. Each author's contribution, however, must be more than *de minimis*. *Id.* § 6.07[A][1], at 21. The contribution must be one of authorship, and merely contributing financing does not suffice. *Id.* § 6.07[A][2], at 21.

b. *Application*

Here, a reasonable jury could only find that Lappin and Coltin (working on behalf of the Foundation) were joint authors of *GJA*. I reach this conclusion for the following reasons.

First, Lappin and Coltin made independently copyrightable contributions to *GJA*. Their input clearly was more than *de minimis* and involved at least a "minimal degree **[**34]** of creativity." *See* *Feist Pub'lns, Inc. v. Rural Tel. Serv. Co., 499 U.S. 340, 345, 111 S. Ct. 1282, 113 L. Ed. 2d 358 (1991)*. As Baker conceded, *GJA* was Lappin's "brainchild." Both Lappin and Coltin made specific suggestions with respect to the script and to individuals to include or omit. They both played a role in writing the script and asked for dozens of changes. The script and film were revised to reflect those requests. The documents, and the e-mail exchanges in particular, show that Lappin and Coltin provided extensive comments and feedback and made many specific suggestions, including on how to express certain ideas. Moreover, Lappin and Coltin made the final decisions. (*See* Baker Dep. 172 ("Bob could have pulled the plug on this project any time he wanted to if his confidence in me was not what he thought it should be.")).

Although Baker apparently did the vast majority of the work, equality in quantity of contribution is not required, and a reasonable jury could only find that Lappin and Coltin were "true collaborators **[*488]** in the creative process." *Childress v. Taylor, 945 F.2d 500, 504 (2d Cir. 1991)*. Similarly, even assuming Lappin and Coltin were not present in the **[**35]** editing room when the film was edited, as Baker alleges, the law does not require that joint authors work together or in the same place or contribute to every aspect of a project. *See* *Gillespie v. AST Sportswear, Inc., No. 97 Civ. 1911 (PKL), 2001*

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[7] Although defendants commissioned Baker to make *GJA*, defendants have not relied on the theory that they own the copyright to the film because it is a "work made for hire." *See* *17 U.S.C. § 201(b)* ("In the case of a work made for hire, the employer or other person for whom the work was prepared is considered the author for purposes of this title, and, unless the parties have expressly agreed otherwise in a written instrument signed by them, owns all of the rights comprised in the copyright."). A "work specially ordered or commissioned" qualifies as a "work made for hire" only if "the parties expressly agree in a written instrument signed by them that the work shall be considered a work made for hire." *17 U.S.C. § 101*. Here, no such instrument exists, and hence defendants rely instead on the theory that *GJA* is a joint work. ***HN3***[] If a work is prepared by an independent contractor on commission, no written instrument exists between the parties, and "the commissioning party also materially contributed as an author to the creation of the work, he may be held to be a joint author together with the independent contractor." 1 Melville B. Nimmer & David Nimmer, *Nimmer on Copyright* § 5.03[B][2][b], at 55 (2005) ("Nimmer on Copyright").

U.S. Dist. LEXIS 1997, at *19 (S.D.N.Y. Feb. 22, 2001)
("[A] person need not hold the camera or push a button to be considered the author of a visual work, since one can exercise control over the content of a work without holding the camera.").

Second, a reasonable jury could only find that Lappin and Coltin intended to be joint authors. They clearly intended to merge their respective contributions into a unitary whole with the product that Baker was creating, and Baker even acknowledged at his deposition that *GJA* was the product of joint work by him, Lappin, and Coltin. (Baker Dep. 203). Baker chose not to take any credit for any of his work on *GJA,* even though he created the closing credits himself. (*Id.* 225-28). On the other hand, the credits list Lappin and Coltin as the Executive Producer and Associate Producer, and the Foundation is mentioned both as the source of the funding and also as the entity to **[**36]** contact for consent to broadcast. (CX 1 at 55:33-56:05).

Third, although defendants cannot take advantage of the work for hire provisions of the Copyright Act because of the absence of a signed instrument, the overall circumstances are still relevant to ascertaining the parties' intent. If not in the strict sense of the Copyright Act, this project still was a work for hire in a practical sense. The Foundation hired Baker to make the film, and both the Foundation and Baker fully expected that the Foundation would take control of the film to distribute it free of charge to Jewish educational and religious organizations. In the end, the Foundation paid some $ 177,500 to make the film. It did not do so with the expectation that Baker would retain the sole rights to the film, and Baker surely had no such expectation himself. Indeed, to the contrary, Baker testified at his deposition that he believed that Lappin or the Foundation owned "the rights to the film." (Baker Dep. 230).

Accordingly, summary judgment will be granted in favor of defendants dismissing Baker's copyright infringement claim. Baker's eighth claim for relief, alleging conversion, is also dismissed as it is dependent on **[**37]** the copyright claim. [8]

[8] For the most part, the parties have not discussed the website, teaching guide, and other materials separately from *GJA* itself. My ruling as to the claim for copyright ownership to *GJA* applies to the website and other materials as well, as they were part of the same overall project and were to be used hand in hand with *GJA*.

B. *Baker's Motion*

Baker's motion for partial summary judgment seeks judgment granting him relief on his copyright claim and dismissing all defendants' counterclaims. The first part of the motion is denied, for the reasons I discussed above in granting defendants' motion for summary judgment dismissing Baker's copyright claim.

The second part of the motion seeks dismissal of defendants' five counterclaims. First, I discuss the three copyright counterclaims and the dependent counterclaim for replevin, which seeks return of the "master" of *GJA.* Second, I discuss the counterclaim for breach of warranty.

[*489] 1. *The Copyright and Replevin* [38] *Counterclaims***

Defendants have asserted three copyright counterclaims (the second, third, and fourth counterclaims). The second counterclaim seeks a declaratory judgment that the Foundation is "the sole owner to and author" of *GJA* and related works. The third counterclaim seeks a declaratory judgment that the Foundation and Baker are "joint owners" of *GJA* and the related works. The fourth counterclaim seeks a declaratory judgment that the Foundation had and still has an implied license to copy and distribute *GJA* and the related works. The fifth counterclaim is for replevin -- return of the "master" of *GJA* based on the theory that the Foundation is entitled to the master.

Baker's motion is denied as to the second counterclaim. Although Baker clearly made independently copyrightable contributions to *GJA* and the works, it is not clear that he intended to retain an interest in the copyrights. Certain of his actions -- he did not want his name associated with *GJA* -- belie any intent to be a co-author for copyright purposes.

Baker's motion is denied as to the third counterclaim. At a minimum, the Foundation is a joint author of *GJA* and the related materials.

[39]** Baker's motion is granted as to the fourth counterclaim, as the issue of an implied license is now moot.

Baker's motion is denied as to the fifth counterclaim for replevin, as his argument that he is entitled to possession of the master of *GJA* is premised on the incorrect assertion that he is the sole author of the film. (P1. Supp. Mem. at 20 n.15).

2. *The Breach of Warranty Counterclaim*

In their first counterclaim, defendants allege that they had a binding agreement with Baker, the agreement contained an express warranty that *GJA* would be completed to the Foundation's "complete satisfaction," Baker breached that warranty by including two non-Jewish persons in the film, and defendants therefore are entitled to damages. (Answer PP41-45). Baker moves for summary judgment dismissing the claim.

The motion is granted. On the record before the Court, no reasonable jury could find that Baker made an express warranty that would give rise to a breach of warranty claim for damages.

Acknowledging that there is not a single, signed agreement governing the rights of the parties, defendants rely on two e-mails as the bases for the breach of warranty claim. First, they cite **[**40]** an e-mail from Baker to Lappin dated May 7, 2001, in which Baker writes:

> While busy . . ., I may have the time to write at least [] one or two of the segments you need. My fee for research, writing and a re-write, wouldn't exceed $ 2,500 per fifteen minute script. A writer who wanted much more than that, might be asking too much.
>
> I might add that it's very important to have the four scripts *completely finished to your satisfaction,* and in hand, before contracting for production work.

(Schacter 7/11/05 Decl. Ex. F) (emphasis added). Taking the underscored language out-of-context, defendants argue that "Baker expressly warranted that GJA would be 'completely finished to [the Foundation's] satisfaction.'" (Def. Opp. Mem. at 20 (quoting Schacter 7/11/05 Decl. Ex. F)). Of course, Baker was not warranting that he would finish *GJA* completely to the Foundation's satisfaction, and he was not even undertaking to do all four scripts; he was merely saying that the Foundation **[*490]** should have all four scripts in hand and completed to its satisfaction before it contracted for production work. No reasonable jury could conclude that this was an express warranty as alleged in **[**41]** the first counterclaim.

Second, the Foundation relies on an e-mail dated October 3, 2001, in which Baker was apparently responding to complaints that Lappin had made about the expenses. After explaining certain expenses, Baker wrote:

> if i gave the impression that i expect you to pay for material that doesn't meet your approval, i apologize . . . the point is, i HAD NO CHOICE but to invest another $ 2,000 so that i could even show you what i saw in my mind . . . at no time have i ever expected you, or any other client i've ever worked for, to pay for material that isn't perfectly acceptable.

(Schacter 7/11/05 Decl. Ex. G). Defendants argue that this e-mail constitutes an express warranty by Baker that "the Foundation would not have to 'pay for material that isn't perfectly acceptable.'" (Def. Opp. Mem. at 20-21 (quoting Schacter 7/11/05 Decl. Ex. G)). Again, this is simply not so. In explaining an expense, Baker was merely saying that he had never expected the Foundation or any other client to pay for material that was not perfectly acceptable. This expectation was not an express warranty as alleged in the first counterclaim, the breach of which could provide a basis **[**42]** for an award of damages.

Defendants are free to rely at trial on the alleged deficiencies in Baker's work to seek to defeat his claims for damages or to reduce the amount of any award. They may not, however, pursue the breach of warranty counterclaim to seek recovery of their own purported damages.

CONCLUSION

For the foregoing reasons, the parties' cross-motions for summary judgment are granted in part and denied in part. The first, seventh, and eighth claims for relief in the complaint are dismissed, with prejudice, as to both defendants. The second, third, fourth, fifth, and sixth claims for relief are dismissed as to Lappin individually. The first counterclaim is dismissed, with prejudice. The fourth counterclaim is dismissed as moot, without prejudice to re-filing in the event the Court's dismissal of Baker's copyright claim is reversed on appeal.

Counsel for the parties shall appear for a status conference on March 3, 2006, at 10:30 a.m.

SO ORDERED.

Dated: New York, New York

February 22, 2006

DENNY CHIN

United States District Judge

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Bertalo's Restaurant v. Exchange Ins. Co.

Supreme Court of New York, Appellate Division, Second Department

May 5, 1997, Submitted ; June 9, 1997, Decided

96-02516, 96-04406, 96-04410

Reporter
240 A.D.2d 452 *; 658 N.Y.S.2d 656 **; 1997 N.Y. App. Div. LEXIS 6497 ***

Bertalo's Restaurant Inc., Appellant, v. Exchange Insurance Company, Respondent.

Prior History: [*1]** In an action, *inter alia,* to recover damages for breach of a property insurance policy, the plaintiff appeals (1), as limited by its brief, from so much of an order of the Supreme Court, Westchester County (Gurahian, Special Referee), entered February 27, 1996, as denied those branches of its motion which were for (a) summary judgment dismissing the defendant's affirmative defenses, (b) partial summary judgment to recover under the policy, (c) leave to serve an amended complaint asserting five additional causes of action, and (d) leave to assert a sixth cause of action to recover damages for conversion which imposed a condition thereon, (2), as limited by its brief, from so much of an order of the same court (Gurahian, Special Referee), entered April 17, 1996, as denied that branch of its motion which was to impose sanctions upon the defendant and its counsel, and (3), as limited by its brief, from so much of an order of the same court (Scarpino, J.), entered April 19, 1996, as, upon renewal by the defendants, modified a prior order of the same court granting its motion to compel discovery, and denied those branches of its motion which were to compel discovery of documents **[***2]** 1-8, 11-18, and 20-26, in the privilege log and granted those branches of its motion which were to compel discovery of documents 19, 27, 28, and 29 only to the extent of compelling discovery of those documents as redacted.

Disposition: ORDERED that the order entered February 27, 1996, is affirmed insofar as appealed from, without costs or disbursements; and it is further, ORDERED that the order entered April 17, 1996, is affirmed insofar as appealed from, without costs or disbursements; and it is further, ORDERED that the order entered April 19, 1996, is modified by deleting the provisions thereof which denied those branches of the plaintiff's motion which were to compel discovery of documents 1-8, 11, 12, and 14-18, and 20-26 in the privilege log and directed discovery of documents numbered 19 and 27-29 only as redacted and substituting therefor a provision granting the motion to compel discovery of documents 1-8, 11, 12, 14-29 in the privilege log in their entirety; as so modified, the order is affirmed insofar as appealed from, with costs or disbursements.

Core Terms

carrier, policyholder, documents, coverage, insurance carrier, privilege log, communications, disbursements, discovery, defenses, disturb, costs, affirmative defense, decision to reject, insurance company, compel discovery, decision to deny, regular business, legal character, rejected claim, deny coverage, disclaimer, disclosure, sanctions, estopped, modified, nonlegal, waived

Case Summary

Procedural Posture
Plaintiff insured challenged an order from the Supreme Court, Westchester County (New York), which denied its motions, including summary judgment dismissing defendant's affirmative defenses; partial summary judgment to recover under the policy; leave to serve an amended complaint; to impose sanctions upon defendant and its counsel; and to compel discovery.

The trial court granted defendant insurer's motion to compel discovery.

Overview

Plaintiff insured contended that defendant insurer made an internal decision to deny coverage of its fire damage claim but failed to disclose that decision for two months. Plaintiff argued that defendant waived its affirmative defenses and should have been estopped from relying on those defenses. The trial court denied plaintiff's motions for summary judgment, partial summary judgment, leave to amend the complaint, to impose sanctions upon defendant and its counsel, and to compel discovery. On appeal, the court affirmed all orders, with the exception of the motion to compel, which was modified. The court held that reports by attorneys involved in the property damage claims that were made before defendant decided to deny coverage were not protected from disclosure either as work product or materials prepared in anticipation of litigation. Therefore, plaintiff was entitled to discovery of all documents prepared prior to the date on which defendant decided to deny the claim. The court found no basis to disturb the lower court's determination that defendant's conduct did not warrant sanctions or the denial of the motion for leave to serve an amended complaint.

Outcome

The court affirmed in all respects, except as to plaintiff insured's motion to compel certain discovery. The court found no basis to disturb the trial court's decision denying leave to amend the complaint or its refusal to impose sanctions against defendant insurer for discovery misconduct. The court held that plaintiff was entitled discovery of documents prepared prior to the date upon which defendant decided to deny coverage for the claim.

LexisNexis® Headnotes

Insurance Law > Claim, Contract & Practice Issues > Fiduciary Responsibilities

Insurance Law > Liability & Performance Standards > Good Faith & Fair Dealing > General Overview

HN1 **Claim, Contract & Practice Issues, Fiduciary Responsibilities**

Once a demand for payment has been made and a firm decision to reject a claim has been made, the carrier is obligated to issue a disclaimer of coverage.

Evidence > Inferences & Presumptions > General Overview

Insurance Law > Claim, Contract & Practice Issues > Estoppel & Waiver > General Overview

HN2 **Evidence, Inferences & Presumptions**

A policyholder must establish that a carrier's defenses are waived or that the policyholder is prejudiced to such an extent that the carrier should be estopped from asserting the defenses.

Civil Procedure > Appeals > Standards of Review > Abuse of Discretion

Civil Procedure > ... > Discovery > Methods of Discovery > Inspection & Production Requests

Civil Procedure > ... > Discovery > Misconduct During Discovery > Motions to Compel

Civil Procedure > ... > Discovery > Privileged Communications > General Overview

HN3 **Standards of Review, Abuse of Discretion**

It is within a court's discretion to grant renewal on a plaintiff's motion to compel production of certain documents that a party alleges are protected by the attorney-client privilege.

Civil Procedure > ... > Privileged Communications > Work Product Doctrine > General Overview

Insurance Law > ... > Property Insurance > Obligations > Notice Requirements

Civil Procedure > ... > Discovery > Privileged Communications > General Overview

HN4[] Privileged Communications, Work Product Doctrine

Reports by attorneys upon examining property damage claims which are made before an insurance carrier has decided to deny coverage are not protected from disclosure either as work product or materials prepared in anticipation of litigation.

Civil Procedure > ... > Privileged Communications > Work Product Doctrine > General Overview

Evidence > Inferences & Presumptions > General Overview

Civil Procedure > ... > Discovery > Privileged Communications > General Overview

Evidence > Privileges > Attorney-Client Privilege > General Overview

Evidence > Privileges > Attorney-Client Privilege > Scope

HN5[] Privileged Communications, Work Product Doctrine

In order to raise a valid claim of privilege, the party seeking to withhold the information must show that it was a confidential communication made between the attorney and the client in the context of legal advice or services. Documents which are not primarily of a legal character, but express substantial nonlegal concerns are not privileged. However, so long as the communication is primarily or predominantly of a legal character, the privilege is not lost merely by reason of the fact that it also refers to certain nonlegal matters.

Civil Procedure > ... > Privileged Communications > Work Product Doctrine > General Overview

Insurance Law > Liability & Performance Standards > Good Faith & Fair Dealing > General Overview

Civil Procedure > ... > Discovery > Privileged Communications > General Overview

HN6[] Privileged Communications, Work Product Doctrine

The payment or rejection of claims is a part of the regular business of an insurance company. Consequently, reports which aid it in the process of deciding which of the two indicated actions to pursue are made in the regular course of its business. Merely because such an investigation was undertaken by attorneys will not cloak the reports and communications with privilege because the reports, although prepared by attorneys, are prepared as part of the "regular business" of the insurance company. Therefore, those communications which occurred before the date that the insurer had reasonable grounds to reject the claim are not immune from discovery.

Civil Procedure > Appeals > Standards of Review > Abuse of Discretion

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Leave of Court

Civil Procedure > Discovery & Disclosure > Disclosure > Sanctions

Civil Procedure > Discovery & Disclosure > Discovery > Misconduct During Discovery

HN7[] Standards of Review, Abuse of Discretion

In view of the trial court's broad discretion in supervising disclosure, its determination that sanctions were not warranted must not be disturbed absent an improvident exercise of that discretion.

Counsel: Pagano & Shaw, White Plains, N.Y. (Robert P. Pagano and Terrence J. O'Connor of counsel), for

appellant.

Bouck, Holloway, **[***3]** Kiernan and Casey, Albany, N.Y. (Donald J. Feerick, Jr., of counsel), for respondent.

Judges: Bracken, J. P., Rosenblatt, Thompson and Krausman, JJ., concur.

Opinion

[*453] **[**658]** Ordered that the order entered February 27, 1996, is affirmed insofar as appealed from, without costs or disbursements; and it is further,

Ordered that the order entered April 17, 1996, is affirmed insofar as appealed from, without costs or disbursements; and it is further,

Ordered that the order entered April 19, 1996, is modified by deleting the provisions thereof which denied those branches of the plaintiff's motion which were to compel discovery of documents 1-8, 11, 12, and 14-18, and 20-26 in the privilege log and directed discovery of documents numbered 19 and 27-29 only as redacted and substituting therefor a provision granting the motion to compel discovery of documents 1-8, 11, 12, 14-29 in the privilege log in their entirety; as so modified, the order is affirmed insofar as appealed from, with costs or disbursements.

The plaintiff, a fire insurance policyholder (hereinafter the policyholder), contends that the defendant insurance carrier made an internal decision to deny coverage of **[***4]** its fire damage claim but failed to disclose that decision, while continuing to solicit the policyholder's cooperation. It was not until approximately two months after the action was initiated that the carrier advised the policyholder that coverage was denied on the basis, *inter alia,* that the policyholder was a procuring cause of the fire that destroyed the property. The policyholder argues that the carrier waived its affirmative defenses and should be estopped from relying on those defenses.

[*454] We reject the carrier's contention that a property damage insurance carrier has no duty to inform its policyholder at any time that it intends to deny coverage. Although the date that the carrier makes a firm decision to reject the claim is not necessarily the date it issues a disclaimer, ***HN1***[↑] once a demand for payment has been made and a "firm decision to reject a claim" has been made, the carrier is obligated to issue a disclaimer of coverage *(see, Landmark Ins. Co. v Beau Rivage Rest., 121 AD2d 98, 101)*. However, the denial of the policyholder's motion to dismiss the affirmative defenses asserted by the insurance carrier was appropriate because, in the case before us, ***HN2***[↑] **[***5]** the policyholder failed to establish that the carrier's defenses were waived or that the policyholder was prejudiced to such an extent that the carrier should be estopped from asserting the defenses *(see, Brown v State Farm Ins. Co., 237 AD2d 476*; *Ferraraccio v Hartford Ins. Co., 187 AD2d 954*).

While it was ***HN3***[↑] within the court's discretion to grant renewal to the carrier on the plaintiff's motion to compel production of certain documents that the carrier alleges were protected by the attorney-client privilege, we are not persuaded that the majority of the documents requested are within the privilege. ***HN4***[↑] Reports by attorneys upon examining property damage claims which are made before an insurance carrier has decided to deny coverage are not protected from disclosure either as work product or materials prepared in anticipation of litigation *(see, Westhampton Adult Home v National Union Fire Ins. Co., 105 AD2d 627, 628)*. A review of the documents submitted for inspection establishes that they consist primarily of reports made by the attorneys who conducted the investigation of the claim on behalf of the defendant carrier, and communications from the carrier to those attorneys. **[***6]** ***HN5***[↑]

In order to raise a valid claim of privilege, the party seeking to withhold the **[**659]** information must show that it was a "confidential communication" made between the attorney and the client in the context of legal advice or services *(see, Matter of Priest v Hennessy, 51 NY2d 62, 69*; *Coastal Oil N. Y. v Peck, 184 AD2d 241*). Documents which are "not primarily of a legal character, but [express] substantial nonlegal concerns" are not privileged (*Cooper-Rutter Assocs. v Anchor Natl. Life Ins. Co., 168 AD2d 663*). However, "[s]o long as the communication is primarily or predominantly of a legal character, the privilege is not lost merely by reason of the fact that it also refers to certain nonlegal matters" (*Rossi v Blue Cross & Blue Shield, 73 NY2d 588, 594)*.

" '***HN6***[↑] [T]he payment or rejection of claims is a part of the regular **[*455]** business of an insurance

company. Consequently, reports which aid it in the process of deciding which of the two indicated actions to pursue are made in the regular course of its business' " (*Landmark Ins. Co. v Beau Rivage Rest., supra,* at 101, quoting *Millen Indus. v American Mut. Liab. Ins. Co., 37 AD2d 817*). **[***7]** Merely because such an investigation was undertaken by attorneys will not cloak the reports and communications with privilege *(see, Spectrum Sys. Intl. Corp. v Chemical Bank, 78 NY2d 371, 377)* because the reports, although prepared by attorneys, are prepared as part of the "regular business" of the insurance company. Therefore, those communications which occurred before the date that the defendant had reasonable grounds to reject the claim *(see, Landmark Ins. Co. v Beau Rivage Rest., supra,* at 101) are not immune from discovery. In opposition to the motion to compel, the defendant argued that the decision to deny coverage was made at or about the time this action was commenced, December 21, 1994. As all but document number 13 in the privilege log were prepared prior to that date, the plaintiff is entitled to discovery of all documents except number 13. In view of this finding we do not reach the remaining privilege arguments.

HN7[↑] In view of the trial court's broad discretion in supervising disclosure, its determination that sanctions are not warranted must not be disturbed absent an improvident exercise of that discretion (*Cruzatti v St. Mary's Hosp., 193 AD2d 579, **[***8]** 580*; *Meraner v Albany Med. Ctr., 211 AD2d 867*). There is no basis to disturb the court's determination that the defendant's conduct did not warrant sanctions. There is also no basis for disturbing the denial of the motion for leave to serve an amended complaint.

Bracken, J. P., Rosenblatt, Thompson and Krausman, JJ., concur.

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Burns v Burns

Supreme Court of New York, Appellate Division, Fourth Department

July 25, 2018, Decided ; July 25, 2018, Entered

399 CA 17-01854

Reporter
163 A.D.3d 210 *; 81 N.Y.S.3d 846 **; 2018 N.Y. App. Div. LEXIS 5399 ***; 2018 NY Slip Op 05411 ****; 2018 WL 3569023

[**1]** Eleanor McQuilkin Burns, Appellant, v Andrew McIntosh Burns, Respondent.

Prior History: Appeal from an order of the Supreme Court, Monroe County (Richard A. Dollinger, A.J.), entered June 13, 2017. The order, among other things, denied plaintiff's motion to hold defendant in contempt.

Burns v Burns, 56 Misc 3d 864, 57 NYS3d 651, 2017 NY Misc LEXIS 2088 (May 26, 2017), affirmed.

Counsel: **[***1]** *Barney & Affronti, LLP*, Rochester (*Francis C. Affronti* of counsel), for appellant.

Burns & Schultz LLP, Pittsford (*Andrew M. Burns* of counsel), for respondent.

Judges: PRESENT: CENTRA, J.P., NEMOYER, CURRAN, AND TROUTMAN, JJ.

Opinion

[*211] **[**847]** NeMoyer, J.

According to the Domestic Relations Law and its common-law antecedents, the concept of spousal maintenance is limited to payments made to an unmarried ex-spouse. If divorcing spouses wish to vary this definition and provide for post-remarriage maintenance, they must do so clearly and unambiguously. In this case, nothing in the parties' agreement reflects an intent to depart from the statutory definition of maintenance with the clarity required by the governing case law. Consequently, as Supreme Court properly determined, defendant husband's maintenance obligation ended when plaintiff wife remarried.

[848]** Facts

The parties were married in June 1992. **[***2]** In September 2004, the husband vacated the marital residence; shortly thereafter, the wife sued for divorce. The parties subsequently executed a divorce settlement agreement pursuant to *Domestic Relations Law § 236 (B) (3)*. In the agreement, the parties specified that "[a]ll matters affecting . . . interpretation of this [a]greement and the rights of the parties [t]hereto shall be governed by the laws of the State of New York."

The agreement obligated the husband to pay "rehabilitative maintenance" to the wife pursuant to the following schedule:

> **[*212]** "(a) From December 1, 2007 - November 30, 2012: $5,500.00 Per Month = $66,000.00 Rehabilitative Maintenance Per Annum
>
> "(b) From December 1, 2012 - November 30, 2014: $2,916.00 Per Month = $34,992.00 Rehabilitative Maintenance Per Annum
>
> "(c) From December 1, 2014 - November 30, 2015: $2,500.00 Per Month = $30,000.00 Rehabilitative Maintenance Per Annum
>
> "(d) From December 1, 2015 - November 30, 2020: $2,200.00 Per Month = $26,400.00 Rehabilitative Maintenance Per Annum."

The foregoing constitutes the entirety of the agreement's maintenance provision. Critically, the agreement is silent regarding the effect, if any, of the wife's remarriage upon the husband's maintenance obligation. The agreement **[***3]** was subsequently incorporated, but not merged, into a judgment of divorce rendered by Supreme Court (Doyle, J.) in July 2008. The judgment includes a verbatim reproduction of the agreement's maintenance provision.

The wife remarried in December 2015. In April 2016, the husband emailed the wife to inform her that he would stop paying maintenance as a result of her remarriage. The husband's last maintenance payment was made

that month.

The wife then moved to, inter alia, recover a monetary judgment for the amount outstanding and hold the husband in contempt for ending the maintenance payments. According to the wife, "a plain reading of . . . the agreement[ ] leads to only one conclusion: [the husband's] rehabilitative maintenance obligation survives [her] remarriage." That was so, the wife continued, because

> "[o]ther than November 30, 2020, no termination events are identified in the agreement. Since none can be implied and the Court cannot rewrite the parties' agreement, this Court must conclude [that the husband's] obligation to pay maintenance survives not only the wife's remarriage, but also her death and his death. The maintenance obligation ends on November 30, 2020 and no other time." **[***4]

The husband opposed the wife's motion. Noting that the agreement contains no provision entitling the wife to continued maintenance payments upon her remarriage, the husband **[*213]** argued that the "fact that the parties did not expressly provide in the Agreement that maintenance payments would continue if [the wife] remarried establishes that the parties intended that [the husband's] obligation to pay [the wife] maintenance terminated upon her remarriage."

Supreme Court (Dollinger, A.J.) denied the wife's motion in its entirety. In a well-reasoned and thorough decision, the court held that, in light of the agreement's silence on the subject, the wife's remarriage ended the husband's obligation to pay maintenance. The wife now appeals.

Discussion

The friction point here is easily stated: the wife says that the husband's **[**849]** maintenance obligations are unaffected by her remarriage; the husband says that his maintenance obligations do not extend beyond the wife's remarriage. For the reasons that follow, we agree with the husband.

I

A divorce settlement agreement is a contract, subject to standard principles of contract interpretation (*see* Rainbow v Swisher, 72 NY2d 106, 109, 527 NE2d 258, 531 NYS2d 775 [1988]; Gurbacki v Gurbacki, 270 AD2d 807, 807-808, 708 NYS2d 761 [4th Dept 2000]). The agreement at issue does not explicitly define the term "maintenance," **[***5]** and it is silent regarding the effect of the wife's remarriage upon the husband's maintenance obligation. Thus, the plain text of the agreement—which the Court of Appeals says is the best source of the parties' intent (*see* Goldman v White Plains Ctr. for Nursing Care, LLC, 11 NY3d 173, 176, 896 NE2d 662, 867 NYS2d 27 [2008])—is not conclusive of the question on appeal.

> "Nevertheless, it is basic that, unless a contract provides otherwise, the law in force at the time the agreement is entered into becomes as much a part of the agreement as though it were expressed or referred to therein, for it is presumed that the parties had such law in contemplation when the contract was made and the contract will be construed in the light of such law" (Dolman v United States Trust Co. of N.Y., 2 NY2d 110, 116, 138 NE2d 784, 157 NYS2d 537 [1956]; *see* Ronnen v Ajax Elec. Motor Corp., 88 NY2d 582, 589, 671 NE2d 534, 648 NYS2d 422 [1996] [applying *Dolman*]).

[*214] The *Dolman* rule is of longstanding vintage, and the "principle embraces alike those [laws in force at the time of a contract's execution] which affect its validity, *construction*, discharge, and enforcement" (Von Hoffman v City of Quincy, 4 Wall [71 US] 535, 550, 18 L Ed 403 [1867] [emphasis added]). By virtue of the *Dolman* rule, when **[****2]** parties enter into an agreement authorized by or related to a particular statutory scheme, the courts will presume—absent something to the contrary—that the terms of the agreement are to be interpreted consistently with the corresponding statutory scheme (*see* ***[***6]*** *e.g.* Mayo v Royal Ins. Co. of Am., 242 AD2d 944, 945, 662 NYS2d 654 [4th Dept 1997], *lv dismissed 91 NY2d 887, 691 NE2d 636, 668 NYS2d 564 [1998]*; Matter of Andy Floors, Inc. [Tyler Constr. Corp.], 202 AD2d 938, 938-939, 609 NYS2d 692 [3d Dept 1994]).

The statutory scheme corresponding to the agreement in this case is *Domestic Relations Law § 236*, which authorizes divorce settlement agreements and directs that such agreements specify the "amount and duration of maintenance," if any (*§ 236 [B] [3] [3]*). The term " 'maintenance' " is defined within this statutory scheme as "payments provided for in a valid agreement between the parties or awarded by the court . . . , to be paid at fixed intervals for a definite or indefinite period of time" (*§ 236 [B] [1] [a]*). Critically, the statutory definition includes the following caveat: any maintenance award "shall terminate upon the death of either party or upon

the payee's valid or invalid marriage" (*id.*). As thus defined, the concept of maintenance is unequivocally limited to payments made to an *unmarried* ex-spouse (*see Matter of Howard v Janowski, 226 AD2d 1087, 1088, 641 NYS2d 940 [4th Dept 1996]*). And unless the parties contract otherwise, the *Dolman* rule incorporates this statutory limitation directly into a divorce settlement agreement "as though it were expressed or referred to therein" (*2 NY2d at 116*; **[**850]** *see United States Trust Co. of N. Y. v New Jersey, 431 US 1, 19, 97 S Ct 1505, 52 L Ed 2d 92 n 17 [1977], reh denied 431 US 975, 97 S Ct 2942, 53 L Ed 2d 1073 [1977]*).

Thus, we categorically reject the wife's argument that the statutory definition of maintenance embodied in *Domestic Relations Law § 236 (B) (1) (a)* is irrelevant simply because the parties chose to settle the **[***7]** terms of their divorce in a written agreement. To the contrary, the statutory definition of maintenance supplies the interpretive context necessary to understanding the agreement as an integrated whole, and it provides the benchmark against which those contractual provisions are to be construed. In short, the statutory definition shines a **[*215]** beacon light of clarity unto a term that might otherwise be subject to varying interpretations.[1]

II

The default rule of construction supplied **[***8]** by the statutory definition of maintenance is merely that, however—a default rule. There are many reported instances in which parties to a divorce settlement agreement have varied the statutory definition of maintenance so that payments would continue beyond the remarriage of the payee (*see e.g. Burn v Burn, 101 AD3d 488, 489, 956 NYS2d 19 [1st Dept 2012]*; *Matter of DeAngelis v DeAngelis, 285 AD2d 593, 593-594, 727 NYS2d 481 [2d Dept 2001]*; *Quaranta v Quaranta, 212 AD2d 683, 684, 622 NYS2d 778 [2d Dept 1995]*; *Jung v Jung, 171 AD2d 993, 994, 567 NYS2d 934 [3d Dept 1991]*; *Fredeen v Fredeen, 154 AD2d 908, 908, 546 NYS2d 60 [4th Dept 1989]*). In so doing, such parties effectively rebutted the presumption, embodied in the *Dolman* rule, that they intended to incorporate the corresponding statutory definitions into their agreement.

As the wife's appellate brief spills much ink in demonstrating, such a variance does not offend public policy (*see Fredeen, 154 AD2d at 908*). But the courts will not lightly infer the parties' intent to depart from the statutory definition of maintenance (*see Scibetta v Scibetta-Galluzzo, 134 AD2d 823, 824, 521 NYS2d 584 [4th Dept 1987]*), and it is well established that mere silence will not do (*see Quaranta, 212 AD2d at 684*; *Scibetta, 134 AD2d at 824*; *Jacobs v Patterson, 112 AD2d 402, 403, 492 NYS2d 59 [2d Dept 1985]*). Far from it—the parties' "intent to vary the statutory and precedential preference of an end to maintenance payments upon [remarriage] of **[****3]** the pay[ee] *must be expressed clearly*" (*Matter of Riconda, 90 NY2d 733, 737, 688 NE2d 248, 665 NYS2d 392 [1997]* [emphasis added]), for compelling a person to support a remarried ex-spouse, "absent an agreement to the contrary," most assuredly does violate the **[*216]** public policy of this State (*Jacobs v Patterson, 143 AD2d 397, 398, 532 NYS2d 429 [2d Dept 1988]*; *see Scibetta, 134 AD2d at 824*).[2]

[851]** The requisite degree of "clarity" in an agreement can be gleaned from the cases in which the parties successfully varied the statutory definition of maintenance. In *Burn*, for example, the First Department held that the wife's "waiver of a share of assets worth millions of dollars . . . evinces the intent of the parties that the maintenance payments would continue until [her] death or the death of [the husband], regardless of [her] marital status" (*101 AD3d at 489*).

---

[1] In point I of her brief, the wife also argues that the summary maintenance-terminating procedure of *Domestic Relations Law § 248* "do[es] not apply when the parties settle maintenance with a[n] opting out agreement." Perhaps so, but we need not definitively resolve that issue because the husband did not move to terminate maintenance under *section 248*, and the court did not direct such relief. To the contrary, as the wife recognizes elsewhere in her brief, this is a contract-interpretation case that requires us to construe the term "maintenance" in the agreement. Thus, although the substantive provisions of *section 248* are arguably relevant to the public policy considerations of our interpretive inquiry, the summary procedure provided therein is not in play here.

[2] Although *Riconda* involved the other enumerated **[***9]** component of the definition of maintenance set forth in ***Domestic Relations Law § 236 (B) (1) (a)***—namely, that payments continue only so long as both payor and payee are living—that distinct prong of the definition is equally variable by the parties upon the same "clear" expression of intent. Thus, as the Third Department has recognized, the cases that explicate the degree of clarity necessary to vary the still-living prong of the statutory definition of maintenance are equally instructive when determining whether or not the parties effectively varied the remarriage prong of the definition (*see Sacks v Sacks, 168 AD2d 733, 734-735, 563 NYS2d 884 [3d Dept 1990]*).

Quaranta is similar to *Burn*. There, the Second Department held that "the parties intended that the [wife] receive lifetime maintenance payments" because she "gave up her right to a distributive **[***10]** share of [certain valuable] property in exchange for maintenance payments[, which] the [husband] could deduct . . . for income tax purposes" (*Quaranta, 212 AD2d at 684*).

In *DeAngelis*, the divorce settlement agreement specified, "in detail," multiple events that would terminate the husband's maintenance obligations, but it did not include the wife's remarriage among them (*285 AD2d at 593*). Such an agreement, the Second Department held, established that the husband had "implicitly agreed to pay post-remarriage maintenance" (*id. at 594*).

In *Jung*, the Third Department held that the divorce settlement agreement "clearly evinces the intent of the parties that [the husband's] maintenance obligation would continue for a five-year period unconditioned on [the wife's] marital status," given the parties' multiple affirmative statements on the record that the agreement's maintenance-terminating events, which did not include remarriage, were exclusive and unconditional (*171 AD2d at 994* [internal quotation marks and brackets omitted]).

And in *Fredeen*, we held that "the agreement clearly evinces the intent of the parties that [the husband's] maintenance **[*217]** obligation would continue until February 1991 . . . unconditioned on [the wife's] marital status," given the language **[***11]** in the agreement that such payments would continue past February 1991 unless, inter alia, the wife had remarried in the interim (*154 AD2d at 908*).

The wife points to nothing in this record that establishes the parties' intent to vary the statutory definition of maintenance with the clarity required by *Riconda* and demonstrated in *Burn*, *DeAngelis*, *Quaranta*, *Jung*, and *Fredeen*. The wife did not waive her right to any particular property distribution in exchange for a sum certain of maintenance (as the wife did in *Burn* and *Quaranta*); the agreement does not indicate that the wife's remarriage would preclude further maintenance payments after a certain date or under certain circumstances (as it did in *Fredeen*); the agreement does not set forth, in detail, various termination events while omitting remarriage from the list (as it did in *DeAngelis*); and there is no extrinsic evidence **[**852]** indicating that a remarriage clause was purposefully omitted from the agreement (as there was in *Jung*).[3]

III

Rather than attempting to establish, based on the unique facts of this case, that the parties intended to vary the statutory definition of maintenance, the wife contends that by setting the *duration* of maintenance, the parties necessarily varied the *definition* of maintenance to include payments after remarriage. We reject that contention.[4]

The concept of "maintenance," as noted above, is explicitly limited by statute to payments made to an unmarried payee (*see Domestic Relations Law § 236 [B] [1] [a]*; *Howard, 226 AD2d at 1088*), and the legislature explicitly invited parties to **[*218]** a divorce settlement agreement to fix the duration of "maintenance" *as defined within the operative statutory universe*, i.e., **[***13]** as payments that "shall terminate" upon the remarriage of the payee (*§ 236 [B] [3] [3]*; *see generally* McKinney's Cons Laws of NY, Book 1, Statutes § 236).[5] It follows that, by setting the duration of "maintenance" in an agreement pursuant to *Domestic Relations Law § 236*, the parties are necessarily fixing the length of an obligation that continues in force only so long as the payee remains unmarried. If the parties wish

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[3] The other cases upon which the wife relies—*Matter of Benny v Benny (199 AD2d 384, 605 NYS2d 311 [2d Dept 1993])* and ***Gush v Gush (9 AD2d 815, 192 NYS2d 678 [3d Dept 1959])***—are simply inapposite. The agreement in *Benny* was governed by California law (*see 199 AD2d at 386-387*), and the agreement in *Gush*—which was executed before the advent of equitable distribution **[***12]** —stated that the husband's alimony obligation was to be " 'absolute, unconditional and irrevocable' " (***9 AD2d at 815***).

[4] Given the many statutory and policy differences between maintenance and child support, the agreement's child support provisions do not logically inform the proper interpretation of the maintenance provisions, nor do the child support provisions assist in answering the discrete question posed by this appeal, i.e., whether the parties clearly varied the statutory definition of maintenance by providing for continued payments after the wife's remarriage.

[5] Statutes ***§ 236***, as distinct from ***Domestic Relations Law § 236***, provides that, "[i]n the absence of anything in the statute indicating an intention to the contrary, where the same word [here, 'maintenance,'] is used in different parts of a statute, it will be presumed to be used in the same sense throughout." Thus, the term "maintenance" means the same thing in ***Domestic Relations Law § 236 (B) (3) (3)*** as it does in ***Domestic Relations Law § 236 (B) (1) (a)***.

to depart from that statutory definition, they must do so "clearly" (*Riconda, 90 NY2d at 737*), not simply by following the statutory directive to set the "duration" of a thing already defined. Any other construction would impermissibly frustrate the legislative definition of "maintenance." To the extent that our decision in *Hancher v Hancher (31 AD3d 1152, 818 NYS2d 384 [4th Dept 2006])* suggests a contrary rule, it should no longer be followed.

Indeed, the wife's proposed rule would mean that the legislature initially defined the term "maintenance," yet then proceeded, **[***14]** within the same section of the Domestic Relations Law, to direct contracting parties to take an act—i.e., set the "duration" of "maintenance" in a settlement agreement—that would necessarily and fundamentally change the very definition that the legislature had just adopted. In short, according to the wife, the legislature simultaneously defined a term and set up a procedure that invariably negates a core feature of that definition in each and **[**853]** every case. Such a statutory scheme would be at war with itself, and we cannot countenance such a result.

The wife's argument overlooks the fact that, in practice, virtually every divorce settlement agreement will fix the duration of a maintenance award. Consequently, in the mine-run of matrimonial dissolutions, the wife's proposed holding would effectively flip the statutory presumption: maintenance payments would presumptively survive the payee's remarriage, and **[****4]** the parties would need to take affirmative steps in the agreement to provide otherwise. But that is precisely the opposite of the legislature's decree, and it is not for the courts to legislate in **[*219]** the guise of construction (*see generally Matter of Tormey v LaGuardia, 278 NY 450, 451, 17 NE2d 126 [1938]*).[6]

Conclusion

Unless the parties clearly provide otherwise in a divorce settlement agreement, the payor's obligation to pay maintenance ends upon the remarriage of the payee. Here, the relevant agreement is silent as to whether the husband's maintenance obligation survives the wife's remarriage. As a result, the husband's maintenance obligation terminated upon the wife's remarriage. Supreme Court therefore properly denied the wife's motion to, inter alia, hold the husband in contempt and recover the unpaid maintenance. Accordingly, the order appealed from should be affirmed.

CENTRA, J.P., CURRAN and TROUTMAN, JJ., concur.

It is hereby ordered that the order so appealed from is unanimously affirmed without costs.

End of Document

[6] It is true, as the wife argues at great length, **[***15]** that parties to a divorce settlement agreement need not *explicitly* modify the statutory definition of maintenance in order to do so *effectively*. No one suggests otherwise. But the mere fact that the statutory definition of maintenance could be varied *implicitly* does not, as the wife argues, relieve contracting parties of the obligation to express that variance *clearly*.

Castellotti v Free

Supreme Court of New York, Appellate Division, First Department

March 8, 2016; March 8, 2016, Entered

158162/12, 16143

Reporter
138 A.D.3d 198 *; 27 N.Y.S.3d 507 **; 2016 N.Y. App. Div. LEXIS 1614 ***; 2016 NY Slip Op 01625 ****

[**1]** Peter Castellotti, Appellant, v Lisa Free, Respondent.

Subsequent History: Decision reached on appeal by, in part, Appeal dismissed by, in part *Castellotti v. Free, 165 A.D.3d 535, 86 N.Y.S.3d 50, 2018 N.Y. App. Div. LEXIS 6999 (N.Y. App. Div. **1st** **Dep't**, Oct. 23, 2018)*

Prior History: Appeal from an order of the Supreme Court, New York County (Eileen A. Rakower, J.), entered July 11, 2014, as amended by an order of that court, entered August 5, 2014. The amended order granted defendant's motion to dismiss the complaint.

Castellotti v. Free, 2014 N.Y. Misc. LEXIS 6131 (N.Y. Sup. Ct., Aug. 5, 2014)
Castellotti v. Free, 2014 N.Y. Misc. LEXIS 3084 (N.Y. Sup. Ct., July 10, 2014)

Core Terms

statute of frauds, oral agreement, promise, unjust enrichment, alleges, divorce, estate tax, promissory estoppel, cause of action, divorce action, sole beneficiary, public policy, shareholder, fiduciary relationship, fiduciary duty, funds, life insurance policy, inheritance, proceeds, argues, partial performance, real property, the will, matrimonial, accounting, grounds, parties

Case Summary

Overview

HOLDINGS: [1]-A brother's breach of oral contract claim against his sister was barred by the statute of frauds because the oral agreement included a promise by the sister to name the brother as sole beneficiary of a life insurance policy, *General Obligations Law § 5-701(a)(9)*; the agreement's life insurance provision was not severable because the life insurance provision was intertwined with and dependent on the provision involving transfer of the assets and served as "collateral" to ensure satisfaction of the other provisions; [2]-The brother sufficiently pleaded an unjust enrichment claim because the complaint alleged that the sister was enriched at the brother's expense when he paid the estate taxes and insurance premiums, despite the sister being the sole beneficiary of the will.

Outcome
Order modified, and, as so modified, order affirmed.

LexisNexis® Headnotes

Contracts Law > Statute of Frauds > Requirements > Writings

HN1[] Requirements, Writings

General Obligations Law § 5-701(a)(9) provides that an agreement must be in writing if it is a promise to name a beneficiary of a life insurance policy. As a general rule, if part of an entire contract is void under the Statute of Frauds, the whole contract is void.

Business & Corporate Compliance > ... > Contracts Law > Types of Contracts > Oral Agreements

Contracts Law > Contract Interpretation > Severability

HN2[] Types of Contracts, Oral Agreements

Where an oral agreement is a severable one, i.e., susceptible of division and apportionment, having two or more parts not necessarily dependent upon each other, that part which, if standing alone, is not required to be in writing, may be enforced, provided such apportionment of the agreement may be accomplished without doing violence to its terms or making a new contract for the parties.

Business & Corporate Compliance > ... > Contracts Law > Standards of Performance > Partial Performance

Real Property Law > Purchase & Sale > Remedies > Specific Performance

Contracts Law > Remedies > Specific Performance

Contracts Law > Statute of Frauds > Requirements > Writings

Real Property Law > ... > Contracts of Sale > Enforceability > Statute of Frauds

HN3[] Standards of Performance, Partial Performance

Although General Obligations Law § 5-703 requires certain contracts concerning real property to be in writing, § 5-703(4) permits a court, acting in equity, to compel the specific performance of agreements that have been partially performed. The partial performance exception applies only to the statute of frauds provision in § 5-703, and has not been extended to General Obligations Law § 5-701.

Business & Corporate Compliance > ... > Contract Formation > Consideration > Promissory Estoppel

Contracts Law > Statute of Frauds > Exceptions

HN4[] Consideration, Promissory Estoppel

The elements of a promissory estoppel claim are: (i) a sufficiently clear and unambiguous promise; (ii) reasonable reliance on the promise; and (iii) injury caused by the reliance. If a contract is barred by the statute of frauds, a promissory estoppel claim is viable in the limited set of circumstances where unconscionable injury results from the reliance placed on the alleged promise.

Contracts Law > Defenses > Illegal Bargains

Contracts Law > Defenses > Public Policy Violations

HN5[] Defenses, Illegal Bargains

Illegal contracts, or those contrary to public policy, are unenforceable.

Family Law > ... > Property Distribution > Classification > Inheritances

Family Law > ... > Property Distribution > Characterization > Separate Property

HN6[] Classification, Inheritances

An inheritance is generally considered to be separate property. Domestic Relations Law § 236(B)(1)(d)(1).

Contracts Law > Remedies > Equitable Relief

HN7[] Remedies, Equitable Relief

To establish unjust enrichment, a plaintiff must show that the defendant was enriched, at the plaintiff's expense, and that it is against equity and good conscience to permit the defendant to retain what is sought to be recovered.

Contracts Law > Remedies > Equitable Relief

Contracts Law > Statute of Frauds > Exceptions

HN8[] **Remedies, Equitable Relief**

The statute of frauds does not bar an unjust enrichment cause of action where it does not seek to enforce a promise but rather seeks to recover the reasonable value of property or services rendered in reliance on the promise.

Torts > Intentional Torts > Breach of Fiduciary Duty > Elements

HN9[] **Breach of Fiduciary Duty, Elements**

To state a claim for breach of fiduciary duty, a plaintiff must allege the existence of a fiduciary relationship, misconduct by the other party, and damages directly caused by that party's misconduct.

Governments > Fiduciaries

HN10[] **Governments, Fiduciaries**

The mere fact that parties are siblings, standing alone, is insufficient to support a fiduciary relationship.

Civil Procedure > Remedies > Equitable Accountings > Grounds for Accountings

Governments > Fiduciaries

HN11[] **Equitable Accountings, Grounds for Accountings**

The right to an accounting is premised upon the existence of a fiduciary relationship.

Torts > Intentional Torts > Conversion > Elements

HN12[] **Conversion, Elements**

A conversion takes place when someone, intentionally and without authority, assumes or exercises control over personal property belonging to someone else, interfering with that person's right of possession.

Headnotes/Summary

Headnotes

Frauds, Statute of — Agreements Required to be in Writing — Agreement to Name Beneficiary of Life Insurance Policy

1. Plaintiff's breach of contract claims arising out of an oral agreement wherein defendant, plaintiff's sister and the sole beneficiary of their mother's estate, agreed to, in exchange for plaintiff's payment of their mother's estate taxes, name plaintiff as sole beneficiary of a life insurance policy and to transfer to him a share of the estate were barred by the statute of frauds. *General Obligations Law § 5-701 (a) (9)* provides that an agreement must be in writing if it is "a promise . . . to name a beneficiary of [a life insurance] policy." Thus, the life insurance provision fell squarely within the statute of frauds, rendering the entire agreement void. Since the policy would be in existence up until the date of the physical transfer of the assets, the life insurance provision was intertwined with and dependent on the provision involving the transfer of the assets, and could not be apportioned without doing violence to the terms of the agreement. Further, the life insurance provision and the remaining provisions of the agreement were both supported by the same consideration, namely, plaintiff's payment of the estate taxes. Although *General Obligations Law § 5-703 (4)* permits a court, acting in equity, to compel the specific performance of agreements that have been partially performed, defendant asserted a statute of frauds defense under *section 5-701*, not *section 5-703*. Thus, the partial performance doctrine was inapplicable.

Estoppel — Promissory Estoppel — Oral Agreement Barred by Statute of Frauds — Unconscionable Injury

2. Plaintiff sufficiently stated a promissory estoppel claim based upon the alleged failure of defendant, plaintiff's sister and the sole beneficiary of their mother's estate, to transfer to plaintiff a share of the estate in exchange for his payment of the estate taxes, even though the parties' oral agreement was void under the

statute of frauds. If a contract is barred by the statute of frauds, a promissory estoppel claim is viable in the limited set of circumstances where unconscionable injury results from the reliance placed on the alleged promise. The allegations of the complaint showed that plaintiff detrimentally relied on defendant's promises by paying a substantial amount in taxes for the mother's estate, and suffered resulting monetary damages. Further, plaintiff, who received nothing under the mother's will, allegedly paid $2 million in estate taxes expecting that he would later receive his share of the inheritance. To dismiss the claim as a matter of law would have permitted defendant to keep all of the assets despite plaintiff's alleged substantial payment of the estate taxes. Moreover, there was nothing illegal about the parties' agreement so as to bar plaintiff's recovery on public policy grounds. The mother was free to leave her property to whomever she pleased, and the siblings were free to enter into an agreement to redistribute that inheritance.

Equity — Unjust Enrichment — Recovery of Amount of Enrichment under Oral Agreement Not Precluded by Statute of Frauds

3. Plaintiff sufficiently stated an unjust enrichment claim based upon the alleged failure of defendant, plaintiff's sister and the sole beneficiary of their mother's estate, to transfer to plaintiff a share of the estate in exchange for his payment of the estate taxes, even though the parties' oral agreement was void under the statute of frauds. The complaint's allegations showed that defendant was enriched at plaintiff's expense because plaintiff paid the estate taxes and insurance premiums, despite defendant's being the sole beneficiary of the will, and that it would be against equity and good conscience to allow defendant to retain that windfall. That theory of unjust enrichment was not precluded by the statute of frauds because it was not an attempt to enforce the oral contract but instead sought to recover the amount by which defendant was enriched at plaintiff's expense.

Torts — Breach of Fiduciary Duty — Existence of Fiduciary Relationship

4. Supreme Court properly dismissed plaintiff's claim for breach of fiduciary duty against defendant, plaintiff's sister, alleging that she misused the funds of and committed improper acts relating to a company she inherited upon their mother's death, since the complaint failed to allege that a fiduciary relationship existed between the parties. Plaintiff had no ownership interest in the company, and the fact that the parties were siblings, standing alone, was insufficient to support a fiduciary relationship.

Counsel: **[***1]** *Schwartz, Levine & Kaplan, PLLC*, New York City (*Chad T. Harlan* and *Jeffrey A. Kaplan* of counsel), for appellant.

Fox Rothschild LLP, New York City (*James M. Lemonedes* and *Zev Singer* of counsel), for respondent.

Judges: Peter Tom, J.P., David B. Saxe, Rosalyn H. Richter, Judith J. Gische, JJ. Opinion by Richter, J. All concur.

Opinion by: Rosalyn H. Richter

Opinion

[*200] **[**510]** Richter, J.

This action involves a family dispute between plaintiff Peter Castellotti and his sister, defendant Lisa Free.[1] Before her death, the parties' late mother, Madeline Castellotti, removed Peter from her will, leaving Lisa as sole beneficiary. Madeline made this change because Peter was going through a divorce, and Madeline wanted to prevent Peter's then-wife from benefiting from any of Madeline's assets. At about the same time, Peter and Lisa allegedly entered into an oral agreement whereby Lisa agreed, inter alia, to give Peter half **[**511]** of the inheritance when his divorce became final, in return for Peter's paying **[***2]** Madeline's estate taxes. After Peter paid the taxes, Lisa allegedly reneged on the deal, and this action ensued. We conclude that the complaint **[****2]** states viable claims for both promissory estoppel and unjust enrichment,

[1] The facts set forth are taken from the complaint and are accepted as true for purposes of this appeal.

even though the parties' oral agreement is barred by the statute of frauds. Further, under the circumstances presented here, Peter's claims need not be dismissed on public policy grounds merely because he entered into the alleged oral agreement for the purpose of delaying the receipt of assets that he never owned in the first place.

Madeline was the sole shareholder of Whole Pies, Inc., a business that owns John's Pizzeria in midtown Manhattan. In February 2003, prior to Madeline's death, Peter brought a divorce action against his then-wife, Rea Castellotti. After the divorce action was commenced, Madeline, who was seriously ill, decided to change her will to remove Peter as 50% beneficiary **[*201]** and instead make his sister Lisa the sole beneficiary. Madeline made the change because she disliked Rea, and wanted to ensure that Rea would not benefit in the divorce action from **[***3]** any of Madeline's assets.

In June 2004, Madeline passed away and, pursuant to her will, Lisa received all of Madeline's assets, including 100% of Whole Pies, 51% of PMPL, LTD (the general partner of a real estate partnership), Madeline's residence on Staten Island, and funds contained in various bank accounts (collectively the assets). In 2004, both before and again after Madeline's death, Peter and Lisa allegedly entered into an oral agreement whereby Peter agreed to pay Madeline's estate taxes with his share of Madeline's life insurance proceeds. In return, Lisa agreed to give Peter 50% of the assets upon the finality of his divorce, and 50% of the income and proceeds generated from the assets before the divorce was final. Lisa also agreed to name Peter as sole beneficiary of a life insurance policy valued at no less than $5 million, and to maintain that policy until the assets were physically transferred to Peter.

In February 2005, pursuant to the oral agreement, Peter allegedly paid Madeline's estate taxes with his share of the life insurance proceeds. After Peter's divorce became final in November 2008, Lisa failed to transfer 50% of the assets to Peter. Lisa did maintain an account **[***4]** in her name at Wachovia Bank, to which Peter was given access, and told Peter that she was depositing his 50% of the net proceeds from Whole Pies into the account. Lisa, however, did not deposit the agreed-upon 50%, but only made sporadic deposits; in May 2011, Lisa denied Peter access to the account. Lisa also procured, at Peter's expense, a $5 million insurance policy naming Peter as sole beneficiary. Lisa maintained this policy from February 2005 until May 2012, when she refused to sign the renewal documents and let the policy lapse.

Peter commenced this action, asserting claims against Lisa for breach of contract, unjust enrichment, breach of fiduciary duty, an accounting, fraud, breach of the covenant of good faith and fair dealing, and conversion.[2] Lisa answered, and asserted **[**512]** affirmative defenses, including that Peter's claims were barred **[*202]** by the statute of frauds. Lisa thereafter moved, pursuant to *CPLR 3211*, to dismiss the complaint. In a decision entered July 11, 2014, the motion court granted Lisa's motion and dismissed the **[****3]** complaint in its entirety *(2014 NY Slip Op 31798[U] [2014])*.[3] This appeal ensued.

[1] The complaint contains two causes of action for breach of contract. In the first, Peter alleges that although he fully complied with the oral agreement by paying Madeline's estate taxes, Lisa breached the contract by failing to transfer any of the assets to Peter or provide him with 50% of the income and proceeds generated from the assets. The second cause of action alleges that Lisa breached the agreement by failing to renew the $5 million life insurance policy. The motion court properly dismissed these claims as barred by the statute of frauds. ***HN1***[] *General Obligations Law § 5-701 (a) (9)* provides that an agreement must be in writing if it is "a promise . . . to name a beneficiary of [a life insurance] policy." As alleged in the complaint, the oral **[***6]** agreement here included a promise by Lisa to name Peter as sole beneficiary of a life insurance policy. Thus, that provision falls squarely within the statute of frauds, rendering the entire agreement void (*see Apostolos v R.D.T. Brokerage Corp., 159 AD2d 62, 65, 559 NYS2d 295 [**1st** Dept 1990]* ["As a general rule, if part of an entire contract is void under the Statute of Frauds, the whole contract is void"]).[4]

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[2] In June 2013, Peter's ex-wife Rea moved to intervene in this action to bring claims against Peter and Lisa for falsely **[***5]** representing during the divorce action that Peter had no ownership interest in Whole Pies. The lower court granted Rea's motion, but that order was reversed on appeal *(118 AD3d 631, 990 NYS2d 168 [**1st** Dept 2014])*. This Court concluded that the proper remedy for any possible fraud committed during the divorce action was to move to vacate the divorce judgment, and not to collaterally attack that judgment in this action (*118 AD3d at 631-632*).

[3] On August 5, 2014, an amended order was entered correcting the original order by adding decretal language.

[4] There is no merit to Peter's claim that Lisa failed to meet her

Peter argues that even if the life insurance provision falls within the statute of frauds, that provision is severable and does not void the remainder of the agreement.

> HN2[] "[W]here an oral agreement is a severable one, i.e., susceptible of division and apportionment, having two or more parts not necessarily dependent upon each other, that part which, if standing alone, is not required to be in writing, may be enforced, provided such apportionment of the agreement may be accomplished without doing violence to its terms or making a new contract for the parties" (*id.*).

[*203] Under the oral agreement alleged **[***7]** here, Peter promised to pay Madeline's estate taxes and, in exchange, Lisa agreed to give Peter 50% of the assets upon his divorce being final, and 50% of the income and proceeds generated by the assets prior to the finality of the divorce. Lisa also promised to name Peter as the sole beneficiary on a life insurance policy that would be in existence up until the date of the physical transfer of the assets. Thus, the life insurance provision is intertwined with and dependent on the provision involving transfer of the assets, and cannot be apportioned without doing violence to the terms of the agreement (*see e.g. Jordache Ltd. v Oved, 40 AD3d 400, 400, 836 NYS2d 136 [1st Dept 2007]*; *Whitman Heffernan Rhein & Co. v Griffin Co., 163 AD2d 86, 87, 557 NYS2d 342 [1st Dept 1990]*, *lv denied 76 NY2d 715, 565 NE2d 1269, 564 NYS2d 718 [1990]*). Indeed, in his appellate brief, Peter concedes that the life insurance provision serves as "collateral" to ensure satisfaction of the other provisions. Further, the life insurance provision and the remaining provisions **[**513]** of the agreement are both supported by the same consideration, namely, Peter's payment of Madeline's estate taxes (*see Sheresky v Sheresky Aronson Mayefsky & Sloan, LLP, 35 Misc 3d 1201[A], 950 NYS2d 611, 2011 NY Slip Op 52504[U], *11 [Sup Ct, NY County 2011]* [portions of oral agreement not severable where the plaintiff alleged the same consideration for both promises]).

The motion court properly rejected Peter's claim that the alleged partial performance of the agreement removes it **[***8]** from the statute of frauds. HN3[] Although General Obligations Law § 5-703 requires certain contracts concerning real property to be in writing, section 5-703 (4) permits a court, acting in equity, to compel the specific performance of agreements that have been partially **[****4]** performed. This Court has held, however, that the partial performance exception applies only to the statute of frauds provision in section 5-703, and has not been extended to section 5-701 (*Gural v Drasner, 114 AD3d 25, 32, 977 NYS2d 218 [1st Dept 2013]* ["the law simply does not provide for or permit a part performance exception for oral contracts other than those to which General Obligations Law § 5-703 applies"], *lv dismissed 24 NY3d 935, 993 NYS2d 546, 17 NE3d 1144 [2014]*). Here, Lisa asserted a statute of frauds defense under General Obligations Law § 5-701, not section 5-703. Thus, the partial performance doctrine is inapplicable (*see Rose v Spa Realty Assoc., 42 NY2d 338, 343, 366 NE2d 1279, 397 NYS2d 922 [1977]* ["Although the General Obligations Law (§ 5-703, subd 2) subjects the sale of real property to the Statute of Frauds, it was not pleaded by defendants and is therefore not involved in this case"]).

[*204] Peter argues that the partial performance doctrine is properly invoked here because the oral agreement involves conveyances of real property. Specifically, Peter points to Lisa's promise to transfer 50% of PMPL, and 50% of Madeline's Staten Island residence. First, PMPL is not real property, but rather, only an entity that is a general partner in another entity **[***9]** that owns real property. Second, even if the promised conveyance of PMPL and the Staten Island home could be saved by the partial performance doctrine contained in General Obligations Law § 5-703, those provisions of the contract are not severable from the larger agreement, the whole of which is barred by General Obligations Law § 5-701.

Although the breach of contract causes of action cannot stand, the complaint sufficiently states a claim under the doctrine of promissory estoppel.[5] HN4[] The elements of a promissory estoppel claim are: (i) a sufficiently clear and unambiguous promise; (ii) reasonable reliance on the promise; and (iii) injury caused by the reliance (*see MatlinPatterson ATA Holdings LLC v Federal Express Corp., 87 AD3d 836, 841-842, 929 NYS2d 571 [1st Dept 2011]*, *lv denied 21 NY3d 853 [2013]*; *Agress v*

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burden to affirmatively disprove the existence of a written contract. Because the complaint explicitly states that the parties entered into an oral agreement, there was no need for Lisa to show that no writing existed.

[5] Although a cause of action for promissory estoppel is not expressly asserted in the complaint, the factual allegations therein sufficiently "fit within" a promissory estoppel claim (*Leon v Martinez, 84 NY2d 83, 87-88, 638 NE2d 511, 614 NYS2d 972 [1994]*).

Clarkstown Cent. School Dist., 69 AD3d 769, 771, 895 NYS2d 432 [2d Dept 2010]; Fleet Bank v Pine Knoll Corp., 290 AD2d 792, 797, 736 NYS2d 737 [3d Dept 2002]; Chemical Bank v City of Jamestown, 122 AD2d 530, 531, 504 NYS2d 908 [4th Dept 1986], *lv denied 68 NY2d 608, 500 NE2d 874, 508 NYS2d 1025 [1986])*. If a contract is barred by the statute of frauds, a promissory estoppel claim is viable in the limited set of circumstances where unconscionable **[**514]** injury results from the reliance placed on the alleged promise (*see* Fleet Bank, 290 AD2d at 796-797; *Melwani v Jain, 281 AD2d 276, 277, 722 NYS2d 145 [**1st** Dept 2001]*; Steele v Delverde S.R.L., 242 AD2d 414, 415, 662 NYS2d 30 [**1st** Dept 1997]; WE Transp. v Suffolk Transp. Serv., 192 AD2d 601, 602, 596 NYS2d 166 [2d Dept 1993], *lv denied 82 NY2d 656, 622 NE2d 306, 602 NYS2d 805 [1993]*; *Buddman Distribs. v Labatt Importers, 91 AD2d 838, 839, 458 NYS2d 395 [4th Dept 1982])*.

[2] Here, the allegations of the complaint show an unambiguous promise by Lisa to provide Peter with half of the income generated by the assets during **[***10]** the pendency of Peter's divorce, to transfer half of the assets upon the finality of the divorce, and to name Peter as sole beneficiary of a life insurance policy of at least $5 million. The complaint's allegations also show **[*205]** that Peter detrimentally relied on those promises by paying a substantial amount in taxes for Madeline's estate, and suffered resulting monetary damages (*see* Forman v Guardian Life Ins. Co. of Am., 76 AD3d 886, 888-889, 908 NYS2d 27 [**1st** Dept 2010] [reading the complaint in a light most favorable to the plaintiffs, the pleadings sufficiently allege a clear and unambiguous promise, reliance on the promise and damages]).[6]

Further, triable issues of fact exist as to whether Peter has suffered the requisite unconscionable injury (*see* Ackerman v Landes, 112 AD2d 1081, 1083-1084, 493 NYS2d 59 [2d Dept 1985]). At a minimum, Peter, who received nothing under Madeline's will, allegedly paid $2 **[***11]** million in estate taxes, expecting that he would later receive his share of the inheritance. To dismiss this claim as a matter of law would permit Lisa to keep all of the assets, which include a successful New York restaurant business, despite Peter's alleged substantial payment of the estate taxes (*see Buddman Distribs. v Labatt Importers, 91 AD2d 838, 839, 458 NYS2d 395 [4th Dept 1982]* [whether circumstances rise to the level of unconscionable injury should not be determined on the pleadings]).

Lisa does not dispute that a promissory estoppel claim may lie even where an underlying contract is barred by the statute of frauds. Instead, she argues that public policy should bar Peter from any recovery because he entered into the alleged oral agreement for the purpose of delaying the receipt of the prospective assets until after the conclusion of the divorce action. Although **HN5**[↑] "illegal contracts, or those contrary to public policy, are unenforceable" (Szerdahelyi v Harris, 67 NY2d 42, 48, 490 NE2d 517, 499 NYS2d 650 [1986]), there is nothing illegal about the parties' agreement here. Madeline was free to leave her property to whomever she pleased, and the siblings were free to enter into an agreement to redistribute that inheritance.

Lisa does not identify any statute, rule or regulation that was violated by Peter and Lisa's entry into the agreement. **[***12]** Nor is there any claim that Peter concealed or transferred any property actually owned by him or titled in his name, either **[*206]** before or during the divorce action. Indeed, the purported assets alleged to have been undisclosed, i.e., the shares in Whole Pies, were never within Peter's possession. At **[**515]** most, there is a claim that Peter attempted to delay the receipt of these shares, which he was never legally entitled to in the first place, and did not disclose this potential revenue source to his then-wife. While the failure to disclose Peter's right to receive the assets in the future may impact the financial issues in the matrimonial action, that factor alone does not require wholesale dismissal of Peter's claims on public policy grounds.

This case stands in contrast to the cases cited by Lisa, where courts invoked public policy principles to deny recovery where illegality was manifest (*see e.g.* McConnell v Commonwealth Pictures Corp., 7 NY2d 465, 470, 166 NE2d 494, 199 NYS2d 483 [1960] [money the plaintiff sued for was the fruit of admitted crime]; *Anonymous v Anonymous, 293 AD2d 406, 407, 740 NYS2d 341 [**1st** Dept 2002]* ["an agreement for financial support in exchange for illicit sexual relations is violative of public policy and thus unenforceable"]; Abright v Shapiro, 214 AD2d 496, 626 NYS2d 73 [**1st**

[6] On appeal, Peter asserts this figure is $2 million. Although the complaint does not explicitly set forth the $2 million figure, it does refer to a "significant financial expenditure." We note that an affidavit submitted in opposition to Lisa's dismissal motion characterizes the amount as "over a million dollars," and during oral argument before the motion court, Peter's counsel stated that the estate taxes paid by Peter amounted to $2 million.

Dept 1995] [denying recovery where the parties were engaged in a scheme in violation of rent stabilization **[***13]** laws and zoning regulations]; United Calendar Mfg. Corp. v Huang, 94 AD2d 176, 180, 463 NYS2d 497 [2d Dept 1983] [fee-splitting arrangement was, on its face, violative of the Education Law]; Braunstein v Jason Tarantella, Inc., 87 AD2d 203, 450 NYS2d 862 [2d Dept 1982] [dismissing claims with respect to distribution of a film that was produced in violation of obscenity statutes]).[7]

In invoking public policy, Lisa purports to be protecting Peter's ex-wife Rea from a fraud allegedly committed in the divorce action. To deny Peter recovery here, however, would do nothing to protect Rea, the alleged victim of the fraudulent scheme. Instead, Lisa, who allegedly participated in the fraud, would obtain a windfall by inheriting all of the assets, despite Peter's having allegedly paid $2 million in estate taxes. Such a perverse outcome would not serve any important public policy goals. If we were to accept Lisa's public policy argument, we **[*207]** would be rewarding families who seek to secrete prospective assets from a soon-to-be ex-spouse, something we decline to do.

In reaching this decision, **[***14]** we do not condone parties in matrimonial actions being less than candid with their spouses about their assets. Peter's alleged fraudulent behavior, however, should be explored in the matrimonial action, but should not preclude him from moving forward with at least some of his claims here. In our earlier decision denying Rea leave to intervene in this action, we concluded that her remedy for any fraud committed during the course of the matrimonial proceeding was to move to vacate the divorce judgment (118 AD3d at 631-632). We note that the record here does not allow us to determine whether Peter intentionally concealed the alleged oral agreement from Rea, or what the legal significance of that would be. Nor can we make any determination whether or not Peter made any false statements during the divorce proceeding about his assets, including in his net worth statement.

Further, allowing Peter to recover in this action may provide Rea with the **[**516]** opportunity to reopen the divorce action to explore the circumstances surrounding Peter and Lisa's alleged oral contract. We recognize that **HN6**[↑] an inheritance is generally considered to be separate property (*see* Domestic Relations Law § 236 [B] [1] [d] [1]; Tatum v Simmons, 133 AD3d 550, 550, 21 NYS3d 208 [**1st** Dept 2015]). However, in her intervenor complaint, Rea stated that if **[***15]** she had known that Peter would later receive half of the inheritance, she would have sought more when she settled her equitable distribution claims. Rea also maintained that the matrimonial court's awards of maintenance and child support would have been greater if the court had known of the alleged oral agreement.

[3] The factual allegations of the complaint sufficiently state a cause of action for unjust enrichment with respect to Peter's payment of Madeline's estate taxes and Lisa's life insurance premiums.**HN7**[↑] To establish unjust enrichment, the plaintiff must show that the defendant was enriched, at the plaintiff's expense, and that it is against equity and good conscience to permit the defendant to retain what is sought to be recovered (Georgia Malone & Co., Inc. v Rieder, 19 NY3d 511, 516, 973 NE2d 743, 950 NYS2d 333 [2012]). Here, the complaint's allegations show that Lisa was enriched at Peter's expense because Peter paid the estate taxes and insurance premiums, despite Lisa's being the sole beneficiary **[*208]** of the will, and that it would be against equity and good conscience to allow Lisa to retain that windfall.[8]

This theory of unjust enrichment is not precluded by the statute of frauds because it is not an attempt to enforce the oral contract but instead seeks to recover the amount by which Lisa was enriched at Peter's expense (*see Grimes v Kaplin, 305 AD2d 1024, 1024, 758 NYS2d 591 [4th Dept 2003]* **HN8**[↑] [statute of frauds does not bar unjust enrichment cause of action where it does not seek to enforce a promise but rather seeks to recover the reasonable value of property or services rendered in reliance on the promise]; *Kearns v Mino, 83*

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[7] Lisa's reliance on Reid v McLeary (271 AD2d 668, 706 NYS2d 179 [2d Dept 2000]) and Gould v Gould (261 App Div 733, 27 NYS2d 54 [**1st** Dept 1941], *lv denied* 262 App Div 833, 29 NYS2d 503 [**1st** Dept 1941]) is misplaced. In those cases, courts found agreements to be against public policy where the main objective was to dissolve a marriage and to facilitate the obtaining of a divorce. Here, the parties' alleged agreement does neither.

[8] Although the unjust enrichment cause of action in the complaint does not expressly advance this theory, it does "repeat[ ] and reallege[ ]" all allegations set forth previously, **[***16]** including those showing that Peter made the tax payment even though he was not a beneficiary of the will. Given the liberal pleading standards and standard of review on a CPLR 3211 motion (*see* Leon, 84 NY2d at 87-88), Peter should be permitted to pursue this cause of action.

AD2d 606, 606, 441 NYS2d 297 [2d Dept 1981] [upholding unjust enrichment claim despite dismissal of contract claim on statute of frauds grounds]; *see also Farash v Sykes Datatronics, 59 NY2d 500, 503, 452 NE2d 1245, 465 NYS2d 917 [1983]* [quasi contract claim may proceed where it did not attempt to enforce an oral agreement, but merely sought to recover expenditures made by the plaintiff in reliance upon statements made by and at the request of the defendant]).

For the reasons previously discussed, there is no merit to Lisa's contention that the unjust enrichment claim should be dismissed on public policy grounds. Peter's recovery **[***17]** on this claim, however, cannot extend to the benefits he was allegedly due under the oral agreement (*see Komolov v Segal, 117 AD3d 557, 557, 985 NYS2d 411 [**1st** Dept 2014]* [precluding unjust enrichment claim because it sought same relief that was barred by the statute of frauds]; *Andrews v Cerberus Partners, 271 AD2d 348, 348, 707 NYS2d 85 [**1st** Dept 2000]* [dismissing claim for unjust enrichment that was indistinguishable from breach of contract claim barred by statute of frauds]). To the **[**517]** extent the complaint alleges unjust enrichment based on Lisa's misuse of corporate monies, any such claim belongs to the companies, not Peter individually (*see Dragon Inv. Co. II LLC v Shanahan, 49 AD3d 403, 404-405, 854 NYS2d 115 [**1st** Dept 2008]*).

The complaint alleges that Lisa owed Peter a fiduciary duty of care and loyalty, and that Lisa breached that duty in two **[*209]** ways: by using the funds of Whole Pies for her own personal purposes, and by committing a host of improper acts, including failing to pay the company's sales and payroll taxes, filing a false insurance application, and operating John's Pizzeria in violation of numerous administrative regulations. **HN9**[↑] To state a claim for breach of fiduciary duty, a plaintiff must allege the existence of a fiduciary relationship, misconduct by the other party, and damages directly caused by that party's misconduct (*see Pokoik v Pokoik, 115 AD3d 428, 429, 982 NYS2d 67 [**1st** Dept 2014]*).

[4] The motion court properly dismissed the fiduciary duty claims because **[***18]** the complaint fails to allege that a fiduciary relationship existed between Peter and Lisa. Although Peter argues that he is owed a fiduciary duty as a "rightful" shareholder of Whole Pies, it is undisputed that he has no ownership interest in the company. Nor has he ever had any such interest in the past. Rather, the complaint states that 100% of the shares in Whole Pies were transferred to Lisa upon Madeline's death. Indeed, the complaint acknowledges that Peter entered into an agreement with Lisa specifically to forestall his becoming a shareholder.

Peter nevertheless argues that he would become a shareholder of Whole Pies if he were to prevail in this action. But the complaint seeks only monetary damages and contains no request for declaratory relief as to Peter's shareholder status. Nor did the now-dismissed breach of contract claims seek specific performance of Lisa's alleged promise to transfer the shares. In any event, even if Peter could somehow obtain shareholder status as a result of this lawsuit, that would not retroactively make him a shareholder for the time period when the alleged breaches of fiduciary duty took place.

Although not alleged in the complaint, on appeal, **[***19]** Peter contends that a fiduciary relationship exists based on his familial relationship as Lisa's sibling, along with unspecified prior business dealings. **HN10**[↑] The mere fact that the parties are siblings, standing alone, is insufficient to support a fiduciary relationship (*see Chasanoff v Perlberg, 19 AD3d 635, 635-636, 798 NYS2d 116 [2d Dept 2005]* [no fiduciary relationship between plaintiff sister and defendant brother]). Although family members in a co-owned business venture can owe each other fiduciary duties (*see Braddock v Braddock, 60 AD3d 84, 88, 871 NYS2d 68 [**1st** Dept 2009]*), **[*210]** the complaint contains no facts to **[****5]** suggest that Peter and Lisa had any business dealings.[9]

Even if a fiduciary relationship did exist, the claims that Lisa misappropriated Whole Pie's funds and failed to operate the company in compliance with the law belong to the company, not to Peter individually (*see Abrams v Donati, 66 NY2d 951, 953, 489 **[**518]** NE2d 751, 498 NYS2d 782 [1985]*). Although not pleaded in the complaint, **[***20]** in his appellate brief, Peter argues that Lisa also breached her fiduciary duty by failing to transfer to him his purported interest in Whole Pies. These allegations merely duplicate one of the contract claims dismissed on statute of frauds grounds, and the requirement of a writing cannot be circumvented by

[9] Peter's reliance on Rea's proposed intervenor complaint is unavailing. In that pleading, Rea alleges that in 1996, Peter began working toward opening John's Pizzeria, and provided initial funding for the venture. Simply because Peter may have helped to start John's Pizzeria 20 years ago sheds no light on whether Peter and Lisa subsequently had any business relationship, let alone the nature of any such dealings.

recasting the claim as one sounding in tort (*see* Pollak v Moore, 85 AD3d 578, 579, 926 NYS2d 434 [**1st** Dept 2011]; Kaminer v Wexler, 40 AD3d 405, 405, 836 NYS2d 139 [**1st** Dept 2007], *lv dismissed in part and denied in part* 9 NY3d 955, 877 NE2d 298, 846 NYS2d 79 [2007]).

The complaint contains two causes of action for an accounting, one for Whole Pies and the other for its management company. **HN11**[↑] The right to an accounting is premised upon the existence of a fiduciary relationship (Adam v Cutner & Rathkopf, 238 AD2d 234, 242, 656 NYS2d 753 [**1st** Dept 1997]). Since no fiduciary relationship is alleged, the accounting claims cannot stand (*see* Royal Warwick S.A. v Hotel Representative, Inc., 106 AD3d 451, 452, 965 NYS2d 409 [**1st** Dept 2013]). Nor has Peter alleged that he is a shareholder of either entity, which would give rise to the right to an accounting (*see* Seretis v Fashion Vault Corp., 110 AD3d 547, 548, 973 NYS2d 176 [**1st** Dept 2013], *lv denied* 22 NY3d 861, 995 NYS2d 1, 19 NE3d 869 [2014]).

The motion court properly dismissed the conversion claim, which alleges that Lisa used the funds of Whole Pies and its management company for her own personal purposes. **HN12**[↑] "A conversion takes place when someone, intentionally and without authority, assumes or exercises control over personal property belonging to someone else, interfering with that person's right of **[***21]** possession" (Colavito v New York Organ Donor Network, Inc., 8 NY3d 43, 49-50, 860 NE2d 713, 827 NYS2d 96 [2006]). The complaint fails to allege that Peter had any possessory interest in the corporate monies, and, in any event, such claim would belong to the **[*211]** companies, not Peter individually (*see* Ehrlich v Hambrecht, 19 AD3d 259, 259, 797 NYS2d 471 [**1st** Dept 2005]). To the extent Peter alleges that Lisa converted the funds Peter allegedly paid for Madeline's estate taxes, the complaint alleges no facts that would establish that Lisa exercised any control over such funds.

The claim for breach of the covenant of good faith and fair dealing fails, because there is no enforceable contract (*see* Randall's Is. Aquatic Leisure, LLC v City of New York, 92 AD3d 463, 463, 938 NYS2d 62 [**1st** Dept 2012], *lv denied* 19 NY3d 804, 969 NE2d 786, 946 NYS2d 567 [2012]; Guarino v North Country Mtge. Banking Corp., 79 AD3d 805, 807, 915 NYS2d 84 [2d Dept 2010]). Finally, the fraudulent inducement claim was properly dismissed because it alleges only an insincere promise of future performance under the oral contract (*see* Forty Cent. Park S., Inc. v Anza, 117 AD3d 523, 524, 985 NYS2d 543 [**1st** Dept 2014]).

We have considered the parties' remaining contentions and find them unavailing.

Accordingly, the order of Supreme Court, New York County (Eileen A. Rakower, J.), entered July 11, 2014, as amended by the order of the same court and Justice, entered August 5, 2014, which granted defendant's motion to dismiss the complaint, should be modified, on the **[****6]** law, to deny the motion as to the claims for promissory estoppel, and unjust enrichment to the extent indicated herein, and otherwise affirmed, **[***22]** without costs.

Tom, J.P., Saxe and Gische, JJ., concur.

Order, Supreme Court, New York County, entered July 11, 2014, as amended by order **[**519]** , entered August 5, 2014, modified, on the law, the motion denied as to the claims for promissory estoppel, and unjust enrichment to the extent indicated, and otherwise affirmed, without costs.

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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.

For Local 710 International Brotherhood of Teamsters, successor Chicago Truck Drivers, Helpers and Warehouse Workers Union, Defendant: Marvin Gittler, Stephen Jay Feinberg, Asher, Gittler, Greenfield, Cohen & D'Alba, Chicago, IL.

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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Clifford R. Gray, Inc. v. LeChase Constr. Servs., LLC

Supreme Court of New York, Appellate Division, Third Department

July 20, 2006, Decided; July 20, 2006, Entered

500048, 500049

Reporter
31 A.D.3d 983 *; 819 N.Y.S.2d 182 **; 2006 N.Y. App. Div. LEXIS 9478 ***; 2006 NY Slip Op 5850 ****

[**1]** Clifford R. Gray, Inc., Respondent-Appellant, v LeChase Construction Services, LLC, et al., Appellants-Respondents.

Subsequent History: [*1]**

Subsequent appeal at *Clifford R. Gray, Inc. v. LeChase Constr. Services, 2008 N.Y. App. Div. LEXIS 4021 (N.Y. App. Div. 3d Dep't, May 8, 2008)*

Counsel: Davidson, Fink, Cook, Kelly & Galbraith, L.L.P., Rochester (Fernando Santiago of counsel), for appellants-respondents.

McNamee, Lochner, Titus & Williams, P.C., Albany (Christopher Massaroni of counsel), for respondent-appellant.

Judges: Before: Crew III, J.P., Peters, Spain, Lahtinen and Kane, JJ. Crew III, J.P., Peters, Lahtinen and Kane, JJ., concur.

Opinion by: Spain

Opinion

[*983] [183]** Spain, J. Cross appeals (1) from an order of the Supreme Court (Kramer, J.), entered October 24, 2005 in Schenectady County which, inter alia, partially denied defendants' motion to compel disclosure, and (2) from an order of said court, entered January 26, 2006 in Schenectady County, which, inter alia, denied defendants' motion for summary judgment dismissing the complaint.

Plaintiff is an electrical and communications contractor that has provided services to the Knolls Atomic Power Laboratory (hereinafter KAPL) for more than 40 years. Defendants are affiliated business entities **[***2]** from the City of Rochester, Monroe County, that were seeking to win a **[**184]** contract for the design and **[*984]** construction of a building in the Town of Niskayuna, Schenectady County (hereinafter the project). After attending a meeting about the project, defendants learned of plaintiff's relationship with KAPL and the parties began to discuss plaintiff's potential involvement in the project. Plaintiff alleges that in September 2001, the parties reached an agreement, which plaintiff denominates an "exclusivity agreement." Pursuant thereto, plaintiff agreed to the following three conditions: (1) to refrain from participating with any other general contractors who were seeking the KAPL contract; (2) to refrain from sharing with any third party **[****2]** any documentation or drawings provided by defendants to plaintiff in connection with defendants' proposal; and (3) if defendants were not awarded the project, plaintiff would not deal in any manner with the successful contractor. Plaintiff alleges that in exchange for its agreement to these conditions, defendants promised to use plaintiff as the exclusive subcontractor for all electrical and teledata work if defendants were awarded the prime contract. **[***3]** The exclusivity agreement was never reduced to writing, nor did the parties execute a subcontract. Although plaintiff asserts that they agreed upon a contract form, it concedes that the parties never fully agreed on the details of a subcontract and agreed only that the outstanding details of the subcontract would be discussed if defendants were ultimately awarded the KAPL contract.

Plaintiff's estimators traveled from Schenectady County to Rochester to meet with defendants' design team in September 2001. During and subsequent to this meeting, information about the project and KAPL flowed mutually between the parties. Over the next few months, plaintiff submitted various bid proposals to defendants, who were ultimately awarded the contract. Notwithstanding the parties' alleged oral agreement to use plaintiff as the exclusive subcontractor for the electrical and teledata portions of the contract, defendants put those aspects of the contract out to competitive bidding, and plaintiff was not awarded the subcontract that it claims was due under the exclusivity agreement. Plaintiff thereafter commenced this action,

seeking damages for lost profits and other revenues it would have earned **[***4]** if it had been given the subcontract. Defendants moved for summary judgment dismissing the complaint and plaintiff cross-moved for summary judgment on liability. Following oral argument, Supreme Court denied both **[*985]** motions. Defendants and plaintiff cross appeal from that order [*] and both parties cross appeal from a separate order that partially granted a motion by defendants to compel plaintiff to respond to certain interrogatories.

The complaint in this action asserts five causes of action, sounding in **[***5]** breach of contract, promissory estoppel, unjust enrichment, equitable estoppel and fraud. For the reasons that follow, we conclude that only the second cause of action, asserting promissory estoppel, survives defendant's motion for summary judgment.

Defendant contends that the exclusivity agreement is unenforceable as a matter of law, and we agree. "It is well **[**185]** settled that a contract must be definite in its material terms in order to be enforceable" (*Spectrum Research Corp. v Interscience, Inc., 242 AD2d 810, 811, 661 NYS2d 871 [1997]*; *see Cobble Hill Nursing Home v Henry & Warren Corp., 74 NY2d 475, 482, 548 NE2d 203, 548 NYS2d 920 [1989]*, *cert denied 498 US 816, 112 L Ed 2d 33 [1990]*; *Marraccini v Bertelsmann Music Group, 221 AD2d 95, 97, 644 NYS2d 875 [1996]*, *lv denied 89 NY2d 809, 678 NE2d 502, 655 NYS2d 889 [1997])*. Thus, an "agreement to agree, in which a material term is left for future negotiations, is unenforceable" (*see Joseph Martin, Jr., Delicatessen v Schumacher, 52 NY2d 105, 109, 417 NE2d 541, 436 NYS2d 247 [****3] [1981]*; *Spectrum Research Corp. v Interscience, Inc., supra*; *Marraccini v Bertelsmann Music Group, supra*; *Bower v Atlis Sys., 182 AD2d 951, 952-953, 582 NYS2d 542 [***6] [1992]*, *lv denied 80 NY2d 758, 602 NE2d 1125, 589 NYS2d 309 [1992])*. Viewing the exclusivity agreement as defined by plaintiff, the parties agreed that if plaintiff refrained from having contact with any other contractor that was seeking the project, and if defendant was awarded the prime contract, the parties would enter into a subcontract for the electrical and teledata work on the project. This is merely an agreement to later agree upon the "precise nature of the work to be subcontracted, price and manner of payment and time of performance" (*Spectrum Research Corp. v Interscience, Inc., supra at 811*).

Plaintiff's contention that the pricing information for the subcontract is ascertainable by reference to the proposals that plaintiff submitted to defendant does not satisfy the requirement that the material terms of the agreement be definite. While it is true that application of the definiteness doctrine is **[*986]** not absolutely rigid (*see Matter of 166 Mamaroneck Ave. Corp. v 151 E. Post Rd. Corp., 78 NY2d 88, 91, 575 NE2d 104, 571 NYS2d 686 [1991]*; *Cobble Hill Nursing Home v Henry & Warren Corp., supra at 482-483*), there must be "an objective method for supplying a missing **[***7]** term" (*Matter of 166 Mamaroneck Ave. Corp. v 151 E. Post Rd. Corp., supra at 91*). Here, although the exclusivity agreement contemplates the parties' execution of a subcontract, that implicit provision cannot be viewed as a binding formula for supplying a missing term (*see Joseph Martin, Jr., Delicatessen v Schumacher, supra at 110-111*), nor does it "invite[] recourse to an objective extrinsic event, condition or standard" (*id. at 110*; *see Matter of 166 Mamaroneck Ave. Corp. v 151 E. Post Rd. Corp., supra* [agreement provided for arbitration]; *Cobble Hill Nursing Home v Henry & Warren Corp., supra* [agreement provided that price was to be determined by the Department of Health in accordance with applicable statutes, rules and regulations]). Rather, it requires further expressions by the parties and therefore fails to "reduc[e] uncertainty to certainty" (*Cobble Hill Nursing Home v Henry & Warren Corp., supra at 483*). To the extent that the bid proposals are utilized to determine pricing as a matter of commercial practice (*see Henri Assoc. v Saxony Carpet Co., 249 AD2d 63, 66, 671 NYS2d 46 [1998])*, **[***8]** the record is wholly devoid of evidence that defendant agreed to the prices proposed by plaintiff (*compare id.*; *see T. Moriarty & Son v Case Contr., 287 AD2d 390, 731 NYS2d 618 [2001])*. In sum, the exclusivity agreement that is the basis for plaintiff's first cause of action for breach of contract is unenforceable as a matter of law, and defendant's motion for summary judgment **[**186]** dismissing that cause of action should have been granted.

Plaintiff correctly contends that it is possible to state a cause of action for fraud in the inducement separate and apart from a claim for breach of the contract (*see*

[*] Defendants contend that defendant LeChase Data/Telecom Services, LLC and defendant LeChase Construction Corporation were uninvolved in the events giving rise to this action, and they sought summary judgment dismissing the complaint against them. Plaintiff did not oppose that request before Supreme Court, and does not oppose it upon appeal. Accordingly, it will be granted. Therefore, further references to defendant in this decision shall pertain to the remaining defendant, LeChase Construction Services, LLC.

Deerfield Communications Corp. v Chesebrough-Ponds, Inc., 68 NY2d 954, 956, 502 NE2d 1003, 510 NYS2d 88 [1986]; *Sabo v Delman, 3 NY2d 155, 162, 143 NE2d 906, 164 NYS2d 714 [1957])*. To the extent, however, that plaintiff's fifth cause of action may be construed as such, it must also be dismissed because there can be no viable claim for fraudulent inducement to enter an unenforceable contract (*see Held v Kaufman, 91 NY2d 425, 431-432, 694 NE2d 430, 671 NYS2d 429 [1998])*.

Plaintiff's second cause of action asserts a claim sounding in promissory estoppel. A party relying upon promissory estoppel must demonstrate **[***9]** that there was a clear and unambiguous promise upon which it reasonably and detrimentally relied (*see Bunkoff Gen. Contrs. v Dunham Elec., 300 AD2d 976, 978, 753 NYS2d 156 [2002]*; *Fourth Branch Assoc. Mechanicville v Niagara Mohawk Power Corp., 235 AD2d 962, 964, 653 NYS2d 412 [1997]*; *Freedman & Son v A.I. **[*987]** Credit Corp., 226 AD2d 1002, 1003, 641 NYS2d 429 [1996])*. Plaintiff has submitted evidence in admissible form that defendants promised to give plaintiff the project subcontract, and that plaintiff refrained from working with other general contractors who were seeking the project in reliance on that alleged but ultimately unfulfilled promise. Defendants submit evidence that they never promised plaintiff the **[****4]** subcontract, and that plaintiff did, in fact, seek to work with another general contractor who was pursuing the project. Clearly, the parties' submissions create issues of material fact regarding whether defendant made the alleged promise and whether plaintiff reasonably relied thereon, and Supreme Court properly denied the motions for summary judgment on the promissory estoppel cause of action.

Plaintiff's fourth cause of action sounds in equitable **[***10]** estoppel. In support of the cause of action, plaintiff alleges facts similar to those underlying its promissory estoppel claim, along with allegations of the scienter that is an element to be established by a party seeking equitable estoppel (*see Michaels v Travelers Indem. Co., 257 AD2d 828, 829, 683 NYS2d 640 [1999]*; *State Bank of Albany v Fioravanti, 70 AD2d 1011, 1012-1013, 418 NYS2d 202 [1979]*, *affd 51 NY2d 638, 417 NE2d 60, 435 NYS2d 947 [1980])*. The fundamental and fatal flaw in this cause of action is plaintiff's demand for money damages upon it; equitable estoppel is invoked to prohibit a party from engaging in certain conduct (*see e.g. Matter of Hession v New York State & Local Employees' Retirement Sys., 24 AD3d 1008, 1010, 806 NYS2d 281 [2005]* [the petitioner sought to equitably estop the respondent from denying tier 1 retirement status]; *Doe v Holy See [State of Vatican City], 17 AD3d 793, 794-795, 793 NYS2d 565 [2005]*, *lv denied 6 NY3d 707, 845 NE2d 1274, 812 NYS2d 443 [2006]* [the plaintiffs sought to estop the defendants from asserting statute of limitations defense]; *Matter of Sarah S. v James T., 299 AD2d 785, 751 NYS2d 61 [2002]* [equitable estoppel **[***11]** invoked to prevent denial of paternity]; *McKay v Healthcare Underwriters Mut. Ins. Co., 295 AD2d 686, 688, 743 NYS2d 593 [2002]*, *lv denied 99 NY2d 503, 783 NE2d 896, 753 NYS2d 806 [2002]* [equitable estoppel sought to prevent denial of insurance coverage]). Here, because plaintiff does not seek the type of remedy that would be available upon a successful **[**187]** invocation of equitable estoppel, the fourth cause of action should have been dismissed. To the extent that equity may provide plaintiff with a remedy in damages in this particular case, plaintiff's avenue of recovery rests on its promissory estoppel claim (*see Bunkoff Gen. Contrs. v Dunham Elec., supra at 976-977*).

Plaintiff's third cause of action generally alleges that defendant was unjustly enriched by plaintiff's experience with KAPL as well as plaintiff's direct contributions to defendant's successful proposal for the prime contract. A cause of action for unjust **[*988]** enrichment requires a showing that (1) the defendant was enriched, (2) at the expense of the plaintiff, and (3) that it would be inequitable to permit the defendant to retain that which is claimed by the plaintiff (*see* **[***12]** *Cruz v McAneney, 29 AD3d 512, 512, 813 NYS2d 671 [2006]*; *Mente v Wenzel, 178 AD2d 705, 706, 577 NYS2d 167 [1991])*. The essence of such a cause of action is that one party is in possession of money or property that rightly belongs to another (*see Paramount Film Distrib. Corp. v State of New York, 30 NY2d 415, 421, 285 NE2d 695, 334 NYS2d 388 [1972]*, *cert denied 414 US 829, 38 L Ed 2d 64 [1973]*; *Town of Butternuts v National Grange of Patrons of Husbandry, 20 AD3d 637, 798 NYS2d 773 [2005]*; *George S. May Intl. Co. v Thirsty Moose, Inc., 19 A.D.3d 721, 796 NYS2d 196 [2005]*; *Anesthesia Group of Albany v State of New York, 309 AD2d 1130, 1131-1132, 766 NYS2d 448 [2003]*; *Mente v Wenzel, supra*). Here, plaintiff's submissions on the parties' competing motions for summary judgment make only conclusory allegations that defendant benefitted from plaintiff's involvement in the bid formulation process, and plaintiff asserts no facts suggesting that defendant is in possession of money or property belonging to plaintiff. Thus, there is no issue of fact requiring a trial on this cause of action (*see Hamlin Beach Camping, Catering, & Concessions Corp. v State*

of New York, 303 AD2d 849, 853, 756 NYS2d 354 ***[***13]*** *[2003]*; *Absher Constr. Corp. v Colin, 233 AD2d 279, 280, 649 NYS2d 174 [1996])*, and defendant's motion for summary judgment dismissing plaintiff's cause of action for unjust enrichment should have been granted.

Turning to defendant's appeal and plaintiff's cross appeal from Supreme Court's order addressed to defendant's discovery motion, it is well settled that the trial court has broad **[****5]** discretion in supervising discovery (*see Bohlke v General Elec. Co., 27 AD3d 924, 810 NYS2d 583 [2006]*; *Mora v RGB, Inc., 17 AD3d 849, 851, 794 NYS2d 134 [2005]*; *Di Mascio v General Elec. Co., 307 AD2d 600, 601, 762 NYS2d 696 [2003])*. Upon our review of the record and supplemental record, we find that the order directing and conditioning plaintiff's disclosure of certain allegedly confidential information upon the execution of a court-approved confidentiality agreement and denying other aspects of defendant's motion to compel disclosure was rendered well within the bounds of Supreme Court's discretion. Further, in the context of this protracted and contentious discovery dispute, we find no merit in defendant's contention that plaintiff waived its objections to defendant's **[***14]** demands for interrogatories.

Crew III, J.P., Peters, Lahtinen and Kane, JJ., concur. Ordered that the order entered October 24, 2005 is affirmed, without costs. Ordered that the order entered January 26, 2006 is modified, on the law, without costs, by reversing so much thereof as **[*989]** denied defendants' motion for summary judgment (1) dismissing the complaint against defendants LeChase Data/Telecom Services, LLC and LeChase **[**188]** Construction Corporation and (2) dismissing the first, third, fourth and fifth causes of action against defendant LeChase Construction Services, LLC; motion granted to that extent, summary judgment awarded to defendants and all causes of action dismissed except the second cause of action which remains against LeChase Construction Services, LLC only; and, as so modified, affirmed.

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Columbia Mem. Hosp. v Hinds

Supreme Court of New York, Columbia County

September 3, 2019, Decided

14064-19

Reporter
2019 N.Y. Misc. LEXIS 5072 *; 2019 NY Slip Op 51508(U) **; 65 Misc. 3d 1205(A); 2019 WL 4620674

[1]** The Columbia Memorial Hospital, Plaintiff, against Marcel E. Hinds, M.D., Defendant.

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

Counsel: **[*1]** For Plaintiff: Anthony Prinzivalli, Esq., of counsel, Kevin G. Donoghue, Esq., of counsel, Garfunkel Wild, P.C., Great neck, New York.

For Defendant: Seth A. Nadel, Esq., of counsel, Weiss Zarett Brofman Sonnenklar & Levy, P.C., New Hyde Park, New York.

Judges: Henry F. Zwack, Acting Supreme Court Justice.

Opinion by: Henry F. Zwack

Opinion

Henry F. Zwack, J.

Pending before the Court is a motion to dismiss the complaint in this action filed by defendant Marcel E. Hinds, M.D., and for declaratory judgment. The defendant alleges that dismissal is required pursuant to *CPLR 3211(a)(1)* and *CPLR 3211(a)(7)*; and an order pursuant to *CPLR 3001* declaring that he is legally entitled to cash consideration in the amount of $412,418.93 arising from the demutualization of Medical Liability Mutual Insurance Company ("MLMIC"). The plaintiff opposes.

The dispute arises out of the sale and demutualization of MLMIC, a mutual insurance company formed and existing under New York Law, which plan was approved by the Department of Financial Services ("DFS") on September 6, 2018. The DFS Decision confirmed, on pages 4, 23 (affirmation of Seth Nadel, Exhibit "A") that it is in the *Insurance Law 7307 (e)(3)* which explicitly defines those policyholders who are **[**2]** eligible to receive the purchase price consideration." **[*2]**

In connection with the demutualization, certain sums of money were to be paid to the policyholders (physicians) who were the mutual owners of MLMIC during the statutory eligibility period prior to the sale. An objection procedure was put in place (and later extended) by MLMIC where certain employers of eligible physician policyholders were given the right to object to the cash distribution, to the extent the employer believed that it, and not the physician, was entitled to the funds. The plaintiff is the former employer of the defendant, and submitted an objection and commenced this action seeking a determination of its right to the cash contribution presently held in escrow.

According to the complaint, the $412,418.93 in dispute represents what the plaintiff paid to MLMIC for professional liability insurance on behalf of the defendant from July 15, 2013 to July 15, 2016. The complaint sets out four causes of action: declaratory judgment, unjust enrichment, money had and received, and breach of implied covenant of good faith and fair dealing. The plaintiff alleges that it is entitled to the MLMIC funds, currently being held in escrow, because it alone paid for the policies, administered **[*3]** and controlled them as the designated Policy Administrator, was always the beneficiary of any dividends, rebates or refunds under the policies, and because the defendant has no rights to receive any additional monies following his separation from the plaintiff hospital. The defendant has refused to sign the Assignment Agreement, requested by the plaintiff in order for the escrow funds to be turned over to it. The plaintiff argues that allowing the defendant to receive and retain the MLMIC funds would result in his unjust enrichment. The complaint alleges that the defendant has already received all that he is entitled to under his employment agreement.

In lieu of an answer, the defendant has moved to dismiss the complaint on the grounds that the complaint fails to state a cause of action, and on the basis that the

claims fail due to documentary evidence.

The defendant argues he is entitled to the cash proceeds under the authority which governs the demutualization, the Plan of Conversion of Medical Liability Mutual Insurance Company adopted on May 31, 201, and *Insurance Law 7307*. The Plan provided that policyholders, or their designees would be provided with cash consideration for their membership interest **[*4]** according to the premiums timely paid under their eligible policies. The Plan further provided that the cash consideration was to go directly to the policyholder unless they had affirmatively **[**3]** designated a policy administrator to receive the benefit—the affirmative designation is the only instance in which the policy administrator could receive the cash consideration payable to the policyholder. The defendant asserts that he is the policyholder (as demonstrated on the policy declarations page supplied by defendant); he did not sign an Assignment Agreement (although asked to do so on at several occasions); and the plaintiff is not entitled to receive any of the cash consideration. The defendant explains that according to his Employment Agreement, at Section 3 (b) — which is attached as an Exhibit to his affidavit — he actually paid the premiums, as the plaintiff deducted the amounts it paid for his malpractice insurance from his incentive compensation. The policy administrator designation served only to appoint the plaintiff as the defendant's agent for the purposes of managing the policy, and to receive dividends to offset the cost of the policy. The defendant argues that the cash consideration **[*5]** is not a dividend or return premium as 1099 forms were sent to policyholders that confirm the proceeds arose from the sale of stock.

In opposition, the plaintiff argues that the defendant's dismissal motion is improper, by utilizing affidavits to establish "facts" rather than just to introduce documentary evidence. According to the plaintiff, there is a bona fide dispute which must be determined by the court. The plaintiff argues that the complaint should not be dismissed because there is a binding decision from the Appellate Division on point in this case. In *Shaeffer, Schonholtz & Drossman, LLP v Title, 171 AD3d 465, 465, 96 N.Y.S.3d 526 [1st Dept 2019]* the Court found that despite respondent being named as the policyholder, appellant had paid all the premiums and all the costs related to the policy and there was no record of bargaining for the benefit of the demutualization proceeds, so "awarding respondent with the cash proceeds of the MLMIC's demutualization would result in unjust enrichment." The plaintiff argues that this is the situation here — Dr. Hinds did not pay any of the premiums for the insurance, and awarding him the funds from the demutualization results in unjust enrichment. The plaintiff also argues that stare decisis applies, and this Court must follow the **[*6]** determination made by the First Department. Stare decisis provides that once a court has resolved a legal issue, it should not be re-examined each and every time it is presented *(Battle v State, 257 AD2d 745, 682 N.Y.S.2d 726 [3d Dept 1999])*.

For the reasons that follow the Court grants the defendant's motion to dismiss the plaintiff's complaint.

Here, the Court is mindful, on a motion to dismiss pursuant to **[**4]** *CPLR 3211*, it must "accept the facts as alleged in the complaint as true, according the plaintiffs the benefit of every possible favorable inference, and determine only whether the facts as alleged fit within any cognizable legal theory" (*Leon v Martinez, 84 NY2d 83, 87-88, 638 N.E.2d 511, 614 N.Y.S.2d 972 [1994]*). "[A]llegations consisting of bare legal conclusions as well as factual claims flatly contradicted by documentary evidence are not entitled to consideration" (*Mass v Cornell University, 94 NY2d 87,91, 721 N.E.2d 966, 699 N.Y.S.2d 716 [1999]*).

Insurance Law 7307 governs the process by which MLMIC was converted from a mutual insurance company into a stock insurance company. *Insurance Law 7307 (e) (3)* provides in pertinent part that "each person who had a policy of insurance in effect at any time during the three year period immediately proceeding the date of the adoption of the resolution shall be entitled to receive in exchange for such equitable share, without additional payment, consideration payable in voting shares of the insurer or other **[*7]** consideration, or both." The statute repeatedly refers to those eligible for cash consideration as the "policyholder." It is important to note that "[n]o distinction is made between a policyholder who pays the premium out of his own pocket versus a policyholder whose employer pays the premium as part of an employee compensation package. *Insurance Law 7307* does not confer an ownership interest...on anyone other than the policyholder" (*Maple-Gate Anesthesiologists, P.C. v Nasrin, 63 Misc 3d 703, 709, 96 N.Y.S.3d 837 [Sup Ct, Erie County, 2019]*).

Here, the defendant is clearly the policyholder, and the plaintiff the policy administrator. The documentary evidence — the Employment Agreement — establishes that the insurance premiums were deducted before the

defendant received any incentive pay. That is, the defendant was to receive incentive pay, 65% of the amount by which his revenue exceeded the expenses paid by the hospital, and one the expenses being his medical malpractice insurance. Stated differently, the defendant would not receive incentive pay until the revenue generated by his services exceeded the amount of his medical malpractice insurance. Further, under the plain language of the Insurance Law, the cash consideration cannot be given to the plaintiff unless the defendant signs the agreement to do so. **[*8]** Here, the defendant has not signed such an agreement, and given the circumstances of this case — the Employment Agreement which required him to pay the cost of his malpractice premiums by way of his salary incentives — does not have to agree to do so.

The plaintiff's entire argument, as framed by the complaint, **[**5]** focuses on the bare and incorrect assertion that the hospital paid the policy premiums and that equity, not ownership, dictates that it should be the recipient of the cash contribution. However viewed, this assertion is belied by the terms of the Employment Agreement, whereby the defendant's incentive compensation is reduced by the policy premiums. On this record, equity does not dictate that the plaintiff should be compensated.

Nor has the plaintiff demonstrated that the defendant has been unjustly enriched. Unjust enrichment, also known as an action for money had or received, or implied contract (*Federal Ins. Co. v Groveland State Bank, 37 NY2d 252, 258, 333 N.E.2d 334, 372 N.Y.S.2d 18 [1975]*), arises when a plaintiff demonstrates "that (1) the other party was enriched, (2) at (the plaintiff's) expense, and (3) that it is against equity and good conscience to permit the other party to retain what is sought be recovered" (*New York State Worker's Compensation Bd. v Program Risk Mgt, Inc., 150 AD3d 1589, 1594, 55 N.Y.S.3d 790 [3d Dept 2017]*). Given that the plaintiff received the defendant's **[*9]** services in exchange for compensation — which was reduced by the cost of the premium payments made on the defendant's behalf by the plaintiff — there is simply no merit to the plaintiff's claim of unjust enrichment.

"The implied covenant of good faith and fair dealing between parties to a contract embraces a pledge that neither party shall do anything which will have the effect of destroying or injuring the right of the other party to receive the fruits of the contract" (*Moran v Erk, 11 NY3d 452, 456, 901 N.E.2d 187, 872 N.Y.S.2d 696 [2008]*, internal citations and quotations omitted). In all likelihood neither party appreciated that a windfall could occur as a result of the MLMIC sale, because, quite simply, they did not appreciate the meaning and the value of an ownership stake prior to the demutualization plan (*Urgent Medical Care PLLC v Amedure, 64 Misc 3d 1216[A], 2019 NY Slip Op 51188[U] [Sup Ct, Greene County 2019]*) . It cannot therefore be said that this cash contribution was negotiated or bargained for, but is simply rather an operation of law, and therefore no one's interest in the actual contract was compromised. 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.

Contrary to plaintiff's arguments **[*10]** that *Shaeffer, Schonholtz & Drossman, LLP v Title, 171 AD3d 465, 465, 96 N.Y.S.3d 526 [1st Dept 2019]* controls, this case is not entitled to stare decisis treatment. The doctrine of stare decisis clearly exists to provide guidance and consistent results in cases that share essentially the same facts (*Matter of Howard Johnson Co. v State Tax Commn., 65 NY2d 726, 727, 481 N.E.2d 551, 492 N.Y.S.2d 11[1985]*). It does not apply where, as here, the facts are not the same. Here, like the defendant Nasrin in *Maple-Gate Anesthesiologists (63 Misc 3d 703, 96 N.Y.S.3d 837*) the defendant's insurance premiums were paid in lieu of compensation (Nasrin received her **[**6]** malpractice insurance as part of her employee compensation plan, and the Court awarded the cash contribution to her). That being said, it is equally well established that courts are free to correct prior erroneous interpretations of the law (*Matter of Charles A. Field Delivery Serv. (Roberts), 66 NY2d 516, 488 N.E.2d 1223, 498 N.Y.S.2d 111 [1985]*).

Finally, the plaintiff's complaint itself is some what of a 'ticking time-bomb." Paragraph 10 affirmatively provides the following: "The Hospital compensated Defendant for his services with a 'Base Salary' plus ***incentive compensation***, on call compensation, and afforded him the ***full panoply of benefits, including payment of premiums for medical malpractice insurance***..." There is no other way to read this than for it to mean that the defendant's medical malpractice insurance premiums were a part of his employee compensation plan. As to the Employee Agreement **[*11]** itself, at Article 9 it reads that the hospital "shall maintain an individual occurrence -based medical malpractice policy in the minimum amounts required....and provide you with evidence of same upon request." Following the determination in *Maple-Gate Anesthesiologists* (63Misc 3d 703), the Court dismisses the plaintiff's complaint.

Accordingly, it is

ORDERED, the defendant Marcel Hinds M.D.'s motion to dismiss is granted, and the plaintiff's complaint is dismissed, and it is further

ORDERED, that the defendant Hinds is entitled to the $412,418.93 arising from the sale and demutualization of Medical Liability Mutual Insurance Company, and the funds are to be dispersed accordingly.

This constitutes the Decision and Order of the Court. This original Decision and Order is returned to the attorneys for the defendant. All other papers are delivered to the Supreme Court Clerk for transmission to the County Clerk. The signing of this Decision and Order shall not constitute entry or filing under *CPLR 2220*. Counsel is not relieved from the applicable provisions of this rule with regard to filing, entry and Notice of Entry.

Dated: September 3, 2019

Troy, New York

Henry F. Zwack

Acting Supreme Court Justice

Dolman v. United States Trust Co.

Court of Appeals of New York

October 2, 1956, Argued ; November 15, 1956, Decided

No Number in Original

Reporter
2 N.Y.2d 110 *; 138 N.E.2d 784 **; 157 N.Y.S.2d 537 ***; 1956 N.Y. LEXIS 649 ****

Robert Dolman, Respondent, v. United States Trust Company of New York, as Trustee under the Will of Eugene Higgins, Deceased, Appellant

Prior History: [**1]** Dolman v. United States Trust Co. of N. Y., 1 A D 2d 809, reversed.

Appeal from a judgment of the Appellate Division of the Supreme Court in the first judicial department, entered March 2, 1956, affirming, by a divided court, a judgment of the Supreme Court in favor of plaintiff, entered in New York County upon a decision of the court at a Trial Term (S. Samuel Di Falco, J.), without a jury.

Disposition: Judgments reversed, etc.

Counsel: *Williams S. Gaud* and *John P. Allee* for appellant. **[****4]** Defendant has breached no duty it owed plaintiff. (*Matter of City of New York* [*Ely Ave.*], 217 N. Y. 45; Bacon v. Miller, 247 N. Y. 311; Mawhinney v. Millbrook Woolen Mills, 231 N. Y. 290; Kip v. New York & Harlem R. R. Co., 67 N. Y. 227; Goodyear Shoe Mach. Co. v. Boston Term. Co., 176 Mass. 115.)

Milton M. Bergerman and *Joseph Calderon* for respondent. I. The finding that defendant induced and co-operated in the condemnation for the purpose of ending plaintiff's possessory rights has been affirmed by the Appellate Division and may not be reviewed in this court, and accords with the evidence. II. Defendant breached its covenant granting plaintiff quiet enjoyment of the leased premises. (Mack v. Patchin, 42 N. Y. 167; Ganz v. Clark, 252 N. Y. 92; Snow v. Pulitzer, 142 N. Y. 263; Williams v. Getman, 114 App. Div. 282; Lindwall v. May, 111 App. Div. 457; Edesheimer v. Quackenbush, 68 Hun 427; *Matter of City of New York* [*191 E. Houston St. Realty Corp.*], 194 Misc. 124; *Al's 334 9th Ave. Corp. v. Herbener, 275 App. Div. 904*; Matter of O'Donnell, 240 N. Y. 99; Fifth **[****5]** Ave. Bldg. Co. v. Kernochan, 221 N. Y. 370; Times Square Improvement Co. v. Fleischmann Vienna Model Bakery, 173 App. Div. 633.)

Judges: Dye, Froessel and Burke, JJ., concur with Conway, Ch. J.; Fuld, J., concurs in result; Desmond, J., dissents in an opinion in which Van Voorhis, J., concurs.

Opinion by: CONWAY

Opinion

[*112] [784] [***538]** This action was brought to recover damages for an alleged breach of the covenant of quiet enjoyment contained in the lease **[**785]** between the defendant as landlord and the plaintiff as tenant. It is claimed that the landlord breached the covenant by its inducement of and co-operation in the condemnation of the leased premises by the City of New York, resulting in the eviction of the plaintiff at the end of two years of the five-year term of the lease. Trial Term awarded plaintiff damages and the Appellate Division affirmed, two Justices dissenting.

Plaintiff first took possession of the land in question in 1941 from the then owner, Eugene Higgins. In 1947 the premises began to be used as a parking lot, plaintiff subletting the property to one Kane. Higgins died in 1948 and defendant, as testamentary trustee, took title **[****6]** to the property. After the expiration of plaintiff's lease on May 1, 1949, defendant began negotiations for the sale of the property with the City of New York, the Board of Education having notified the Board of Estimate that the property was desired for a public school playground. That communication of the Board of Education was on the Board of Estimate's calendar of December 8, 1949, and the matter was then referred to the City Planning Commission, the director of real estate, and the director of the budget for report. Desultory negotiations then followed with nothing being accomplished. On or about January 22, 1952, the defendant trustee had discussions concerning the status of the property with members of its own organization and its attorneys. At that time it was pointed out in the discussion that it might be a year or two before the city

would acquire it, and that, therefore, rather than operate the property at a substantial **[***539]** loss, the defendant, as trustee, was obligated to secure the best price by waiting and, in the meantime, to enter into a lease with the tenant which would pay real estate taxes and insurance. The result was that on March 6, 1952 defendant **[****7]** notified the city that it intended to enter into a lease and inquired as to the city's interest. Negotiations then broke off. Thereafter, on April 29, 1952, plaintiff, with knowledge of the foregoing negotiations, and defendant entered into a lease, which contained, among others, the following two clauses:

"Sixth: Should the hereby demised premises or any part thereof be condemned for public use, then and in that event, **[*113]** upon the condemnation of the same for such public use, this lease shall at the option of the Landlord become null and void and the term cease with the same force as if the term herein had fully expired on the date when possession shall be required, anything herein contained to the contrary notwithstanding. The Tenant shall not be entitled to any part of the award or to any apportionment thereof."

"Twelfth: The said Landlord doth covenant that the said Tenant on paying the said rent and performing the covenants aforesaid, shall and may peaceably and quietly have, hold and enjoy the said demised premises for the term aforesaid."

On January 20, 1953, the city contacted the defendant to inquire whether it would be willing to sell the property. This resumption **[****8]** of negotiations was commenced by the city as a result of the pressure brought by various civic groups to acquire the property for playground purposes in conjunction with Public School 75. The defendant, in view of the continuing operating loss, obtained an appraisal of the property, which was $ 132,000. In February of 1953, the city offered $ 135,000, which the defendant accepted and on March 16, 1953 defendant sent the city a copy of the proposed contract of sale along with a copy of the outstanding lease to the plaintiff. On March 18th, the city rejected the contract as drawn and returned the copy of the lease, stating that inasmuch as the property was to be used for a playground it must be free and clear of any incumbrances. The city then introduced the defendant, for the first time, to an agreement whereby the **[**786]** city would be given an option to purchase any condemnation award to which the defendant would be entitled upon condemnation. Such procedure is specifically authorized in section B15-30.0 of the Administrative Code of the City of New York, which section appears in title B of chapter 15 of the Administrative Code entitled "*Consolidated Condemnation Procedure* **[****9]** ". The agreement proposed by the city, which was entered into, provided that the city could purchase the assignment of the award for $ 135,000. On December 17, 1953, the Board of Estimate held a meeting and at that time unanimously resolved to authorize the corporation counsel's office to institute condemnation **[***540]** proceedings and exercised the option to purchase the award in condemnation. The minutes of this meeting of the Board of Estimate clearly disclose that the acquisition of the property **[*114]** was for a "much sorely-needed playground." The condemnation authorized also took in three other damage parcels adjacent to the parking lot, one of which was owned by a party other than the defendant. In April, 1954 title vested and the city applied in the Supreme Court for an order condemning the premises, and on April 30, 1954 an order granting such relief was made and entered in the New York County Clerk's office.

Plaintiff then sued defendant for breach of the covenant of quiet enjoyment contained in the lease alleging: "17. The defendant wrongfully induced the City of New York to acquire the premises by condemnation in violation of the covenant of quiet enjoyment **[****10]** contained in the lease between the plaintiff and the defendant."

In answering defendant's demand for a bill of particulars, the plaintiff stated that: "7. The defendant's acts, which induced the City of New York to acquire the premises by condemnation, were the option to sell to the city for $ 135,000 any award to which defendant would be entitled on condemnation of the premises and such other of defendant's acts relating to said option, of which the plaintiff has no personal knowledge * * *."

As we view the case, the fundamental issue presented is whether the landlord breached the covenant of quiet enjoyment by co-operating with the city to the extent of granting the city an option, pursuant to section B15-30.0 of the Administrative Code, to purchase for $ 135,000 its rights in the condemnation award in the event that the city thereafter condemned the property. We think it did not.

A covenant of quiet enjoyment is not breached by the landlord when the tenant is evicted by the sovereign's exercise of its power to take by eminent domain, inasmuch as such a covenant goes only to the lessor's title, and does not warrant against those fundamental liabilities to action on the part of **[****11]** the sovereign

power which lie behind all private titles (see *Goodyear Shoe Mach. Co. v. Boston Term. Co., 176 Mass. 115*, per Holmes, Ch. J.). The rights of the lessee in the land owned by the lessor are held as the property of all citizens is held, subject to the exercise of the power of eminent domain by the sovereign and the exercise of that power by the sovereign does not constitute a breach of the covenant of quiet enjoyment by the landlord (see *Kip v. New York & H. R. R. Co., 67 N. Y. 227, 229)*.

[*115] **[***541]** In the present case no one can deny that the tenant was evicted by reason only of the exercise of the sovereign power of eminent domain and not by reason of the option given to the city by the landlord. The grant by the landlord of the option to purchase its rights in the condemnation award, in the event that the city thereafter condemned the property, did not constitute an interference by the landlord with the tenant's possessory rights, did not accomplish an eviction of the tenant and did not lead necessarily or inevitably **[**787]** to an eviction of the tenant by the sovereign. The tenant's possessory rights were not interfered with or destroyed **[****12]** until the land in question was subsequently condemned. Nor did the grant of the option to the city empower or enable the city to evict the tenant. The power of eminent domain possessed by the city, and through which the tenant was evicted, was not in any wise dependent upon the city's obtaining an option from the landlord. It is true that by granting the option the landlord "cooperated" with the city, that is, the landlord assisted the city by placing it in a position to know, in advance, the cost to it of acquiring the landlord's property by eminent domain. However, before holding that that type of co-operation creates an exception, in favor of the tenant, to the rule that an eviction resulting from the exercise of the sovereign power of eminent domain does not render a landlord liable for a breach of the covenant of quiet enjoyment, we would have to find some clear expression of intention to that effect in the lease. This must be, for to hold that the giving of the option to purchase renders the landlord guilty of a breach of the covenant of quiet enjoyment would be to render ineffective the legislative action in enacting section B15-30.0 of the Administrative Code in every **[****13]** case where there is present a leasehold interest. No property owner would be willing to follow such procedure for he would be buying himself a potential lawsuit brought by his leaseholding tenants. A great portion of New York City property is under lease and to put an end to or impair this common practice of the city, which serves the useful function of enabling the city to ascertain, with a reasonable degree of certainty, the amount of money which will have to be expended in order to obtain the parcels of land which it seeks, would be to cause great harm to the city.

We find no such clear expression of intention to that effect in the lease before us.

[*116] In paragraph "SIXTH" of the lease the parties expressly agreed that in the event of condemnation the "lease shall at the option of the Landlord become null and void and the term cease with the same force as if the term * * * had fully expired on the date when possession shall be required, anything herein contained to the contrary notwithstanding." The lease itself does not define what is meant by condemnation. Nevertheless, it is basic that, unless a contract provides otherwise, the law **[***542]** in force at the time **[****14]** the agreement is entered into becomes as much a part of the agreement as though it were expressed or referred to therein, for it is presumed that the parties had such law in contemplation when the contract was made and the contract will be construed in the light of such law (see 17 C. J. S., Contracts, § 330). Applying that rule of construction to the facts of this case, if the procedure followed by the defendant in our present case is considered to be condemnation or a mode of condemnation, which the city is authorized to follow by the Administrative Code of the City of New York, then the plaintiff in agreeing to the lease must be presumed to have agreed to lose any leasehold interest which he possessed when the provided-for statutory methods of condemnation were employed. As we stated earlier, the procedure followed by the city and the defendant, i.e., the purchase of the award, is specifically set forth in section B15-30.0 of the Administrative Code, which section appears in title B of chapter 15 of the Administrative Code entitled "*Consolidated Condemnation Procedure*", and clearly must be considered to be a mode of the procedure of condemnation. Therefore, the city in arranging **[****15]** for the purchase of the award was actually following a mode of condemnation.

The tenant specifically agreed *in unambiguous terms* that in the event of condemnation the lease should become null and void at the option of the landlord and that he, the tenant, would not be entitled **[**788]** to any part of the condemnation award. Condemnation took place and the lease was terminated. By the present action the tenant seeks to avoid the effect of his agreement that he would not be entitled to any part of the condemnation award. In answer to that attempt, we can only repeat that the tenant's eviction was the result

of the sovereign's exercise of its power to take by eminent domain and that a covenant of quiet enjoyment is not breached by the landlord **[*117]** when the tenant is evicted by such exercise. There is no forfeiture by the tenant of any interest save that to which he has agreed and to which he must be held.

For the foregoing reasons, we conclude that the defendant did not breach the covenant of quiet enjoyment and that the complaint should be dismissed.

The judgment of the Appellate Division and that of Trial Term should be reversed and the complaint dismissed, with **[****16]** costs to appellant in all courts.

Dissent by: DESMOND

Dissent

Desmond, J. (dissenting). Plaintiff's judgment for damages is based on a Trial Term finding, affirmed by the Appellate Division, that the appellant breached a covenant of quiet enjoyment contained in a lease by defendant to plaintiff of vacant land in New York City used by plaintiff as a parking lot. The **[***543]** lease by its terms ran for five years from May 1, 1952, but on May 1, 1954 plaintiff was deprived of all rights under the lease when the City of New York acquired the premises in condemnation proceedings. The facts hereinafter set forth in more detail justified the trial court's finding that defendant itself had induced and brought about the condemnation proceeding. It can hardly be doubted that a landlord who leases land for a term of years and then turns around and makes an arrangement such as is hereinafter described and whereby the tenant is ousted, violates both the letter and the spirit of the quiet enjoyment covenant. That covenant in the lease under consideration read as follows: "The said Landlord doth covenant that the said Tenant on paying the said rent and performing the covenants aforesaid, shall and **[****17]** may peaceably and quietly have, hold and enjoy the said demised premises for the term aforesaid."

Plaintiff's occupancy of this land began in 1941. In 1947 he took from the then owner, one Higgins, a two-year lease. Higgins died in 1948 and defendant as a testamentary trustee took title to the premises. During the term of that earlier or 1947 lease New York City officials had shown some interest in the possible purchase of the land for use as a playground appurtenant to an adjoining public school. Defendant trustee, after it took title, had some inconclusive negotiations with the city authorities looking to such a sale but, when these did not come to a head, defendant, as of May 1, 1952, made the lease above referred to with plaintiff who had remained in possession **[*118]** without a lease from 1949 to 1952. In January, 1953, 9 or 10 months after the making of the second lease containing the quiet enjoyment covenant, the city inquired from defendant whether the property was for sale and, when defendant replied that it was, the city in March, 1953 made an offer to purchase it for $ 135,000, a little more than the amount of an appraisal which had been made for defendant. Defendant **[****18]** indicated agreement, sent to the city a proposed contract of sale at that price, and notified the city that the sale would be subject to plaintiff's lease. The city replied that it could not sign the contract unless and until defendant obtained a release of the rights of this plaintiff as tenant. Defendant did nothing toward getting such a release. Next, the city notified defendant that the city would be agreeable to an arrangement whereby the city would obtain title through condemnation proceedings but would be given, by defendant, an option to purchase for **[**789]** $ 135,000 an assignment of the award that would be made to defendant in the condemnation proceedings. That arrangement was carried out completely with the result that the city acquired the property for the price of $ 135,000 as originally agreed upon. But the tenant lost all its rights to occupancy or compensation since his 1952 lease contained a provision that if the leased premises should be taken **[***544]** by condemnation, the lease should terminate as if its term had expired, and that the tenant in that event should not be entitled to any part of the condemnation award.

There is no claim here that the arrangement **[****19]** voluntarily made between defendant and the city was invalid as between those two parties (see Administrative Code of City of New York, § B15-30.0). The theory on which plaintiff has recovered is that regardless of such validity the landlord breached the lease and violated plaintiff's rights by co-operating in and agreeing to an arrangement (which the landlord did not have to make) whereby there was a sale of the property at a previously agreed price with complete destruction of the tenant's rights, even though the arrangement took the form of a condemnation proceeding with a prior agreement that the owner's award should be sold back to the city at a price agreed on in advance. "The main object of a covenant for quiet enjoyment is to protect the lessee from the lawful claims of third persons having a title paramount to the lessor; but such a covenant * * * **[*119]** provides also for the protection of the lessee

against the unlawful entry of the lessor himself" (*Mayor of City of New York v. Mabie, 13 N. Y. 151, 156*; see 2 McAdam on Landlord and Tenant [5th ed.], pp. 1528, 1570, 1571). The covenant can mean no less than that the landlord will "abstain from interfering **[****20]** with the right" granted by him to the tenant (*Mabie* case, *supra, p. 157*). When the landlord despite the lease and the covenant presumes to exercise dominion over the property by his own re-entry or by granting rights to others inconsistent with the lease, the landlord breaches the covenant. Under defendant's theory, a landlord could make a lease for a long period, include therein a covenant for quiet enjoyment, permit the tenant to enter and establish himself in the property and then turn around and act toward the property as if there were no lease at all. And all this without incurring any obligation to reimburse the tenant for his loss.

The landlord's defense to this suit can be summed up in a sentence from its brief: "No tenant can recover damages from his landlord merely because a municipality condemns the property which is the subject of his lease". But this plaintiff has been awarded damages not because the municipality exercised its power of eminent domain, but because the landlord induced and made possible the bringing of condemnation proceedings by agreeing to what was, in effect, a voluntary sale. The difference is between an involuntary transfer of the property **[****21]** by the landlord and a carefully worked out bilateral agreement which, although in form a taking by condemnation, was in fact a voluntary sale of the property to the city. The taking of this property by the city was not in hostility to defendant's title but was the carrying out of a bargain. The naked fact that title passed pursuant to a condemnation decree does not invalidate the finding made here that it was the landlord's agreement which resulted **[***545]** in the ouster of plaintiff. An illustrative case is *Lindwall v. May (111 App. Div. 457*) where it was held that a tenant could recover damages for a breach of a covenant of quiet enjoyment although the building had actually been torn down by the municipal authorities as unsafe. It was the landlord's neglect that had produced the violation which in turn produced the lawful governmental act of destroying the property which was the subject of the lease. The Appellate Division held in the *Lindwall* case (*supra*) that the **[*120]** destruction of the premises and the consequent **[**790]** eviction would not have occurred had the landlord performed its duty. In the present case the landlord's duty was to protect **[****22]** the rights which it had granted to plaintiff. Instead of doing so it agreed to a method of ousting him. *Kip v. New York & H. R. R. Co. (67 N. Y. 227*) is not in point here since it deals with the right to condemn of a tenant who had the power of eminent domain. *Goodyear Shoe Mach. Co. v. Boston Term. Co. (176 Mass. 115*) is likewise without pertinence here, since the landlord in that case merely exercised its own power of condemnation.

If there is any doubt as to the meaning of this lease, that doubt "must be resolved against the landlord and in favor of the tenant" (*455 Seventh Ave. v. Hussey Realty Corp., 295 N. Y. 166, 172)*. That settled rule of lease construction should be most strongly applied when the result of a construction in favor of the landlord would be to permit the landlord to forfeit the tenant's valuable remaining term without compensation.

Affirmance of this judgment would not impair or affect the city's practice of arranging in advance an assignment of awards in condemnation proceedings. Affirmance will merely force landlords to perform their covenants.

The measure of damages here applied, that is, the value of the unexpired term less **[****23]** the rent reserved, was correct (*Mack v. Patchin, 42 N. Y. 167*).

The judgment should be affirmed, with costs.

End of Document

Dorrance v. United States

United States Court of Appeals for the Ninth Circuit

April 9, 2015, Argued and Submitted, Pasadena, California; December 30, 2015, Amended

Nos. 13-16548, 13-16635

Reporter
809 F.3d 479 *; 2015 U.S. App. LEXIS 22820 **; 116 A.F.T.R.2d (RIA) 2015-6992

BENNETT DORRANCE; JACQUELYNN DORRANCE, Plaintiffs-Appellees/Cross-Appellants, v. UNITED STATES OF AMERICA, Defendant-Appellant/Cross-Appellee.

Prior History: [1]** Appeal from the United States District Court for the District of Arizona. D.C. No. 2:09-cv-01284-GMS. G. Murray Snow, District Judge, Presiding.

Dorrance v. United States, 807 F.3d 1210, 2015 U.S. App. LEXIS 21287 (9th Cir. Ariz., Dec. 9, 2015)
Dorrance v. United States, 877 F. Supp. 2d 827, 2012 U.S. Dist. LEXIS 94107 (D. Ariz., 2012)

Disposition: REVERSED.

Summary:

SUMMARY*

Tax

The panel reversed the district court's denial of the government's motion for summary judgment in a tax refund action involving the calculation of the cost basis of stock received through demutualization.

Taxpayers received and then sold stock derived from the demutualization of five mutual insurance companies from which they had purchased life insurance policies. Taxpayers initially asserted a zero cost basis in the stock and paid tax on the gain, but later claimed a full refund. The district court held that taxpayers had a calculable basis in the stock and were therefore entitled to a partial refund.

The panel held that the Internal Revenue Service properly denied the refund claim and that the district court had erred in its cost basis calculation because taxpayers had not met their burden of showing that they had in some way paid for the stock.

The panel explained that under the life insurance **[**2]** policies, taxpayers were entitled to certain contractual rights such as a death benefit, the right to surrender the policy for cash value, and annual dividends. After demutualization, taxpayers retained their contractual interests and continued to pay the same premiums. Taxpayers as policyholders also had certain membership rights for which they received nothing upon demutualization. The stock they received was due to the legal requirement that the insurance companies produce a "fair and equitable" allocation of each company's surplus at the time of demutualization, but evidence showed that this was not based on some premium value that taxpayers had paid in the past.

Judge M. Smith dissented. He agreed with the district court's cost basis calculation, and disagreed with the majority's view that taxpayers paid nothing for their membership rights.

Counsel: M. Todd Welty (argued) and Laura L. Gavioli, McDermott Will & Emery LLP, Dallas, Texas, for Plaintiffs-Appellees/Cross-Appellants.

Kathryn Keneally, Assistant Attorney General; Tamara W. Ashford, Principal Deputy Assistant Attorney General; Gilbert S. Rothenberg, Jonathan S. Cohen, and Judith A. Hagley (argued), Attorneys, United States Department **[**3]** of Justice, Tax Division, Washington, D.C., for Defendant-Appellant/Cross-Appellee.

Judges: Before: Stephen Reinhardt, M. Margaret McKeown, and Milan D. Smith, Jr. Circuit Judges. Opinion by Judge McKeown. Dissent by Judge Milan D. Smith, Jr.

Opinion by: M. Margaret McKeown

Opinion

* This summary constitutes no part of the opinion of the court. It has been prepared by court staff for the convenience of the reader.

[*481] AMENDED OPINION

McKEOWN, Circuit Judge:

This appeal requires us to "return to the very basics of tax law" and consider whether taxpayers had a cost basis in assets that they later sold, but for which they paid nothing. *Washington Mut. Inc. v. United States, 636 F.3d 1207, 1217 (9th Cir. 2011)*. The specific question we address is whether a life insurance policyholder has any basis in a mutual life insurance company's membership rights. This issue, one of first impression in our circuit, arises out of a trend in the late 1990s and early 2000s towards the "demutualization" of mutual life insurance companies. As many mutual insurance companies transformed into stock companies, the surplus resulting from the sale of shares in the company was divided among current policy holders, often in the form of stock.

Bennett and Jacquelyn Dorrance received and then sold stock derived from the demutualization of five mutual life insurance companies from which they had purchased policies. The Dorrances initially asserted a zero **[**4]** cost basis in the stock and paid tax on the gain. They later claimed a full refund on the taxes they paid upon on the sale of the stock, either because the stock represented a return of previously paid policy premiums or because their mutual rights were not capable of valuation and, therefore, the entire cost of their insurance premiums should have been counted toward their basis in the stock. The government takes the position that the Dorrances are not entitled to any refund; since they paid nothing for their membership rights, their basis was zero. The district court held that the Dorrances had a calculable basis in the stock, albeit not at the level the taxpayers claimed, and thus they were entitled to a partial refund from the Internal Revenue Service ("IRS"). We disagree. Taxpayers who sold stock obtained through demutualization cannot claim a basis in that stock for tax purposes because they had a zero basis in the mutual rights that were extinguished during the demutualization.

BACKGROUND

A. MUTUAL INSURANCE COMPANIES

The first life insurance company in America was a mutual company called the Presbyterian Minister's Fund, organized in 1759 in Philadelphia.[1] For centuries, mutual **[**5]** insurance companies have provided a structure for collecting policyholder premiums and spreading risk and surplus among policyholders, while maintaining policyholder ownership of the company. Mutual insurance companies are distinct from stock companies in that they are owned by the policyholders, not by stockholders. *See* Edward X. Clinton, *The Rights of Policyholders in an Insurance Demutualization*, 41 Drake L. Rev. 657, 659 (1992). To ensure that they can pay all of the contractual benefits, these mutual insurance companies generally charge slightly higher rates than other life insurance providers. Surplus is returned to the policyholders in dividends. For decades (and even more than a century for some mutual companies) policyholders joined, became members, and terminated their policies without getting anything back for membership rights.

Starting in the middle of the twentieth century and increasing through **[**6]** the 1980s, **[*482]** the mutual model became less economically advantageous when compared to stock companies. *Id. See also* Paul Galindo, *Revisiting the 'Open Transaction' Doctrine: Exploring Gain Potential and the Importance of Categorizing Amounts Realized*, 63 Tax L. 221, 226 (2009). The economic advantage of stock companies comes, in large part, from the fact that they can raise capital by selling shares, whereas mutual companies are able to raise capital only by increasing the number of policies sold or by reducing costs. Additionally, stock companies have a greater capacity to diversify, which provides an additional layer of financial stability. *See* Clinton, *supra*, at 667.

In response to the challenges faced by mutual insurance companies, in the mid-to-late 1990s many states changed their insurance laws to permit "demutualization" of mutual insurance companies. Demutualization entails the legal transformation of a mutual company into a stock company. *See* Jeffrey A. Koeppel, The State of Demutualization, at v (2d ed. 1996). As a consequence, by the late 1990s and early

[1] Even earlier, in 1752, Benjamin Franklin, who had likely become aware of similar innovations in England, formed the Philadelphia Contribution for the Insurance of Houses From Loss by Fire, often characterized as the first mutual insurance company. *See* The Philadelphia Contributionship, *Company History* (2015), *http://www.contributionship.com/history/index.html*.

2000s, many mutual insurance companies had transformed into stock companies.

The rapid shift toward demutualization was made possible only by this **[**7]** widespread change in state insurance law. Clinton, *supra*, at 674. Although state laws vary, including in the scope of regulatory oversight, the demutualization process occurred under operation of law and was monitored by external insurance regulators. *Id.* at 665. Because policyholders exert only weak influence over the mutual company's governance (each policyholder has only one vote, out of possible thousands, regardless of the size of the policy), external regulators focused on ensuring a fair and equitable legal transformation of the insurance companies. *Id.* at 678.

B. The Dorrances' Mutual Life Insurance Policies

Bennett Dorrance is the grandson of the founder of the Campbell Soup Company. At the time the Dorrances purchased life insurance policies from five mutual insurance companies[2] in 1996[3], their net worth was approximately $1.5 billion. They bought the policies to cover estate tax for their heirs. Over time, the Dorrances paid premiums totaling $15,265,608. While that sum is definitely substantial, the face value of the policies totaled just under $88 million, such that they would have received a huge contractual payout upon death.

The Dorrances' contractual rights under the policies entitled them to (1) a death benefit; (2) the right to surrender the policy for "cash value"; and (3) annual policyholder dividends representing the policyholder's portion of the company's "divisible surplus." As policyholders, they also had certain membership rights. Specifically, they were entitled to a portion of any surplus in the event of a solvent liquidation and to certain voting rights. The Dorrances' membership rights in the mutual **[*483]** insurance companies were not transferable or separable from the insurance policy. If the policies **[**9]** terminated, so too would the membership rights, without any rebate or additional compensation. Voting and other membership rights were governed by state law and company charter.

In 2000 and 2001, each of the insurance companies from which the Dorrances bought policies demutualized. Post-demutualization, the Dorrances no longer held any mutual membership rights, but they retained their contractual interests under the insurance policies and continued to pay the same premiums.

Government regulators (both in the United States and Canada) required the insurance companies to produce a "fair and equitable" allocation of the company's surplus at the time of demutualization. Mutual insurance companies complied with this requirement in a variety of ways, but the companies in question here opted to issue stock to their policyholders.

When determining how many shares of stock to distribute to each policyholder, the insurance companies calculated (1) a fixed component for the loss of voting rights, as every policyholder was entitled to a single vote regardless of policy size, and (2) a variable component for the loss of other membership rights, which was calculated based on the policyholder's past **[**10]** and projected future contributions to the company's surplus. As the government's expert report explained, each company used a different allocation calculation to arrive at a distribution that was "fair and equitable" to policyholders. MetLife, for example, "aimed for around 20%" for the fixed portion, but stated this was a "general target." Sun Life did not consider policyholders' contribution to surplus in its allocation calculation, but rather looked at the cash value and annual premiums of eligible policies.

Prior to demutualization, the insurance companies each obtained a ruling from the IRS that the stock ownership company resulting from the demutualization qualified as a tax-free organization under Internal Revenue Code, *I.R.C. § 368*.

Upon demutualization, the Dorrances received 58,455 shares in Prudential, 3,209 shares in Sun Life, 1,601 shares in Phoenix, 5,039 shares in Principal, and 2,721 shares in MetLife. At the time of receipt, the market value of the stock derived from these policies totaled $1,794,771. As the government's expert report explained: "Some may think that the cash paid out in

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[2] The companies are: Prudential Insurance Company; Sun Life Assurance Company; Phoenix Home **[**8]** Life Mutual Insurance Company; Principal Life Insurance Company; and Metropolitan Life Insurance Company ("MetLife").

[3] By 1996, many states already allowed demutualization or were in the process of changing their laws. Demutualization was permitted under New York and Iowa law (governing MetLife, Phoenix, and Principal). *See* *NY Ins. Law § 7312* (McKinney 2011); *Iowa Code § 508B.1 et seq.* The New Jersey demutualization statute (governing Prudential) became effective in July 1998. *N.J. Stat. Ann. 17:17C-1*. In 1999, Canadian regulations (governing Sun Life) were revised to allow for demutualization. Mutual Company (Life Insurance) Conversion Regulations SOR/99-128 s.14 (Can.).

demutualization comes from the distribution of positive surplus of the mutual company; however, **[**11]** such is not the case. The cash actually comes from new stockholders which subscribe to the IPO [initial public offering] . . . ."

In 2003, the Dorrances sold all of the stock for $2,248,806. On their 2003 tax return, in compliance with IRS policy, the Dorrances listed their basis in the stock as zero, reported the $2,248,806 as capital gain, and paid the tax due on that gain. *See* Rev. Rul. 71-233, 1971-1 C.B. 113; Rev. Rul. 74-277, 1974-1 C.B. 88.

C. Prior Proceedings

By 2007, the Dorrances had a change of heart. They filed a tax refund claim with the IRS, in which they argued that they owed no taxes on the stock sale because it represented a return on previously-paid insurance policy premiums. The IRS did not issue a final determination on the 2007 claim, so the Dorrances filed a complaint in district court. The IRS argued that the Dorrances had a zero basis in their stock because the life insurance premiums that they paid were not in exchange for membership rights in the life insurance policies. The district court denied the cross-motions **[*484]** for summary judgment, ruling that there was a calculable basis in the stock, and set the case for trial to determine how the basis should be calculated.

The district court held a two-day bench trial, which featured **[**12]** expert testimony from both sides regarding the basis calculation. The court rejected the Dorrances' argument that the "open transaction" doctrine, espoused by the Court of Federal Claims, applied to their refund request.[4] It also rejected the government's zero basis argument. Instead, the district court ruled that the Dorrances had "paid something for the [membership] rights because they paid premiums for policies that included both policy rights and mutual rights" and that their basis was calculable.

The district court calculated the Dorrances' basis in the stock using the following formula: (1) the initial public offering ("IPO") value of the fixed shares allocated to the Dorrances in 2003, plus (2) 60% of the IPO value of the variable shares. Applying this formula, the court found **[**13]** that the Dorrances were required to pay taxes on $1,170,678, rather than on the full $2,248,806 value of the stock. Because in 2003 the Dorrances had paid taxes based on a zero basis calculation in the stock, the district court found that they were entitled to a refund.

Both parties appeal the adverse portions of the judgment.

Analysis

The crux of this case is how to calculate the basis of stock received through demutualization. The question of basis in the stock is a mixed question of law and fact that "require[s] consideration of legal concepts and involve[s] the exercise about the values underlying legal principles [and is] reviewable de novo." Smith v. Comm'r, 300 F.3d 1023, 1028 (9th Cir. 2002) (citing Mayors v. Comm'r, 785 F.2d 757, 759 (9th Cir. 1986)). The parties do not dispute the district court's factual findings. Instead, their divergence of views stems from the legal conclusions that follow.

As the taxpayers, the Dorrances bear the burden of establishing basis, and "[t]he fact that basis may be difficult to establish does not relieve [them] from [t]his burden." Coloman v. Comm'r, 540 F.2d 427, 430 (9th Cir. 1976). Because they failed to establish that they had a basis in the membership rights, we afford the basis utilized by the IRS a presumption of correctness—even where, as here, that figure is zero. *Id.* The Supreme Court explained long ago in a similar **[**14]** context that "[t]he impossibility of proving a material fact upon which the right to relief depends simply leaves the claimant upon whom the burden rests with an unenforceable claim, a misfortune to be borne by him, as it must be borne in other cases, as the result of a failure of proof." Burnet v. Houston, 283 U.S. 223, 228, 51 S. Ct. 413, 75 L. Ed. 991 (1931).

A. The Structure of Mutual Insurance Policies

In analyzing the insurance policies, it pays to bear in mind that, "[a]s an overarching principle, absent specific provisions, the tax consequences of any particular transaction must reflect the economic **[*485]** reality."

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[4] The district court declined to follow the Court of Federal Claims' approach that "the value of the ownership rights [in mutual rights are] not discernible" and that, therefore, the full basis of the policy should apply under the rarely-used "open transaction" doctrine. Fisher v. United States, 82 Fed. Cl. 780, 799 (2008) *aff'd*, ***333 F. App'x 572 (Fed. Cir. 2009)***. In light of our decision, it is unnecessary to address whether the "open transaction" doctrine is applicable to this situation.

Washington Mut. Inc., 636 F.3d at 1217 (citing *Kraft, Inc. v. United States, 30 Fed. Cl. 739, 766 (Fed. Cl. 1994)*; *United States v. Winstar Corp., 518 U.S. 839, 863, 116 S. Ct. 2432, 135 L. Ed. 2d 964 (1996)*). The reality here is that the Dorrances acquired the membership rights at no cost, but rather as an incident of the structure of mutual insurance policies.

The logic of this conclusion is simple—when the Dorrances purchased their mutual insurance policies in 1996, the premiums they paid related to their rights under the insurance contracts, not to collateral membership benefits such as voting. Under the insurance contract, policyholders paid premiums for the following "contract rights": (1) a death benefit; (2) the right to surrender the policy for a "cash value"; and (3) annual policyholder dividends representing the policyholder's portion **[**15]** of the company's "divisible surplus."

Separate from the contract rights, through operation of law and the company charter, each policyholder had a right to vote on certain matters, such as the election of the board of directors. That vote was restricted to one vote per policyholder, regardless of the size or face value of the policy. In addition, in the very unlikely event of a liquidation, the policyholder was entitled to any surplus from that liquidation.[5] At trial, the government expert stated that he did not know of a single mutual insurance company that had ever had a solvent liquidation, a point echoed by the MetLife representative. This bundle of rights—derived from operation of law—is referred to as "mutual rights" or "membership rights."[6] These rights are not transferable and upon termination of a policy, the policyholder receives nothing for any membership rights.

The difference between contract rights and membership rights is critical to resolution of this case. The premiums paid covered the rights under the insurance contract, not any membership rights. Notably, the policies themselves generally make no reference to any such membership rights. In other words, premium payments go toward the actual cost of the life insurance benefits provided. The mutual companies did not count membership rights as having a cost (apart from minimal administrative costs, if there is a policyholder vote), so they did not charge policyholders for such rights.

The government's expert, American Academy of Actuaries member Ralph Sayre, testified that mutual companies calculate premiums based solely on the expected cost of providing contractual insurance benefits. This calculation process is "very precise in actuarial circles" and "there just is no portion of the premium or charge for membership rights." He linked this analysis to the obvious: "[U]sually you don't pay [for] something if . . . you aren't charged for it." This explanation is consistent with the Supreme Court's description of what the premium pays for: "It **[**17]** is of the essence of mutual insurance that the excess in the premium over the actual cost as later ascertained shall be returned to the policy holder." *Penn Mut. Life Ins. Co. v. Lederer, 252 U.S. 523, 525, 40 S. Ct. 397, 64 L. Ed. 698, T.D. 3046 (1920)*.

In referencing "ownership rights," by which he meant membership rights, the **[*486]** description by the Dorrances' expert was essentially in line with Sayre's conclusion: "The ownership rights were not separate from the policy rights and could not be sold. The cost associated with acquiring ownership rights cannot be established exclusively through premium payments."

Consistent with the general practice for mutual insurances companies, the companies involved in this case did not charge the Dorrances for their membership rights. This point was underscored by Mr. Dorrance's testimony that, at the time he bought the policies, he actually understood that he would pay *less* for a policy from a mutual insurance company than he would for one from a stock company. *See* *S. Bancorporation, Inc. v. United States, 732 F.2d 374, 377 (4th Cir. 1984)* (rejecting refund claim where the taxpayer "introduced no evidence to prove that it intended to pay an enhanced value for the [asset] *at the time of sale*") (emphasis in original). It was no surprise then, that in 2003, when the Dorrances filed their tax returns following the sale of the **[**18]** stock derived from demutualization, they listed their basis as zero.

B. The Effect of Demutualization

The membership rights were assigned a monetary value at the time of the exchange only as a consequence of

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[5] Prior to demutualization, solvent liquidation in a mutual insurance company was unlikely because mutual insurance companies are highly regulated entities that operate conservatively to remain as a "going concern" for their policyholders.

[6] The moniker "mutual rights" more accurately describes what is at issue, though we **[**16]** adopt the term "membership rights" as used by the parties.

the demutualization process. The error of the Dorrances and the district court was to assume that the value received upon demutualization was linked with some premium value paid by the policyholders in the past. But the stock the Dorrances received in exchange for the membership rights cannot be understood as a partial return on their past premium payments and it is well understood that policyholders do not contribute capital to the companies.

By the time of the demutualization, the lion's share of the surplus that fed valuation of the newly issued stock could not be traced to payments made by current policyholders. Nearly all of the surplus held by the companies at that time was attributable to former policyholders, not current policyholders like the Dorrances. For example, at the time of demutualization, less than 10% of the Sun Life surplus was attributable to current policyholders; premiums paid by former policyholders accounted for over 90% of the surplus. Thus, the value at **[**19]** demutualization was not derived from something paid for by the Dorrances.

Sayre explained the situation as follows:

> The demutualization is not a result of [] current policyholders having done something different from the other previous millions of policyholders, but is a result of outside influences, such as tax policy, economic conditions or competitive pressures. The current policyholders are fortunate to be policyholders at the time of demutualization but their value received is a result of the new stockholders who are willing to pay them in order to receive their membership benefits for the purpose of what they can do with them in the future.

This anomaly prompted one insurance company official involved in this case to refer to the receipt of stock as a "windfall" for current policyholders. This characterization was echoed by the Sixth Circuit, which referred to demutualization proceeds as "a pot of money that no one expected or even envisioned." *Bank of New York v. Janowick, 470 F.3d 264, 266 (6th Cir. 2006)*; *see also* Douglas P. Faucette & Timothy S. Farber, *National Insurance Act of 2007 & Demutualization of Insurers: The Devil is in the Details*, 58 Fed'n Def. & Corp. Couns. Q. 109, 127 (2007) (noting that policyholders "receive payouts that **[**20]** they had not expected, consciously bargained for, or purchased. Simply **[*487]** put, distribution of the surplus amounts to 'a windfall resulting from the increase in the value of that policy arising from its unforseen restructuring.'" (citation omitted)).

Following the transfer of stock, it was business as usual in terms of the contract rights. After demutualization, the Dorrances' insurance premiums remained level—reinforcing the fact that they had not been paying a "premium" for any membership rights in the first place. For example, the premium history for Principal Financial Group shows that the Dorrances' premium was $124,450 both before and after the 1999 demutualization. This transition occurred under the oversight of regulators who were charged with ensuring that policyholders were treated fairly during the demutualization process and who did not require a reduction in the premiums to sync with the loss of the now-claimed rights. The Dorrances continued to pay the same premiums and receive the same coverage. The stock exchange, for which they paid nothing, was the only aspect of the transaction related to membership rights.

The demutualizations themselves were structured as tax-free, **[**21]** meaning that the initial transaction by which the Dorrances received the stock did not trigger any taxable gain for the policyholders. As an exchange under *I.R.C. § 354*[7], the deal would not have been tax free if there was a gain upon the exchange. *I.R.C. § 358(a)(1)* (providing that the basis of property received under a *§ 354* exchange "shall be the same as that of the property exchanged"). In other words, the stock was a direct exchange for the lost membership rights.

Put another way, the basis in the new stock was the same as the basis in what was being exchanged—the membership rights. Hence, the companies told policyholders that the tax basis on the stock was "zero." For example, with regard to the receipt of stock, Phoenix explained in its Q&A document:

> If you receive common stock, you will not be taxed when you receive it. However, if you sell or otherwise dispose of your common stock, you will be taxed on the full amount of the proceeds you **[**22]** receive for the common stock. (Your tax basis in the common stock will be zero.)

The other companies alerted policyholders to the same thing: Sun Life advised that the "cost basis of these

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[7] *I.R.C. § 354(a)(1)* provides:

> No gain or loss shall be recognized if stock or securities in a corporation a party to a reorganization are, in pursuance of the plan of reorganization, exchanged solely for stock or securities in such corporation or in another corporation a party to the reorganization.

shares for tax purposes will be zero" and, after saying that the tax cost would be "zero," Principal Mutual stated that "if you later sell or otherwise dispose of your Common Stock, you will generally be taxed on the full amount of the proceeds of that sale or other disposition."

The insurance companies' advice to their policyholders comports with IRS rulings dating back to the 1970s. Those rulings stated that the policyholder's basis in mutual rights is zero. *See* Rev. Rul. 71-233, 1971-1 C.B. 113; Rev. Rul. 74-277, 1974-1 C.B. 88. Revenue Ruling 71-233 addresses the tax consequences to policyholders when they exchange their proprietary interests for preferred stock. Consistent with our explanation above—distinguishing between contract rights and membership rights (which are also referred to as proprietary rights), the IRS advised:

> Payment by each policyholder of the premiums called for by the insurance **[*488]** contracts issued by X represents payment for the cost of insurance and an investment in his contract but not an investment in the assets of X. His proprietary interest in the assets of **[**23]** X arises solely by virtue of the fact that he is a policyholder of X. Therefore, the basis of each policyholder's proprietary interest in X is zero.

Id.

Within the tax code, the transaction exchanging mutual rights for stock does not operate in a vacuum. Treating the premiums as payment for membership rights would be inconsistent with the Code's provisions related to insurance premiums. For example, gross premiums paid to purchase a policy are allocated as income to the insurance company; no portion is carved out as a capital contribution. *See* I.R.C. §§ 803(a)(1), 118. On the flip side, the policyholder is allowed to deduct the "aggregate amount of premiums" paid upon receipt of a dividend or cash-surrender value. I.R.C. § 72(e). No amount is carved out as an investment in membership rights. The taxpayer can't have it both ways—a tax-free exchange with zero basis and then an increased basis upon sale of the stock.

The district court skipped a critical step by examining the *value* of the mutual rights without evidence of whether the Dorrances paid anything to first acquire them. The basis inquiry is concerned with the latter question. The district court also erred when it estimated basis by using the stock price at the time **[**24]** of demutualization rather than calculating basis at the time the policies were acquired. The stock value post-demutualization is not the same as the cost at purchase.

We have previously explained that basis[8] "refers to a taxpayer's capital stake in an asset for tax purposes." Washington Mut. Inc., 636 F.3d at 1217 (citing In re Lilly, 76 F.3d 568, 572 (4th Cir. 1996)). "The taxpayer must prove what, if anything, he actually was required to pay . . . not what he would have been willing to pay or even what the market value . . . was." Better Beverages, Inc. v. United States, 619 F.2d 424, 428 (5th Cir. 1980). Here the Dorrances failed to do so.

CONCLUSION

This analysis brings us back to the Dorrances' burden and the economic realities of this case. Because the Dorrances offer nothing to show payment for their stake in the membership rights, as opposed to premium payments for the underlying insurance coverage, the IRS properly rejected their refund claim. The district court erred when it found after the bench trial that the **[**25]** Dorrances had shown they paid something for the membership rights. It should have found their basis to be zero.

REVERSED.

Dissent by: M. SMITH

Dissent

M. SMITH, Circuit Judge, dissenting:

For thousands of years, philosophers, theologians, and now physicists, have debated whether the earth was created *ex nihilo*, i.e., out of nothing. Whatever the answer to that question, there is little doubt that my colleagues in the majority have performed a notable miracle of their own in this case, by creating nothing out of something, i.e., *nihil ex aliquo*. Let us consider how this miracle was wrought by endeavoring to follow the

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[8] The Code provides that "[t]he basis of property shall be the cost of such property, except as otherwise provided in this subchapter and subchapters C (relating to corporate distributions and adjustments), K (relating to partners and partnerships), and P (relating to capital gains and losses)." I.R.C. § 1012(a). None of these exceptions apply here.

money.

[*489] I. The Government's Conditions to Demutualization

For what precisely did the Dorrances pay when they purchased policies from the mutual life insurance companies involved in this case? The majority contends that they paid only for a death benefit, the right to surrender the policy for a "cash value," and annual policyholder dividends representing their share of the company's "divisible surplus."

But if, as the majority contends, the Dorrances paid nothing for their membership rights, and did not contribute capital, then why did the several governmental regulators involved require, as a condition **[**26]** of demutualization of each of those insurance companies, that they issue stock to their policyholders to compensate them for the loss of those rights?

Since those who acquired shares in the newly publicly traded insurance companies during the IPO process paid cash for their interests, if the policyholders when the insurance companies were structured as mutual insurance companies had not paid for the surplus they later received in stock, then the value of the distributed shares ought to have remained as the insurance companies' working capital, and not been gratuitously gifted to policyholders. Neither the regulators nor the IPO investors would have tolerated such a gratuity.

But the stock distribution to the Dorrances, even if not specifically contemplated at the time they purchased the policies, was no gift. While insurance companies may be powerful, they do not have the power of creation *ex nihilo*. To the contrary, by the very nature of a mutual insurance company, all of its accumulated value comes from premiums paid by its owners, and the investment of those premiums. That is why, when allocating shares during the demutualization process, the insurance companies relied on a calculation **[**27]** of a fixed component based on the loss of voting rights and a variable component related to past and projected future contributions to surplus.

The majority relies on a statement by a government's expert: "Some may think that the cash paid out in demutualization comes from the distribution of positive surplus of the mutual company; however, such is not the case. The cash actually comes from new stockholders which subscribe to the IPO . . . ." Here, the Dorrances received stock, not cash. Of course, when they sold the stock, the cash that they obtained from the sale came from the buyers of the stock, and not from the insurance companies' bank accounts. But that is always true in a stock sale. Of course, that does not mean that all stock sales have a zero basis. Thus, the cited government expert's testimony is merely a truism. It provides no support for the majority's conclusion.

II. Accrued Surplus or Not?

Some context is in order. The majority mentions the IPO value of the Dorrances' stock: $1,794,771. The majority also unworthily mentions the Dorrances' net worth, which is not relevant to any issue before us. While the majority concedes that the premiums the Dorrances had paid to the **[**28]** insurance companies, which totaled $15,265,608, were "substantial," the majority is unimpressed by that figure because the face value of the policies was substantially larger than the premium. Of course, that is always the case in insurance. The relevance of the premiums paid to the question before us is that the distributed stock represents only 11.7% of the money the Dorrances had paid the insurance companies. That may not be far from the usual dividends paid on mutual insurance **[*490]** policies.[1]

However, the majority is quick to call that return of a small proportion of funds expended a "windfall." But while the majority asserts that one insurance company official so characterized the stock distribution, he actually took **[**29]** care to state that "windfall" was the company's characterization, not his. Moreover, the majority ignores the fact that every other insurance company representative deposed in this case either expressly rejected that characterization, or in one instance, did not know how to answer the question.

The majority credits testimony by the government's expert that the insurance companies charged the

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[1] The parties did not identify the dividend rates the policies at issue provided. Data for the Massachusetts Mutual Life Insurance Company, not one of the companies at issue, is publicly available. *See* Historical Dividend Studies from Massachusetts Mutual Life Insurance Company (2015), *available at* https://fieldnet.massmutual.com/public/life/pdfs/li7954.pdf (last visited Nov. 18, 2015). That data shows that a policy purchased after March of 1996 yielded a yearly dividend interest rate of between 8.4% and 7.9% between 1996 and 2003.

Dorrances premiums that were based solely on the expected costs of providing insurance benefits, using calculations that were "very precise in actuarial circles," such that "there is just no portion of the premium or charge for membership rights." That asserted precision is disproved by the existence of a surplus accrued within the insurance company. In fact, the majority elsewhere relies on testimony that, at the time of demutualization, "less than 10% of the SunLife surplus was attributable to current policyholders; premiums paid by former policyholders accounted for over 90% of the surplus."

In other words, despite their asserted actuarial precision, the insurance companies had not been returning via dividend all of the premium surplus. Instead, the surplus accumulated within the companies, where **[**30]** it served the role that any accumulation of capital does. Therefore, the majority errs by stating that "it is well understood that policyholders do not contribute capital to the companies."[2] If not from the policyholders, from whence did that accumulated capital come?

Certainly, the cited testimony raises the question of how much the Dorrances contributed to the surplus. **[**31]** That question was addressed during the demutualization. To determine the number of shares of stock to issue to each member, the insurance companies applied a formula approved by the government regulators, which included a fixed component and a variable component. According to that formula, 14-25% of each company's shares were allocated on a fixed basis to shareholders. The variable shares were allocated based on the "contribution-to-surplus" method, which allocated the total shares based on a policyholder's contribution.

Thus, even if we were to accept the majority's conclusion that the Dorrances had no basis in the voting aspect of the **[*491]** membership rights—remembering that the fixed shares granted solely on that basis were worth $3,164, a minuscule portion of the $1,794,771 of IPO stock at issue—the calculations expressly accounted for their actual contribution to the surplus.

[2] The majority misconstrues government witness Ralph Sayre's testimony in this regard. Sayre testified that, from the view of a mutual insurance company, "because we don't have shareholders who have contributed to surplus or contributed capital to withstand [the demand for benefit payments], we're going to have to charge [the policyholder] a little bit more of that up front. But keep in mind that we will also give it back to you. As our experience unfolds and we realize earnings from that extra charge, or from the use of that extra money, we will return it back to you." Thus, policyholders do contribute capital—but they are eventually supposed to get it back. The majority believes that it comes back with a basis of zero, which complements the majority's belief that the insurance companies created something out of nothing.

III. "Tax Free Exchange" Is Not a Synonym for "Zero Basis"

The majority also misapplies the concept of a tax-free exchange in stating that "[t]he taxpayer can't have it both ways—a tax-free exchange with zero basis and then an increased basis upon sale of the stock."

It is unclear how the Dorrances are trying to "have it **[**32]** both ways." All that is required for the exchange to be tax-free is for the value received in stock to be the same as the value of the property exchanged. *See* *26 U.S.C. § 358(a)(1)*. In this case, the IRS, citing its own interpretations, opined that the basis should be zero. Whether that interpretation squares with the facts is the very question at issue in this case. By relying in part on the IRS's interpretation to answer the question, the majority assumes the conclusion.

IV. The District Court's Sound Calculations

After hearing all of the evidence at trial, the district court determined the Dorrances' cost basis by deducting the expected future premium contribution from the IPO value of the stock, yielding a cost basis of $1,078,128. This was the sum of: (1) the IPO value of the fixed shares allocated to the Dorrances ($3,164) and (2) 60% of the IPO value of the variable shares ($1,074,964). The 60% proportion reflected an expert estimate of past contributions by the Dorrances to the life insurance policies; the remaining 40% was an estimate of the policyholders' future contributions to the policies. Applying this formula, the court found that the Dorrances were required to pay taxes on $1,170,678, which **[**33]** was their sale proceeds of $2,248,806 less their basis of $1,078,128.

Thus, the district court quite sensibly reduced the basis by an expert's estimate of the future contribution component of the IPO value, ensuring that the Dorrances would not underpay the taxes owed. This was a careful analysis using reasonable methodology based on the evidence presented at trial. By contrast, the majority's contrary conclusions do not follow from the facts. A portion of the assets of the insurance companies clearly came from the premiums paid by the

Dorrances, and they had a substantial basis in the stock distributed to them. By contending to the contrary, my colleagues in the majority have created nothing out of something. It's a miracle!

I respectfully dissent.

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Fruchthandler v. Green

Supreme Court of New York, Appellate Division, First Department

November 19, 1996, Decided ; November 19, 1996, ENTERED

59103

Reporter
233 A.D.2d 214 *; 649 N.Y.S.2d 694 **; 1996 N.Y. App. Div. LEXIS 11790 ***

Abraham H. Fruchthandler, Individually and as General Partner on Behalf of FBE, Ltd., Formerly Known as Fruchthandler Brothers Enterprises, Appellant, v. Israel Green, Respondent.

Counsel: **[***1]** For Plaintiff-Appellant: Jonathan David Bachrach.

For Defendant-Respondent: Sheldon Eisenberger.

Judges: Concur--Sullivan, J. P., Ellerin, Nardelli, Tom and Andrias, JJ.

Opinion

[*214] **[**695]** Order, Supreme Court, New York County (Ira Gammerman, J.), entered on or about July 7, 1995, which, *inter alia,* granted defendant's motion to dismiss the amended complaint for failure to state a cause of action, unanimously affirmed, with costs.

Deeming the allegations in the amended complaint to be true and affording plaintiff the benefit of all favorable inferences and implications that may be drawn from the amended complaint (*Underpinning & Found. Constructors v Chase Manhattan Bank, 46 NY2d 459*), it was properly dismissed for failure to state a cause of action since the release plaintiff executed relieved defendant from liability under two promissory notes, and the allegations that such release was procured through economic duress were insufficient (*cf., Bloss v Va'ad Harabonim, 203 AD2d 36*; *Wilf v Halpern, 194 AD2d 508*, *lv dismissed 82 NY2d 846*). To succeed on a duress theory, plaintiff would have to show he was compelled to agree to the terms of the release **[***2]** by means of a wrongful threat which precluded the exercise of his free will (*Muller Constr. Co. v New York Tel. Co., 40 NY2d 955*). On its face, however, the record reveals that the release resulted from vigorous bargaining tactics which do not amount to economic duress (*Laub & Co. v **[*215]** Domansky, 172 AD2d 289*), notwithstanding financial considerations which may have induced plaintiff to enter into the agreement (*Bethlehem Steel Corp. v Solow, 63 AD2d 611*; **[**696]** *Walbern Press v C.V. Communications, 212 AD2d 460*). Moreover, at the time the release was entered into, defendant surrendered his partnership interest in certain properties to plaintiff. Having accepted the benefits of the agreement before commencing this action, plaintiff, in effect, ratified the release and is therefore barred from alleging economic duress in its execution (*Goldstein Prods. v Fish, 198 AD2d 137, 138)*. The claim of economic duress was also waived in light of the inordinate length of time which passed between the alleged duress and the assertion of the claim (*Joseph F. Egan, Inc. v City of New York, 17 NY2d 90, 98*; *Bethlehem Steel Corp. v Solow, supra, **[***3]** at 612*).

The cause of action for unjust enrichment was also properly dismissed since defendant provided consideration for the release and thus plaintiff's conclusory allegations that it would be against equity and good conscience to permit defendant to retain what was sought to be recovered are insufficient (*see, Paramount Film Distrib. Corp. v State of New York, 30 NY2d 415, 421*, *mot to amend remittitur granted 31 NY2d 678*, *cert denied 414 US 829*).

We have considered plaintiff's remaining contentions and find them to be without merit.

Concur--Sullivan, J. P., Ellerin, Nardelli, Tom and Andrias, JJ.

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-

LORRAIN ALLEGRO-SKINNER; MEDICAL LIABILITY MUTUAL INSURANCE COMPANY; and COMPUTERSHARE TRUST COMPANY,

DEFENDANTS.

DECISION AND ORDER
Index No. EF001608-2019
Motion Date: 9/6/19
Motion Seq. #1 & #2

VAZQUEZ-DOLES, J.S.C.

The following papers numbered 1 - 22 were read on Plaintiff's motion for partial summary judgment on its first and eighth causes of action, or in the alternative, on its fifth and eighth causes of action, and a dismissal of Allegro-Skinner's counterclaim(seq. #1); and on Defendant Allegro-Skinners cross-motion(seq. #2) for a declaration that she is the owner and policy-holder of the medical malpractice policy held by MLMIC and entitled to the escrow money being held by Computershare in the amount of $39,325.00;

Notice of Motion/Affirmation of Mitchell Berns, Esq./Exhibits A - G/Affidavit of Joseph Anesi/Exhibits A - F/Memorandum of Law/Supplemental Affidavit of Joseph Anesi ..... 1 - 18
Notice of Cross-Motion/Affidavit of Lorraine Allegro-Skinner/Memorandum of Law in Opposition to motion and in Support of Cross-motion ..... 19 - 21
Memorandum of Law in Opposition to Cross-motion /Affirmation in Opposition to Cross-motion of Matthew Schenker, Esq. 22

This action is in essence, one for a declaratory judgment to determine who should receive the windfall profit created when the medical malpractice insurer, MLMIC, converted from a mutual insurance company to a publically traded one. This process is called 'demutualization' and is heavily regulated by the New York State Department of Insurance. This is the fourth case of this nature where this Court has considered similar arguments and rendered a declaratory opinion. In all prior cases, this Court found that the employment contract was silent as to who

should receive the proceeds, and that Defendant/Doctors would not be unjustly enriched by receiving the proceeds of this sale.[1]

The facts in this case are similar to the prior cases decided by this Court. Here, Plaintiff/Provider and the Defendant/Doctor entered into an extensive written employment contract on or about March 13, 2014 which was effective on or about June 2, 2014. (See "Agreement, Exhibit A). The Physician was employed by the Provider until February 26, 2016. The employment contract included a base salary of $200,000 per year, and the agreement that the Provider would pay all the medical malpractice premiums of the Doctor as part of employment. As part of the negotiation, the Plaintiff had the discretion to choose the insurer and the Doctor was required to cooperate by applying to that insurer for medical malpractice insurance. There is no dispute that the Doctor agreed to allow the Plaintiff to be the 'administrator' of the insurance policy and a form was signed by the Doctor permitting that to occur. This form was created by the insurance company MLMIC, and presented to the Doctor by the Plaintiff. The form gives limited power to the Plaintiff to pay the premiums and receive dividends to offset the cost of the policy, but it does not affect the status of policy holder/member in any way. Plaintiff has submitted no proof that the unexpected demutualization was discussed or addressed between the parties in any way when the employment contract was negotiated and signed. Accordingly, under the terms of the contract, Plaintiff has no right to the proceeds.

Looking at the contract provisions of MLMIC, it is clear that the Doctor is a member of the mutual insurance company. Article II, Section One defines members as policy holders, and Dr. Allegro-Skinner is the policy holder. Plaintiff points to an e-mail letter from MLMIC to its members regarding the sale of the company dated July 18, 2016 which states that "...In most

[1]See *GHVHS v. Arthurs, et al* Index No. EF001609-2019; *GHVHS v. Cornell, et al* Index No. EF001610-2019; *GHVHS v. Sidorski-Nutt*, et al Index No. EF001620-2019.

cases, the person or entity that paid the premium will be considered as the owner of the eligible policy...", this letter is mere rhetoric as the terms of the sale had to be approved by the Department of Insurance after public hearings. Although the Providers voiced objections at the public hearing, the term actually placed into the approved plan was 'policy holder' or its 'assignee', not the person who paid the premium. Therefore, once again, a plain reading of the approved Plan for demutualization requires the Doctor to be recipient of the funds unless the doctor assigns their right to the provider.

Plaintiff also argues that Defendant/Doctor would be unjustly enriched by allowing them to receive all the profits. This Court disagrees. When the contract was written, neither party imagined that the insurance company they chose would be sold and distribute thousands of dollars to policy holders. The terms of the contract indicate that Plaintiff agreed to pay the premiums as well as receive dividends to help offset the cost of the policy. This was recognized by both parties as part of the compensation due to the Doctor. Both parties received the benefit from these terms as both parties needed the malpractice insurance to protect themselves.

When considering the law of unjust enrichment, Plaintiff must prove "...the defendants were enriched, at the plaintiff's expense, and that it is against equity and good conscience to permit the defendants to retain what is sought to be recovered (citing *Old Republic Natl. Tit. Ins. Co. v. Luft*, 52 A.D.3d 491, 859 N.Y.S.2d 261). " 'The essence of unjust enrichment is that one party has received money or a benefit at the expense of another' " (*Goldman v. Simon Prop. Group, Inc.*, 58 A.D.3d 208, 220, 869 N.Y.S.2d 125, quoting *City of Syracuse v. R.A.C. Holding*, 258 A.D.2d 905, 906, 685 N.Y.S.2d 381)." *County of Nassau v Expedia, Inc.*, 120 AD3d 1178, 1180 [2d Dept 2014]. In this case, Plaintiff has not met this burden, and Defendant will not be enriched at the expense of another. In fact, quite the opposite is true. Aside from the fact that

Plaintiff is requesting thousands of unexpected dollars from each doctor who was a policy holder, the facts here are akin to those cases involving the voluntary payment doctrine. This doctrine, " ...bars recovery of payments voluntarily made with full knowledge of the facts, and in the absence of fraud or mistake of material fact or law" *(citing Dillon v. U–A Columbia Cablevision of Westchester,* 100 N.Y.2d 525, 526, 760 N.Y.S.2d 726, 790 N.E.2d 1155; and *Gimbel Bros. v. Brook Shopping Ctrs., Inc.*, 118 A.D.2d 532, 535–536, 499 N.Y.S.2d 435)." *Wells Fargo Bank, N.A. v Burke*, 155 AD3d 668, 671 [2d Dept 2017]. Plaintiff voluntarily paid the premiums of the Defendants malpractice insurance knowing that they would only, at best, be reimbursed by the amount of dividends. It was in Plaintiff's best interest to ensure the payment of the medical malpractice and paying these premiums was not a result of fraud or mistake. Accordingly, Plaintiff has failed to show that Defendant would be unjustly enriched.

Therefore, upon a reading of all the papers submitted herein, 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 in the complaint are dismissed as moot; and it is further

ORDERED, ADJUDGED and DECREED that Defendant, Lorraine Allegro-Skinner, MD's motion and counterclaim for a declaratory judgment in her favor, is granted. This Court

declares that the "eligible policy holder" is Lorraine Allegro-Skinner, and she is entitled to the escrowed amount of $39,325.00 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, Lorraine Allegro-Skinner the amount of $39,325.00 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.

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 7th day of October, 2019.

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-

GILLY ARTHURS, MEDICAL LIABILITY MUTUAL INSURANCE COMPANY and COMPUTERSHARE TRUST COMPANY, N.A.,

DEFENDANTS.

DECISION AND ORDER
Index No. EF001609-2019
Motion date: 8/2/19
Motion #2

VAZQUEZ-DOLES, J.S.C.

The following papers numbered 1 - 15 were read on Plaintiff's motion for partial summary judgment on the first and eighth causes of action, or in the alternative its fifth and eighth causes of action;

Notice of Motion/Affirmation of Mitchell Berns Esq./Exhibits A - F/
Affidavit of Joseph Anesi/Exhibits A - E/Memorandum of Law ..... 1 - 15

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 practioners agreed to assign their rights to Plaintiff, 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 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 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.

[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.

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 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 [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.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 [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 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 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 [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 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,

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

To: Counsel of record via NYSCEF.

Gilly Arthurs, NP
29 Grandview Terrace
Chester, New York 10918

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, at 285 Main Street, Goshen, New York 10924 on the 16th 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. and ORANGE REGIONAL MEDICAL CENTER,

Plaintiffs,

-AGAINST-

DAVID CORNELL, MEDICAL LIABILITY MUTUAL INSURANCE COMPANY and COMPUTERSHARE TRUST COMPANY, N.A.

Defendants.

AMENDED DECISION AND ORDER
INDEX #EF001610/2019
Motion date: 09/05/19
Motion Seq.#1

VAZQUEZ-DOLES, J.S.C.

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 that was paid for as part of the employment contract, by the Provider as his employer. The parties seek, in essence, 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 details Cornell's compensation 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, 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 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, Schonholz & Drossman, LLP v. Rachel Title, MD*, 171 A.D.3d 465 (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 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, 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 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 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, "*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 "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 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 Appeals, (see *Phelps v. Phelps*, 128 A.D.3d 1545 [4th Dept. 2015]; *D'Alessandro v. Carro*, 123 A.D.3d 1 [4th Dept. 2015]; *see Mountain View Coach Lines v. Storms*, 102 A.D.2d 663, 664–665 [2d Dept. 1984],) caution must be applied in some cases. (See *People v Hobson*, 39 NY2d 479, 489-90 [1976], which recognized that conclusory

assertions should be carefully scrutinized.) In this instance, the First Department's two paragraph decision summarily concludes 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 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 N.Y.3d 640, 645, 884 N.Y.S.2d 211, 912 N.E.2d 43, quoting *Greenfield v. Philles Records*, 98 N.Y.2d 562, 569, 750 N.Y.S.2d 565, 780 N.E.2d 166)." *Legum v Russo*, 133 AD3d 638, 639 [2d Dept 2015]. Moreover, this Court is mindful of the fact 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 N. Y. 132, 135; *Friedman v. Handelman*, 300 N. Y. 188, 194.)" *Morlee Sales Corp. v Manufacturers Tr. Co.*, 9 NY2d 16, 19-20 [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 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 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 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.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 [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 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 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 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 the provider. (See for example, *Mejia v Trustees of Net Realty Holding Tr.*, 304 AD2d 627, 628 [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 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, 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 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 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 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.

TO: Counsel via NYSCEF

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 partial 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.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 [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 in 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.

IDT Corp. v. Morgan Stanley Dean Witter & Co.

Court of Appeals of New York

February 10, 2009, Argued; March 26, 2009, Decided

No. 27

Reporter
12 N.Y.3d 132 *; 907 N.E.2d 268 **; 879 N.Y.S.2d 355 ***; 2009 N.Y. LEXIS 42 ****; 2009 NY Slip Op 2262; 47 Comm. Reg. (P & F) 747

[1] IDT CORPORATION, Respondent, v MORGAN STANLEY DEAN WITTER & CO. et al., Appellants.

Subsequent History: Reargument denied by *IDT Corp. v. Morgan Stanley Dean Witter & Co., 12 N.Y.3d 889, 911 N.E.2d 855, 2009 N.Y. LEXIS 2496, 883 N.Y.S.2d 793 (2009)*

Prior History: Appeal, by permission of the Appellate Division of the Supreme Court in the First Judicial Department, from an order of that Court, entered November 20, 2007. The Appellate Division affirmed an order of the Supreme Court, New York County (Herman Cahn, J.; op 2006 NY Slip Op 30076[U]), which, to the extent appealed from, had denied defendants' motion to dismiss the first, second, fourth and fifth causes of action in the complaint. The following question was certified by the Appellate Division: "Was the order of this Court, which affirmed the order of the Supreme Court, properly made?"

IDT Corp. v. Morgan Stanley Dean Witter & Co., 45 A.D.3d 419, 846 N.Y.S.2d 116, 2007 N.Y. App. Div. LEXIS 11936 (N.Y. App. Div. 1st Dep't, 2007)

Disposition: **[****1]** Order reversed, with costs, defendants' motion to dismiss the remaining causes of action granted, complaint dismissed in the entirety, and certified question answered in the negative.

Counsel: *Davis Polk & Wardwell,* New York City (*Guy Miller Struve, Benjamin S. Kaminetzky* and Rebecca Winters of counsel), for appellants. I. IDT Corporation's attempt to relitigate the issue of damages is impermissible under the well-settled doctrine of collateral estoppel. (*Buechel v Bain, 97 NY2d 295, 766 NE2d 914, 740 NYS2d 252*; *D'Arata v New York Cent. Mut. Fire Ins. Co., 76 NY2d 659, 564 NE2d 634, 563 NYS2d 24*; *Kaufman v Eli Lilly & Co., 65 NY2d 449, 482 NE2d 63, 492 NYS2d 584*; *Schwartz v Public Adm'r of County of Bronx, 24 NY2d 65, 246 NE2d 725, 298 NYS2d 955*; *Ryan v New York Tel. Co., 62 NY2d 494, 467 NE2d 487, 478 NYS2d 823*; *Matter of American Ins. Co. [Messinger--Aetna Cas. & Sur. Co.], 43 NY2d 184, 371 NE2d 798, 401 NYS2d 36*; *Rembrandt Indus. v Hodges Intl., 38 NY2d 502, 344 NE2d 383, 381 NYS2d 451*; *New York Lumber & Wood Working Co. v Schneider, 119 NY 475, 24 NE 4*; *Guard-Life Corp. v Parker Hardware Mfg. Corp., 50 NY2d 183, 406 NE2d 445, 428 NYS2d 628*; *Stuzin v Pizza Hut, 241 AD2d 647, 659 NYS2d 573*.) II. IDT Corporation's claims are untimely. (*Kronos, Inc. v AVX Corp., 81 NY2d 90, 612 NE2d 289, 595 NYS2d 931*; *Ackerman v Price Waterhouse, 84 NY2d 535, 644 NE2d 1009, 620 NYS2d 318*; *Snyder v Town Insulation, 81 NY2d 429, 615 NE2d 999, 599 NYS2d 515*; *Spinap Corp. v Cafagno, 302 AD2d 588, 756 NYS2d 86*; *Matter of Martin v C. A. Prods. Co., 8 NY2d 226, 168 NE2d 666, 203 NYS2d 845*; *Norris v Grosvenor Mktg. Ltd., 803 F2d 1281*; *Schwartz v Heyden Newport Chem. Corp., 12 NY2d 212, 188 NE2d 142, 237 NYS2d 714*; *New York Univ. v Continental Ins. Co., 87 NY2d 308, 662 NE2d 763, 639 NYS2d 283*; *Kvetnaya v Tylo, 49 AD3d 608, 854 NYS2d 425*; *Shivers v Siegel, 11 AD3d 447, 782 NYS2d 752*.) III. IDT Corporation's unjust enrichment cause of action fails as a matter of law. (*Clark-Fitzpatrick, Inc. v Long Is. R.R. Co., 70 NY2d 382, 516 NE2d 190, 521 NYS2d 653*; *Rosenberg, Minc & Armstrong v Mallilo & Grossman, 39 AD3d 335, 833 NYS2d 485*; *Hutton v Klabal, 726 F Supp 67*; *Miller v Schloss, 218 NY 400, 113 NE 337*; *Young v Farwell, 165 NY 341, 59 NE 143*; *805 Third Ave. Co. v M.W. Realty Assoc., 58 NY2d 447, 448 NE2d 445, 461 NYS2d 778*; *Wujin Nanxiashu Secant Factory v Ti-Well Intl. Corp., 14 AD3d 352, 788 NYS2d 78*; *Matter of Guttenplan, 222 AD2d 255, 634 NYS2d 702*; *Matter of Moncrief, 235 NY 390, 139 NE 550*; *Morad v Morad, 27 AD3d 626, 812 NYS2d 126*.)

Patterson Belknap Webb & Tyler LLP, New York City (*Stephen P. Younger* of counsel), *Grayson & Kubli, P.C.,* Vienna, Virginia (Alan M. Grayson, of the Virginia

bar, admitted pro hac vice, and Victor A. Kubli of counsel), and *Bracewell & Giuliani, LLP,* Houston, Texas, and New York City (*Glenn A. Ballard, Jr., Jeffrey L. Oldham* and Michael D. Hess of counsel), for respondent. I. The courts below correctly held that IDT Corporation's claims against Morgan Stanley Dean Witter & Co. are not affected by the doctrine of collateral estoppel. (*D'Arata v New York Cent. Mut. Fire Ins. Co., 76 NY2d 659, 564 NE2d 634, 563 NYS2d 24*; *Amarant v D'Antonio, 197 AD2d 432, 602 NYS2d 837*; *PenneCom B.V. v Merrill Lynch & Co., Inc., 372 F3d 488*; *Inchaustegui v 666 5th Ave. Ltd. Partnership, 268 AD2d 121, 706 NYS2d 396*, *96 NY2d 111, 749 NE2d 196, 725 NYS2d 627*; *Guard-Life Corp. v Parker Hardware Mfg. Corp., 50 NY2d 183, 406 NE2d 445, 428 NYS2d 628*; *International Mins. & Resources, S.A. v Pappas, 96 F3d 586*; *Matter of American Ins. Co. [Messinger--Aetna Cas. & Sur. Co.], 43 NY2d 184, 371 NE2d 798, 401 NYS2d 36*; *R.S.J. Leasing Corp. v Michelin Tire Corp., 92 AD2d 914, 460 NYS2d 129*; *Matter of Kellogg, 138 AD2d 799, 525 NYS2d 443*; *Gramatan Home Invs. Corp. v Lopez, 46 NY2d 481, 386 NE2d 1328, 414 NYS2d 308*.) II. The lower courts correctly held the IDT Corporation's claims are timely because they were filed within the applicable limitations periods after IDT learned of Morgan Stanley Dean Witter & Co.'s misconduct, which Morgan Stanley fraudulently concealed. (*Marine Midland Bank v Worldwide Indus. Corp., 307 AD2d 221, 763 NYS2d 27*; *Maric Piping v Maric, 271 AD2d 507, 705 NYS2d 684*; *Green v Albert, 199 AD2d 465, 605 NYS2d 395*; *Zumpano v Quinn, 6 NY3d 666, 849 NE2d 926, 816 NYS2d 703*; *Hetelekides v Ford Motor Co., 299 AD2d 868, 750 NYS2d 404*; *Powers Mercantile Corp. v Feinberg, 109 AD2d 117, 490 NYS2d 190*; *Matter of Steyer, 70 NY2d 990, 521 NE2d 429, 526 NYS2d 422*; *Simcuski v Saeli, 44 NY2d 442, 377 NE2d 713, 406 NYS2d 259*; *General Stencils v Chiappa, 18 NY2d 125, 219 NE2d 169, 272 NYS2d 337*; *Vigliotti v North Shore Univ. Hosp., 24 AD3d 752, 810 NYS2d 82*.) III. The lower courts correctly held that IDT Corporation stated a claim for unjust enrichment. (*Clark-Fitzpatrick, Inc. v Long Is. R.R. Co., 70 NY2d 382, 516 NE2d 190, 521 NYS2d 653*; *Sosnoff v Carter, 165 AD2d 486, 568 NYS2d 43*; *Sergeants Benevolent Assn. Annuity Fund v Renck, 19 AD3d 107, 796 NYS2d 77*; *Duane Reade v Cardinal Health, Inc., 12 AD3d 224, 784 NYS2d 534*; *Wiener v Lazard Freres & Co., 241 AD2d 114, 672 NYS2d 8*.) IV. This Court may properly consider the new allegations in IDT Corporation's amended complaint. (*Hummingbird Assoc. v Dix Auto Serv., 273 AD2d 58, 709 NYS2d 51*; *Halmar Distribs. v Approved Mfg. Corp., 49 AD2d 841, 373 NYS2d 599*; *Millard v Delaware, Lackawanna & W. R.R. Co., 204 App Div 80, 197 NYS 747*; *Wahrhaftig v Space Design Group, 28 AD2d 940, 281 NYS2d 500*; *Anthony J. Demarco, Jr., P.C. v Bay Ridge Car World, 169 AD2d 808, 565 NYS2d 176*; *Vanderwoude v Post/Rockland Assoc., 130 AD2d 739, 515 NYS2d 838*; *Watson v Sony Music Entertainment, 282 AD2d 222, 722 NYS2d 385*.)

Judges: Opinion by Judge Pigott. Judges Ciparick, Graffeo, Read, Smith and Jones concur. Chief Judge Lippman took no part.

Opinion by: Pigott

Opinion

[*357] [**270] [*136]** PIGOTT, J.

IDT Corporation and Telefonica Internacional, S.A., both telecommunications companies, executed a Memorandum of Understanding (MOU) in August 1999 concerning SAm-1, a vast underwater fiber-optic cable network Telefonica was building. Pursuant to the MOU, IDT was to buy from Telefonica a 10% equity share in NewCo, a corporation that would "construct, establish, operate and maintain . . . and . . . sell capacity on" SAm-1. A **[2]** separate entity was to be created to market products associated with the network. IDT would have the right to buy capacity in the network, at a favorable rate, during its operational life.

In June 2000, Telefonica informed IDT that it intended to modify the MOU, replacing NewCo with a larger entity, Emergia, in which Telefonica offered IDT a five percent share. According to IDT, **[****2]** Morgan Stanley Dean Witter & Co. (Morgan Stanley), Telefonica's investment banker, advised IDT in the summer of 2000 that the value of a five percent interest in Emergia was far greater than that of a 10% interest in NewCo. Nevertheless, IDT, unpersuaded, broke off negotiations with Telefonica in October 2000.

Although Morgan Stanley acted as Telefonica's investment banker in relation to SAm-1, it had previously acted on IDT's **[*137]** behalf in 1999, in negotiations concerning a different proposed fiber-optic cable network, and in subsequent matters. IDT engaged Morgan Stanley as its financial adviser in regard to shares in Net2Phone, Inc. that it sold in the summer of 2000 for about $ 1 billion. According to IDT, in 1999-2000, Morgan Stanley requested and received confidential business and financial information concerning IDT, had access to IDT's records, and

enjoyed wide-ranging communications with its executives.

IDT commenced an arbitration proceeding on May 25, 2001, against Telefonica, alleging that Telefonica had breached the MOU, in particular its provisions entitling IDT to an equity share in NewCo and giving it the right to buy capacity in SAm-1. IDT sought an award in an **[****3]** amount no less than $ 3.15 billion. IDT made no allegations against Morgan Stanley. No representative of Morgan Stanley testified, but a valuation memorandum concerning NewCo and Emergia that Morgan Stanley had presented to IDT in 2000 was subpoenaed and submitted to the arbitration panel.

Following a lengthy hearing, the panel concluded that Telefonica had breached both the "capacity purchase" and "equity purchase" provisions of the MOU. It calculated IDT's aggregate damages for Telefonica's capacity purchase breach to be $ 16,883,817. However, noting the weakness of the telecommunications market in the second half of 2000, the panel calculated that the present value of IDT's interest in NewCo was negative, and concluded that IDT had suffered no damages as a result of Telefonica's breach of the equity purchase provisions. [1] Telefonica paid IDT **[**271]** **[***358]** $ 21.6 million, representing damages and interest. **[3]**

On November 5, 2004, IDT commenced this action against Morgan Stanley, alleging that it had provided Telefonica with confidential information about IDT, induced Telefonica to **[*138]** breach the MOU and, moreover, presented false and misleading evidence to the arbitration panel, affecting the panel's assessment of IDT's damages. Its complaint contains five causes of action: (1) breach of fiduciary duty, (2) intentional interference with existing contract, (3) intentional interference with prospective business relations, (4) misappropriation of confidential and proprietary business information, and (5) unjust enrichment. IDT seeks compensatory damages, disgorgement of profits obtained by Morgan Stanley in connection with SAm-1, **[****5]** punitive damages, and the return of a $ 10,000,000 fee that IDT paid Morgan Stanley in relation to the Net2Phone, Inc. transaction, plus interest and fees.

Morgan Stanley moved to dismiss the complaint under *CPLR 3211*, arguing, among other things, that IDT's claims were barred by collateral estoppel and the statute of limitations. Supreme Court dismissed IDT's intentional interference with prospective business relations claim, but otherwise denied the motion (2006 NY Slip Op 30076[U]). On appeal, the Appellate Division affirmed, with one Justice dissenting, holding that IDT's remaining claims were not barred by collateral estoppel, because IDT had not "had an opportunity to conduct discovery on the extent of the damages it suffered due to Morgan Stanley's alleged tortious conduct" *(45 AD3d 419, 419, 846 NYS2d 116 [1st Dept 2007])*. The majority also concluded that the claims stated valid causes of action and were not time-barred. The Appellate Division granted Morgan Stanley leave to appeal to this Court, certifying the question whether its order was properly made. We answer that question in the negative and reverse. [2]

[1] Although the issue of whether IDT is collaterally estopped from relitigating the amount of its compensatory damages divided the Appellate Division in this case, we need not **[4]** address it, because all of IDT's claims are either time-barred or fail to state a cause of action. We conclude that IDT's breach of fiduciary duty, tortious interference with contract, and misappropriation of confidential and proprietary business information **[*139]** claims are untimely and its unjust enrichment claim fails to state a cause of action.

---

[1] The panel rejected IDT's contention that NewCo and Emergia were one and the same. Rather, it found, NewCo was envisaged as a company holding the infrastructure assets of SAm-1, and did not encompass the marketing function and revenues of the enterprise. In reaching this conclusion, the arbitration **[****4]** panel relied on, among other things, minutes of a July 2000 IDT board meeting, indicating that IDT recognized that Emergia was a larger enterprise, with greater growth potential, than NewCo. The arbitration panel expressed skepticism about Morgan Stanley's summer 2000 valuation of NewCo and Emergia, noting that its projections were "prepared by Telefonica and Morgan Stanley be presented to IDT as part of the process of negotiating IDT's ownership percentage in Emergia."

[2] After Supreme Court denied the motion to dismiss, the parties proceeded to discovery and Morgan Stanley produced **[****6]** documents that, according to IDT, reveal further wrongdoing by Morgan Stanley during the arbitration proceeding. IDT filed an amended complaint. Supreme Court granted Morgan Stanley's motion to dismiss the new claims. That decision is under appeal.

In June 2008, IDT moved to dismiss the present appeal as moot, on the ground that the original complaint had been significantly amended. We denied the mootness motion on September 4, 2008 (***11 NY3d 750, 894 NE2d 1187, 864 NYS2d 798 [2008]***).

We address the causes of action in the sequence they appear in the complaint.

IDT's first cause of action alleges that Morgan Stanley breached fiduciary duties it owed to IDT, by "provid[ing] Telefonica with IDT's confidential and **[****7]** proprietary **[***359]** **[**272]** business and financial information without IDT's knowledge or consent," thus inducing Telefonica to renege on the MOU, and by "devis[ing] a fraudulent scheme to dupe both IDT and the Arbitration Panel as to the 'distinction' between NewCo and Emergia and the valuation of these companies." IDT alleges that the arbitration panel was misled into minimizing the amount of damages Telefonica owed to IDT. It seeks full compensatory damages--in an amount it describes at the outset of its complaint as "hundreds of millions of dollars"--as well as disgorgement of profits and punitive damages.

IDT submits that its breach of fiduciary duty claim is governed by a six-year statute of limitations and is therefore timely. Morgan Stanley asserts that a three-year limitations period applies.

New York law does not provide a single statute of limitations for breach of fiduciary duty claims. Rather, the choice of the applicable limitations period depends on the substantive remedy that the plaintiff seeks (*Loengard v Santa Fe Indus., 70 NY2d 262, 266, 514 NE2d 113, 519 NYS2d 801 [1987]*). Where the remedy sought is purely monetary in nature, courts construe the suit as alleging "injury to property" within the **[****8]** meaning of *CPLR 214 (4)*, which has a three-year limitations period (*see e.g. Yatter v Morris Agency, 256 AD2d 260, 261, 682 NYS2d 198 [1st Dept 1998]*). Where, however, the relief sought is equitable in nature, the six-year limitations period of *CPLR 213 (1)* applies (*Loengard, 70 NY2d at 266-267*). Moreover, where an allegation of fraud is essential to a breach of fiduciary duty claim, courts have applied a six-year statute of limitations under *CPLR 213 (8)* (*Kaufman v Cohen, 307 AD2d 113, 119, 760 NYS2d 157 [1st Dept 2003]*).

[2] Here, IDT primarily seeks damages--in the amount of "hundreds of millions of dollars"--and the equitable relief it seeks, including the disgorgement of profits, is incidental to that relief. This is not an action in which it can reasonably be asserted that "the relief demanded in the complaint . . . is equitable in nature and that a legal remedy would not be adequate" (*Loengard, 70 NY2d at 267*). Thus, looking to the **[*140]** reality, rather than the form, of this action (*see Matter of Paver & Wildfoerster [Catholic High School Assn.], 38 NY2d 669, 674, 345 NE2d 565, 382 NYS2d 22 [1976]*), we conclude that IDT seeks a monetary remedy.

Moreover, we are not persuaded by IDT's argument that its breach of fiduciary duty claim is essentially **[****9]** a fraud action and therefore governed by a six-year statute of limitations. The fiduciary relationship alleged by IDT exists between Morgan Stanley and IDT, not between **[5]** Morgan Stanley and the arbitration panel. For us to conclude that IDT's breach of fiduciary duty cause of action is a sufficiently pleaded fraud action, we would have to discern a claim that IDT acted in "justifiable reliance" (*Lama Holding Co. v Smith Barney, 88 NY2d 413, 421, 668 NE2d 1370, 646 NYS2d 76 [1996]*) on Morgan Stanley's alleged misrepresentation or material omission. Although IDT asserts that Morgan Stanley attempted to deceive it in 2000, with regard to the relative values of Emergia and NewCo, IDT does not claim that it was actually duped. In fact, IDT refused to accept a modified MOU, contrary to Morgan Stanley's recommendations. Consequently, we conclude that this is not a fraud allegation, and that the three-year limitations period of *CPLR 214 (4)* applies.

[3] We now turn to the question of when IDT's breach of fiduciary duty claim **[***360]** **[**273]** accrued. A tort claim accrues as soon as "the claim becomes enforceable, i.e., when all elements of the tort can be truthfully alleged in a complaint" (*Kronos, Inc. v AVX Corp., 81 NY2d 90, 94, 612 NE2d 289, 595 NYS2d 931 [1993]*). **[****10]** As with other torts in which damage is an essential element, the claim "is not enforceable until damages are sustained" (*id. at 94*). To determine timeliness, we consider whether plaintiff's complaint must, as a matter of law, be read to allege damages suffered so early as to render the claim time-barred (*id. at 94-97*). Here, the only reasonable inference to be drawn from IDT's allegations is that it first suffered loss, as a result of Morgan Stanley's alleged breach of fiduciary duty, after Telefonica refused to comply with the MOU. The exact date of the injury is not alleged but must have been before May 25, 2001, when IDT commenced the arbitration against Telefonica, alleging that it had sustained a loss of some $ 3.15 billion as a result of Telefonica's breach of their binding agreement. More than three years passed, therefore, **[*141]** before IDT commenced this action, rendering IDT's breach of fiduciary duty claim time-barred. [3]

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[3] Morgan Stanley contends that the breach of fiduciary duty claim fails on the merits, because there was no fiduciary relationship between IDT and Morgan Stanley on the

[4] Turning to IDT's second and fourth causes of action [4] -- intentional interference with existing contract and misappropriation of confidential and proprietary business information, respectively--the statute of limitations in each case is three years, under *CPLR 214 (4)*, which the parties do not dispute. As with IDT's first cause of action, the claims were not enforceable until IDT first suffered damages. The damages are those resulting from Telefonica's refusal to comply with the MOU--intransigence that was allegedly induced by Morgan Stanley by means **[6]** of the disclosure of confidential IDT business information. Again, we must conclude from IDT's complaint that it first suffered loss--as a result of Morgan Stanley's alleged interference with contractual relations and misappropriation of confidential business information--when Telefonica refused to comply with the MOU. And again, although the exact date of the injury is not alleged, it must have been before May 25, 2001, rendering the claims time-barred.

[5] IDT argues that Morgan Stanley's statute of limitations defenses should be barred by equitable **[****12]** estoppel. However, IDT fails to demonstrate that any action or inaction by Morgan Stanley caused IDT's delay in bringing this action (*see Zumpano v Quinn, 6 NY3d 666, 673-676, 849 NE2d 926, 816 NYS2d 703 [2006]*). According to its complaint, IDT learned in 2000 that Morgan Stanley was denigrating it in discussions with Telefonica. IDT, given its awareness that Telefonica's financial adviser had disparaged it, should have made further inquiry before the statute of limitations expired (*see Putter v North Shore Univ. Hosp., 7 NY3d 548, 553-554, 858 NE2d 1140, 825 NYS2d 435 [2006]*).

[6] Finally, IDT alleges that Morgan Stanley was unduly enriched by the investment banking fees it obtained from IDT and from Telefonica "and any other fees Morgan Stanley received for its 'search' for a replacement anchor tenant, as well as any other fees of any kind that Morgan Stanley has earned for additional, presently-unknown **[***361]** **[**274]** misappropriations and misuses of IDT's confidential business and financial information." On appeal, Morgan Stanley does not argue that the unjust **[*142]** enrichment claim is time-barred. Instead it contends that IDT's fifth claim fails to state a cause of action. We agree.

"The theory of unjust enrichment lies as a quasi-contract claim" (*Goldman v Metropolitan Life Ins. Co., 5 NY3d 561, 572, 841 NE2d 742, 807 NYS2d 583 [2005]*). **[****13]** It is an obligation imposed by equity to prevent injustice, in the absence of an actual agreement between the parties concerned. Where the parties executed a valid and enforceable written contract governing a particular subject matter, recovery on a theory of unjust enrichment for events arising out of that subject matter is ordinarily precluded (*Clark-Fitzpatrick, Inc. v Long Is. R.R. Co., 70 NY2d 382, 388, 516 NE2d 190, 521 NYS2d 653 [1987]*).

It follows that the unjust enrichment claim cannot form the basis of IDT's demand that Morgan Stanley return the $ 10,000,000 fee paid in relation to the Net2Phone, Inc. transaction, because that fee arose from services governed by an engagement letter signed by IDT on July 26, 2000. [5] Nor can the unjust enrichment claim support the disgorgement of any profits Morgan Stanley obtained from Telefonica or other companies, in connection with SAm-1. An unjust enrichment claim "rests upon the equitable principle that a person shall not be allowed to enrich himself unjustly at the expense of another" (*Miller v Schloss, 218 NY 400, 407, 113 NE 337 [1916]*; **[7]** *see also Restatement [First] of Restitution § 1*). In seeking Morgan Stanley's profits from SAm-1, IDT does not, and cannot, allege that Morgan **[****14]** Stanley has been unjustly enriched at IDT's expense, because IDT did not pay the alleged fees.

Accordingly, the order of the Appellate Division should be reversed, with costs, defendants' motion to dismiss the remaining causes of action granted, the complaint dismissed in the entirety, and the certified question answered in the negative.

Judges CIPARICK, GRAFFEO, READ, SMITH and JONES concur; Chief Judge LIPPMAN taking no part.

Order reversed, etc.

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transaction in suit, but this too is a question we need not reach because the claim, even if **[****11]** meritorious, is time-barred.

[4] IDT did not appeal Supreme Court's dismissal of its third claim.

[5] IDT's argument that it engaged Morgan Stanley under duress is unpersuasive, in that the coercion by Morgan Stanley that IDT alleged in its complaint occurred after IDT refused to pay the fee, not before the fee was agreed on.

ISS Action, Inc. v Tutor Perini Corp.

Supreme Court of New York, Appellate Division, Second Department

March 6, 2019, Decided

2016-05400

Reporter
170 A.D.3d 686 *; 95 N.Y.S.3d 298 **; 2019 N.Y. App. Div. LEXIS 1551 ***; 2019 NY Slip Op 01577 ****; 2019 WL 1051554

[**1]** ISS Action, Inc., Appellant, v Tutor Perini Corporation, Respondent. (Index No. 53046/14)

Counsel: **[***1]** Coti & Sugrue, New City, NY (Stephen R. Sugrue of counsel), for appellant.

Kaufman Dolowich Voluck LLP, Woodbury, NY (Andrew L. Richards and Megan E. Yllanes of counsel), for respondent.

Judges: RUTH C. BALKIN, J.P., CHERYL E. CHAMBERS, JEFFREY A. COHEN, ROBERT J. MILLER, JJ. BALKIN, J.P., CHAMBERS, COHEN and MILLER, JJ., concur.

Opinion

[*686] **[**300]** In an action, inter alia, to recover damages for fraudulent misrepresentation and unjust enrichment and for declaratory relief, the plaintiff appeals from an order of the Supreme Court, Westchester County (Linda S. Jamieson, J.), dated April 15, 2016. The order denied the plaintiff's motion for summary judgment on its first, third, and fourth causes of action and granted the defendant's cross motion for summary judgment dismissing the complaint.

Ordered that the order is affirmed, with costs, and the matter is remitted to the Supreme Court, Westchester County, for the entry of a judgment, inter alia, making an appropriate declaration in accordance herewith.

The plaintiff alleged that the defendant entered into an agreement with the Port Authority of New York and New Jersey to make certain improvements to a runway at John F. Kennedy International Airport. **[***2]** The plaintiff further alleged that on July 31, 2009, it entered into an agreement (hereinafter the 2009 Agreement) with the defendant, pursuant to which the plaintiff was to provide security services at the job site. The 2009 Agreement set forth the various rates of compensation that the plaintiff was to receive in exchange for the security services. It also stated that those rates were "subject to New York State Sales Tax." The 2009 Agreement stated that "[t]he parties agree that as soon as they are able they will execute a completed contract subject to [the defendant's] terms and conditions."

The plaintiff alleged that it commenced performance in accordance with the 2009 Agreement and, in its first invoice to the defendant, it "included a charge for sales tax." The plaintiff alleged that the defendant paid the full amount of the first invoice, including the charge for sales tax. However, the plaintiff alleged that "one or more representatives" of the defendant informed the plaintiff that the security services it provided "were, as a matter of fact and law, exempt from New York State and local sales and use taxes."

[*687] The plaintiff alleged that the defendant subsequently provided the plaintiff **[***3]** with a New York State and Local Sales and Use Tax Contractor Exempt Purchase Certificate dated August 3, 2009 (hereinafter the Tax Exemption Certificate). The Tax Exemption Certificate, which was **[****2]** signed by an employee of the defendant, stated that "[t]he tangible personal property or service[s] being purchased" by the defendant were "exempt from sales and use tax because," and then listed a number of possible exemptions. The exemption which was marked on the Tax Exemption Certificate stated that "[t]he tangible personal property **[**301]** will be used . . . to improve real property . . . owned by an organization exempt under *section 1116 (a) of the Tax Law*."

The plaintiff alleged that after it received the completed Tax Exemption Certificate, it refunded the sales tax paid by the defendant in connection with the first invoice and did not charge the defendant any further sales tax. A more formal subcontract between the two parties was executed on February 12, 2010 (hereinafter the 2010 Agreement). As relevant here, the 2010 Agreement provided that the plaintiff would be responsible for "all payments of taxes," including "sales and use taxes." The 2010 Agreement recited that it was "the entire

agreement between the parties **[***4]** relating to the work covered hereby." The complaint alleged that "[i]n light of the representations made by [the defendant] . . . that the services being performed by [the plaintiff] on the runway [p]roject were exempt from sales and use taxes," the plaintiff signed the 2010 Agreement.

The plaintiff alleged that it continued to provide services to the defendant in connection with the runway project, and that the runway project was completed on November 1, 2011. A document titled "Final Release and Waiver of Lien" was executed by the plaintiff's representative on January 12, 2012, which "release[d] and forever discharge[d]" the defendant from "any and all claims, demands, liens and claims of lien whatsoever arising out of [the 2010 Agreement] and/or [the described] work."

In March of 2013, the plaintiff was audited by the New York State Department of Taxation and Finance, which determined that the plaintiff owed approximately $125,000 in back taxes plus interest with respect to the work it performed for the defendant. After the defendant refused the plaintiff's demands to pay the back taxes, the plaintiff commenced this action.

The plaintiff asserted four causes of action against the defendant. **[***5]** The first cause of action sought a declaration that the defendant was legally obligated to pay all sales tax, including **[*688]** interest and penalties, if any, owed as a result of the plaintiff's provision of services to the defendant. The second, third, and fourth causes of action sought to recover damages for breach of contract, unjust enrichment, and fraudulent misrepresentation, respectively.

The plaintiff subsequently moved for summary judgment on the first, third, and fourth causes of action. The defendant cross-moved for summary judgment dismissing the complaint. In the order appealed from, the Supreme Court denied the plaintiff's motion and granted the defendant's cross motion. The plaintiff appeals.

"In order to prevail in an action based upon fraudulent representations, whether for rescission of a contract or in tort for damages, the plaintiff must establish a misrepresentation of a material fact, which was false and known to be false by the defendant, made for the purpose of inducing the other party to rely upon it, justifiable reliance of the other party, and injury" (*Sitar v Sitar, 61 AD3d 739, 741, 878 NYS2d 377 [2009]*; *see Lama Holding Co. v Smith Barney, 88 NY2d 413, 421, 668 NE2d 1370, 646 NYS2d 76 [1996]*; *Hecker v Paschke, 133 AD3d 713, 716, 19 NYS3d 568 [2015])*.

A cause of action alleging fraudulent misrepresentation requires that reliance be reasonable (*see Epifani v Johnson, 65 AD3d 224, 230, 882 NYS2d 234 [2009])*. "[I]f **[***6]** the facts represented are not matters peculiarly within the party's knowledge, and the other party has the means available to him [or her] of knowing, by the exercise of ordinary intelligence, the truth or the real quality of the subject of the **[**302]** representation, he [or she] must make use of those means, or he [or she] will not be heard to complain that he [or she] was induced to enter into the transaction by misrepresentations" (*Schumaker v Mather, 133 NY 590, 596, 30 NE 755, 4 Silv A 224 [1892]*; *see ACA Fin. Guar. Corp. v Goldman, Sachs & Co., 25 NY3d 1043, 1044, 10 NYS3d 486, 32 NE3d 921 [2015]*; *DDJ Mgt., LLC v Rhone Group L.L.C., 15 NY3d 147, 154, 931 NE2d 87, 905 NYS2d 118 [2010])*.

Moreover, " '[w]hen the party to whom a misrepresentation is made has hints of its falsity, a heightened degree of diligence is required of it' " (*Centro Empresarial Cempresa S.A. v América Móvil, S.A.B. de C.V., 17 NY3d 269, 279, 952 NE2d 995, 929 NYS2d 3 [2011]*) **[****3]** , quoting *Global Mins. & Metals Corp. v Holme, 35 AD3d 93, 100, 824 NYS2d 210 [2006])*. Under such circumstances, the party " 'cannot reasonably rely on such representations without making additional inquiry to determine their accuracy' " (*Centro Empresarial Cempresa S.A. v América Móvil, S.A.B. de C.V., 17 NY3d at 279*, quoting *Global Mins. & Metals Corp. v Holme, 35 AD3d at 100*).

Here, the fourth cause of action sought to recover damages **[*689]** for fraudulent misrepresentation. The complaint alleged that the defendant's erroneous representations as to the tax-exempt status of the plaintiff's services induced the plaintiff to enter into the 2010 Agreement and forgo the collection of taxes from the defendant in connection with the runway project. However, the defendant established, prima **[***7]** facie, that any such reliance was unreasonable as a matter of law. The plaintiff does not allege that the defendant was in the exclusive possession of any facts which bore upon the tax-exempt status of the plaintiff's work. To the contrary, the plaintiff was aware of the nature of the services it was providing to the defendant. As such, the only representation upon which the plaintiff could have relied was the defendant's legal opinion as to the taxable status of the plaintiff's work. In that regard, the plaintiff was in an equal position to discover the applicable law. Furthermore, the Tax Exemption

Certificate issued by the defendant was, on its face, inapplicable to the plaintiff's work given that the plaintiff was providing security services to the defendant, rather than "tangible personal property." Under such circumstances, a " 'heightened degree of diligence is required' " (*Centro Empresarial Cempresa S.A. v América Móvil, S.A.B. de C.V., 17 NY3d at 279*, quoting *Global Mins. & Metals Corp. v Holme, 35 AD3d at 100*), and yet the plaintiff failed to utilize the means it had to determine the truth of the defendant's legal representations (*see Hecker v Paschke, 133 AD3d at 716-717*; *Sitar v Sitar, 61 AD3d at 742*; *Friedler v Palyompis, 44 AD3d 611, 611-612, 845 NYS2d 347 [2007]*; *Orlando v Kukielka, 40 AD3d 829, 831-832, 836 NYS2d 252 [**303] [2007]*; *Curran, Cooney, Penney v Young & Koomans, 183 AD2d 742, 743-744, 583 NYS2d 478 [1992]*).

In opposition to the defendant's prima facie showing, the plaintiff failed to raise a triable issue of fact as to whether its reliance upon the alleged misrepresentations **[***8]** was justified under the circumstances. Accordingly, we agree with the Supreme Court's grant of that branch of the defendant's cross motion which was for summary judgment dismissing the fourth cause of action (*see Hecker v Paschke, 133 AD3d at 716-717*; *Sitar v Sitar, 61 AD3d at 742*; *Friedler v Palyompis, 44 AD3d at 611-612*; *Orlando v Kukielka, 40 AD3d at 831-832*; *Curran, Cooney, Penney v Young & Koomans, 183 AD2d at 743-744*). For the same reasons, we agree with the court's denial of that branch of the plaintiff's motion which was for summary judgment on that cause of action.

The third cause of action asserted in the complaint alleged unjust enrichment. The doctrine of unjust enrichment invokes an "obligation imposed by equity to prevent injustice, in the **[*690]** absence of an actual agreement between the parties concerned" (*IDT Corp. v Morgan Stanley Dean Witter & Co., 12 NY3d 132, 142, 907 NE2d 268, 879 NYS2d 355 [2009]*; *see Pappas v Tzolis, 20 NY3d 228, 234, 982 NE2d 576, 958 NYS2d 656 [2012]*). Accordingly, "a party may not recover in quantum meruit or unjust enrichment where the parties have entered into a contract that governs the subject matter" (*Cox v NAP Constr. Co., Inc., 10 NY3d 592, 607, 891 NE2d 271, 861 NYS2d 238 [2008]*; *see Pappas v Tzolis, 20 NY3d at 234*).

Here, the defendant established, prima facie, that the payment of applicable taxes was expressly provided for in the parties' agreements (*see CSI Group, LLP v Harper, 153 AD3d 1314, 61 NYS3d 592 [2017]*; *Rayham v Multiplan, Inc., 153 AD3d 865, 868-869, 61 NYS3d 90 [2017]*). Indeed, the plaintiff's complaint alleges as much. In opposition, the plaintiff failed to raise a triable issue of fact. Accordingly, we agree with the Supreme Court's grant of that branch of the defendant's cross motion which was for summary judgment dismissing **[***9]** the third cause of action (*see CSI Group, LLP v Harper, 153 AD3d 1314, 61 NYS3d 592 [2017]*; *Rayham v Multiplan, Inc., 153 AD3d at 868-869*). For the same reasons, we agree with the court's denial of that branch of the plaintiff's motion which was for summary judgment on that cause of action.

The second cause of action sought to recover damages for breach of contract. The complaint alleged that the defendant breached the 2009 Agreement by failing to pay applicable sales tax for services rendered pursuant to that agreement, and that the plaintiff was damaged in the amount of back taxes, and interest imposed thereon, which the New York State Department of **[****4]** Taxation and Finance sought to recover from the plaintiff after the audit.

The defendant established that the unpaid taxes which New York State sought to recover from the plaintiff accrued on invoices which were dated *after* the 2010 Agreement was executed by the parties. The 2010 Agreement required the plaintiff to pay all applicable taxes. Accordingly, the defendant established, prima facie, its entitlement to summary judgment dismissing the second cause of action. In opposition, the plaintiff failed to raise a triable issue of fact as to whether any of the back taxes accrued for work that was performed prior to the execution of the 2010 **[***10]** Agreement such that the terms of the 2009 Agreement would control. Accordingly, we agree with the Supreme Court's grant of that branch of the defendant's cross motion which was for summary judgment dismissing the second cause of action (*see Alvarez v Prospect Hosp., 68 NY2d 320, 324, 501 NE2d 572, 508 NYS2d 923 [1986]*).

Finally, inasmuch as the defendant established, as a matter **[*691]** of law, that it was not required to pay the disputed taxes under any theory advanced by the plaintiff, we agree with the Supreme Court's denial of that branch of the plaintiff's motion which was for summary judgment on the first cause of action, and grant of that branch of the defendant's cross motion which was for summary judgment dismissing **[**304]** the first cause of action. Since this is, in part, a declaratory judgment action, we remit the matter to the Supreme Court, Westchester County, for the entry of a judgment, inter alia, declaring that the defendant is not

legally obligated to pay all sales tax, including interest and penalties, if any, owed as a result of the plaintiff's provision of services to the defendant (*see* *Lanza v Wagner, 11 NY2d 317, 183 NE2d 670, 229 NYS2d 380 [1962]*). Balkin, J.P., Chambers, Cohen and Miller, JJ., concur.

Kasen v. Morrell

Supreme Court of New York, Appellate Division, Second Department

June 16, 1958 - Decided

No Number in Original

Reporter
6 A.D.2d 816 *; 175 N.Y.S.2d 315 **; 1958 N.Y. App. Div. LEXIS 5562 ***

DAVID KASEN, Respondent, v. CHARLOTTE S. MORRELL et al., Appellants, et al., Defendants.

Opinion

[*1]** **[*816]** **[**316]** Appeal from so much of an order as denied a motion, pursuant to subdivision 4 of rule 106 of the Rules of Civil Practice, to dismiss the first cause of action in the complaint (which was pleaded solely against appellant Charlotte S. Morrell) and the third and fourth causes of action in the complaint (which were pleaded solely against appellant Samuel Morrell). Order affirmed, with $10 costs and disbursements. The first cause of action is based on the alleged breach of a written contract between respondent and appellant Charlotte S. Morrell, the owner of a licensed retail liquor store, pursuant to which respondent agreed to purchase, and said appellant agreed to sell, a one-half interest in the liquor store and to become partners in the business, conditioned on the approval of the State Liquor Authority of the application for the retail liquor store license necessary for the sale of the one-half interest and the creation of the partnership.It was agreed therein that application to the State Liquor Authority for approval would be made within a reasonable time and that, in the event the State Liquor Authority did not approve the purchase within four months **[***2]** from the date of the contract, the sale would become of no effect and all money paid to said appellant should be returned to respondent within 60 days thereafter. The contract provided that, subject to the provisions therein contained, respondent and said appellant would become partners in the business. It was also provided therein that "Upon the approval by the State Liquor Authority, as hereinafter provided, the parties hereto, at the closing, will enter into a partnership agreement to effectuate the purposes of this agreement." **[**317]** The complaint was verified about 19 months after the contract was executed. In the first cause of action, it is alleged that respondent loaned $10,000 to said appellant and paid $5,000 on account of the purchase price, pursuant to the terms of the contract, and that respondent is willing to abide by the agreement and to perform. It is also alleged that said appellant failed and refused to make the application to the State Liquor Authority for the approval and sale of the one-half interest in the business and the creation of the partnership. Appellants contend that since the contract provided that, on approval by the State Liquor Authority **[***3]** the parties would enter into a partnership agreement to effectuate the purposes of the agreement, the first contract was nothing more than an agreement to agree and therefore unenforcible. They refer to the fact that there are no provisions in the contract for the duration of the partnership, the drawings of the partners, how the business should be managed and what should happen on the death of a partner or the dissolution of the partnership. The contract was not a mere brief memorandum. It had many provisions which need not now be described. From the contract itself, it is evident that it was executed with consideration of the restrictions imposed by the Alcoholic Beverage Control Law and the Rules of the State Liquor Authority on the issuance and transfer of licenses, and with consideration of the approval required of persons who have, or seek to acquire, interests in licensed premises. It is evident that the contract was executed with the realization that a license is a valuable asset of the owner of licensed premises (see, e.g., *Monclova v. Arnett, 3 N Y 2d 33*). A contract is to be interpreted in accordance with the intention of the contracting parties. Custom **[***4]** or usage, when the parties know or have reason to know of the custom or usage, when the custom or usage is reasonable, uniform, well **[*817]** settled, not in opposition to fixed rules of law and not in contradiction of the express terms of the agreement, is deemed to form a part of the contract and to enter into the intention of the parties. The parties are presumed to contract in reference to the law of this State *(Frye v. State of New York, 192 Misc. 260, 264-265)*. Unless "a contract provides otherwise, the law in force at the time the agreement is entered into becomes as much a part of the agreement as though it were expressed or referred to therein, for it is presumed that the parties

had such law in contemplation when the contract was made and the contract will be construed in the light of such law" *(Dolman v. United States Trust Co., 2 N Y 2d 110, 116)*. In our opinion the allegations in the first cause of action do not require a determination that an agreement on material elements had not been made and that the contract was unenforcible *(Spiritusfabriek Astra of Amsterdam, Holland v. Sugar Prods. Co., 176 App. Div. 829*, **[**318]** affd. **[***5]** *221 N. Y. 581*; cf. *Ansorge v. Kane, 244 N. Y. 395*). The "purposes of this agreement" could have been effectuated by the application of the Partnership Law (see, e.g., *Spiritusfabriek Astra of Amsterdam, Holland v. Sugar Prods. Co., supra)*. Even if the contract were unenforcible, it would not be proper to dismiss the cause as insufficient since it states a cause of action at least for the return of the money paid by respondent pursuant to the contract *(Nisofsky v. Simon, 280 App. Div. 874*; see, e.g., *Healy v. Hourigan, 276 App. Div. 1085*). So far as the causes of action against appellant Samuel Morrell are before us for review, they cannot be dismissed as insufficient even if the contract between respondent and Charlotte S. Morrell were unenforcible. They state at least causes of action to recover damages for breach of a contract signed by appellant Samuel Morrell, the husband of the other appellant, on the same date that the other contract was executed, guaranteeing, in part, performance by the wife of her contract. Wenzel, Acting P.J., Beldock, Murphy, Hallinan and **[***6]** Kleinfeld, JJ., concur. [*10 Misc 2d 176*.]

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SUPREME COURT - STATE OF NEW YORK

PRESENT: HON. JACK L. LIBERT,
Justice.

TRIAL PART 23
NASSAU COUNTY

LONG ISLAND RADIOLOGY ASSOCIATES, P.C.

Plaintiff,

-against-

MOTION # 02, 04, 05
INDEX # 600195/19
MOTION SUBMITTED:
AUGUST 2, 2019

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ABEY KOSHY, ALICIA A. CAMBRIA, AMARYLLIS MENDEZ, ANGELA T. LAINO, ANGELA RAMOS, ARON NAFISI, BASIL J. OSABU, BENJAMIN A. GOBIOFF, BIND KEERIKATTE, BRIGITTE M. GEFFKEN-KELLY, CARLOS A. MONTILLA, CARMEN H. SANTOS, CHRISTINA L. WEEDON, CHRISTINA PALMIERO-WILLIAMS, CYNTHIA BRITO, DANIEL E. BEYDA, DEBORAH A. ASDAHL, DENNIS R. ROSSI, ELVIRA E. ERDAIDE, GEORGE H. CONNELL, GERALD SCHULZE, GEORGINA PEACHEY, HADASSAH HOFFMAN-BROWNSTEIN, HAMIDE CENAJ, IGOR CHER, IRINA MURATOVA, JAMIE L. ESPOSITO, JAMES M. LODOLCE, JASON W. SISK, JASON WILSON, JEFFREY JONES, JENNIFER E. D'AMBROSIO, JESSICA A. BOXER, JONATHAN OLIVERI, JOSE F. VALERIANO, KATIE L. O'SULLIVAN, KHALID U. KHAN, KRISTEN PERDICHIZZI, LANCE S. LEFKOWITZ, LISA G. LEE, MARGARET J. USURIELLO, MARILYN MADRID, MARINA TAMARKINA, MARTHA S. MORALES, MELISSA SPENCER, MICHAEL KLUKO, MILAGROS A. TLATOA, MIRA SHPIGELMAN, NILKA E. SANTANA, NORMA Y. ARCE, OLIVER PRATT, PASHA TORKAMANI, RON PANDOLFINI, SAMUEL M. ISSAC-REJIAH, SCOTT A. MCNALLY, STACY HONOVICH, SUZANNE CARLTON, THIERRY DUVIVIER, TINAMARIE P. THADAL, AND VICTORIA L. BEYDA,

Defendants.

The following papers having been read on this motion:

Notice of Motion/Order to Show Cause.....1, 2
Cross Motion/Answering Affidavits.....3, 4, 5, 6
Reply Affidavits.....7, 8, 9

Pursuant to CPLR 3211 defendant Gerald Schulze moves for summary judgment dismissing the complaint against him and granting the declaratory relief sought in his counterclaims (Motion Seq. # 2); defendants Daniel E. Beyda and Victoria L. Beyda also move for dismissal of the complaint and summary judgment on their counterclaims (Motion Seq. # 4); plaintiff moves for summary judgment granting the relief sought in the complaint and dismissing the counterclaims of Schulze and the Beyda defendants (Motion Seq. # 5]).

Plaintiff owns and operates a radiological medical practice. Schulze is a former physician employee. The Beyda defendants were originally shareholders of plaintiff, but subsequently relinquished their shareholdings and became employees. Plaintiff provided malpractice insurance for each of the moving defendants through Medical Liability Mutual Insurance Company, which was a mutual company. As part of an approved demutualization plan, MLMIC agreed to a dividend payment[1] to policyholders of record, subject to a court determination as to whether that is the party equitably entitled to the proceeds. Plaintiff asserted in the instant action that it is entitled to the dividend distribution, having paid all the premiums and maintained the policies.

Defendant Schulze

At all relevant times Schulze was employed by plaintiff under the terms of an employment contract dated July 1, 2011. The compensation of Schulze was fixed on an annual basis (¶ Third, Schulze Affidavit). In addition to the annual compensation plaintiff agreed to pay certain expenses that Schulze would incur in connection his employment including the cost of malpractice insurance (Exhibit B, ¶ Fourth, Schulze Affidavit). These premium payments were not deducted from the compensation that Schulze received from plaintiff. Essentially they were in lieu of reimbursement

[1]The dividends are calculated based upon the premiums paid (Insurance Law §7307).

to him for expenses he would have otherwise incurred. It is undisputed that plaintiff duly paid the insurance premiums throughout the course of Schulze's employment.

In the *Matter of Schaffer, Schonholz & Drossman, LLP v Title* (171 A.D.3d 465, 96 N.Y.S.3d 526 [1st Dept. 2019]) the court held:

> Although respondent was named as the insured on the relevant MLMIC professional liability insurance policy, petitioner purchased the policy and paid all the premiums on it. Respondent does not deny that she did not pay any of the annual premiums or any of the other costs related to the policy. Nor did she bargain for the benefit of the demutualization proceeds.

In the case at bar plaintiff paid the premiums at its own expense. Schulze received the benefit of his bargain having been relieved of the obligation to pay those premiums. Like the respondent in *Schaffer* (*supra*) Schulze would be unjustly enriched if he received the dividend based upon premiums that plaintiff paid.

The Beyda Defendants

With respect to their tenure as employees of plaintiff the Beyda defendants would be unjustly enriched in the same fashion as Schulze if allowed to collect the policy dividends. With respect to the period of time that they were shareholders, the Beyda defendants argue that the premiums paid were paid out of corporate funds which would otherwise have been distributed to them (presumably in *pari passu* to the respective ownership interests of all shareholders). Since "their equity interest contributed to the payment of MLMIC premiums" they claim to be entitled to the dividends.

Under general principles of corporate law, a shareholder and the corporation are separate entities. Even if they were not separate entities the position of the Beydas is contrary to reason. If the corporation distributed to shareholders the funds used to pay for the malpractice insurance, the

Beyda defendants would not have had the insurance; unless they paid for it themselves in which event they would not have the distributed funds.

Conclusion

Plaintiff is entitled to the cash proceeds resulting from the demutualization of nonparty MLMIC. The motions of moving defendants (Motion Seq. # 2 and #4) are denied. Plaintiff's motion for summary judgment (Motion Seq. #5) is granted and the counterclaims are dismissed.

ORDERED and decreed, it is hereby declared that plaintiff is entitled to the proceeds of the MLMIC distribution; and it is further

ORDERED that MLMIC shall pay the cash proceeds in escrow together with interest accrued to plaintiff.

ORDERED, that any relief not specifically granted is denied.

Submit judgment.

ENTER

DATED: October 7, 2019

Jack L. Libert

HON. JACK L. LIBERT
J. S. C.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER

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MAPLE MEDICAL LLP, RICHARD FRIMER, M.D., ANDREW GOLDSTEIN, M.D., JOANNE TAMBURRI, M.D., AND WILLIAM ZAROWITZ, M.D.,

DECISION, ORDER & JUDGMENT

Petitioner,

Index No. 65929/2018

-against-

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES, MARIA T. VULLO, SUPERINTENDENT OF THE DEPARTMENT OF FINANCIAL SERVICES,

Respondents,

For a judgment, pursuant to Article 78 of the Civil Practice Law and Rules.

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SCHWARTZ, J.

Petitioners commenced this hybrid CPLR Article 78 proceeding and declaratory judgment action seeking an order and judgment (1) reversing, annulling, vacating and setting aside the Decision of the Superintendent of the Department of Financial Services dated September 6, 2018, and/or (2) declaring that the parties that paid the premiums on the polices of insurance for the identified period are the policy holders of the policies issued by Medical Liability Insurance Company, and/or (3) declaring that the parties that paid the premiums on these policies are the parties entitled to receive any payment due upon demutualization. The respondents oppose.

The Court has considered the following papers: the e-filed documents numbered 1-23, 31-48, and 51-57.

Upon the foregoing papers, the petition is disposed of as follows:

Petitioner MAPLE MEDICAL LLP is a multispecialty medical practice in White Plains, New York. As gleaned from the papers, on or about July 15, 2016, Medical Liability Mutual Insurance Company ("MLMIC") announced that it would seek to convert from a domestic mutual property/casual insurance company into a domestic stock property/casualty insurance company and, pursuant to Insurance Law § 7307, filed an application with the respondents for permission to convert. Pursuant to the conversion plan and an acquisition agreement, MLMIC would convert, and, in exchange, the eligible policyholders would receive cash consideration for their interest in MLMIC, rather than stock, which would instead be sold to National Indemnity Company. Policyholders' cash payments would be calculated based upon the pro-rata share of net premiums paid on

eligible policies. The conversion plan defines a policyholder as a person or persons identified on the declaration page of the policy as the insured.

Respondents ordered an examination of MLMIC pursuant to Insurance Law § 7307(b)(3) and after a duly-noticed public hearing, amendments to the acquisition agreement and examination report, the Department approved the conversion plan provided the plan was submitted to a vote by the record date policyholders and, upon approval, the acquisition closed by September 30, 2018, or any agreed upon extended date (*see* Decision, Doc No. 23). On September 13, 2018, the record date policyholders approved the plan and the acquisition by National Indemnity Company's of MLMIC's shares closed on October 1, 2018. As of October 30, 2018, over $2.3 billion has been paid out to eligible policyholders.

On September 28, 2018, the petitioner commenced the instant proceeding and action. Petitioners do not argue that the determination approving demutualization and sale of MLMIC was arbitrary and capricious, irrational, or in violation of proper procedure. Rather, the petitioners argue that the definition of a policyholder in the conversion plan is erroneous because it is contrary to the Insurance Law's definition of a policy holder. Petitioners contend that, in effect, Insurance Law § 7307 requires 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. Since Petitioners paid for and procured medical liability insurance from MLMIC for employees of their practice, Petitioners argue they, not the doctors they paid to insure, should have been deemed the policyholders and thus recipients of cash payments under the conversion plan.

Respondents argue as affirmative defenses that, *inter alia*, the petition must be dismissed as moot and the petitioners failed to name necessary parties. Respondents also contend that, nevertheless, the determination was not contrary to the Insurance Law, arbitrary and capricious, nor irrational, and should be upheld.

Relevant Law

An administrative determination "must be upheld if it has support in the record, a reasonable basis in law, and is not arbitrary or capricious" (*Paloma Homes, Inc. v Petrone*, 10 AD3d 612, 613 [2d Dept 2004]).

"As the power of a court to declare the law only arises out of, and is limited to, determining the rights of persons which are actually controverted in a particular case, courts generally may not pass on academic, hypothetical, moot, or otherwise abstract questions…Thus, courts ordinarily may not consider questions that have become moot by passage of time or change in circumstances…When a determination would have no practical effect on the parties, the matter is moot and the court generally has no jurisdiction to decide the matter" (*Berger v Prospect Park Residence, LLC*, 166 AD3d 937 [2d Dept 2018] [internal citations omitted]; *see also State Farm Mut. Auto. Ins. Co. v TIG Ins. Co.*, 62 AD3d 859, 860 [2d Dept 2009]).

"A party whose interest may be adversely effected by a potential judgment must be made a party in a CPLR article 78 proceeding" (*Karmel v White Plains Common Council*, 284 AD2d 464, 465 [2d Dept 2001]; *see also Feder v Town of Islip Zoning Bd. of Appeals*, 114 AD3d 782 [2nd Dept 2014] and CPLR 1001[a]). Where a necessary party has not been timely joined and does not voluntarily appear or participate in the proceeding, the Supreme Court must deny the petition and dismiss the proceeding. (*see Karmel v White Plains Common Council*, 284 AD2d 464, 465 [2d Dept 2001; *Artrip v Inc. Vil. of Piermont*, 267 AD2d 457, 457 [2d Dept 1999]).

Discussion

Since the filling of the petition, it is not disputed that demutualization has occurred and that over $2.3 billion in cash payments have been distributed to policyholders pursuant to the determination of the Department and the conversion plan. In light of the foregoing and petitioners' failure to seek injunctive relief from this Court to preserve the status quo before demutualization and distribution of cash payments, I find the petition is moot and must be dismissed (*see Berger* at 937; *see also Weeks Woodlands Ass'n, Inc. v Dormitory Auth. of State, 95 AD3d 747 [1st Dept 2012], affd, 20 NY3d 919 [2012]*).

If the petition were not moot, it would still be dismissed for failure to name necessary parties. The policyholders who received cash payments were not made parties to this proceeding, and it cannot be disputed they would be adversely effected by a potential judgment declaring them not entitled to those payments in whole or in part (*see Karmel* at 465). Moreover, of those policyholders who are entitled to receive cash payments under the plan, it is not in dispute some of them are doctors employed by the petitioners' very own medical practice (*see* Doc. No. 4). Yet, the petitioners did not join those doctors in this proceeding and action.

Even if the Court were to reach the merits of the petition, the Court would not annul the respondents' determination. The Court's review of the parties' submissions, including the record, reveals that the respondents properly considered and weighed the relevant criteria and that the determination had a rational basis. Furthermore, the record does not reveal that the respondents acted illegally or arbitrarily and capriciously. Given these circumstances, the Court would not disturb the respondents' determination. Accordingly, it is

ORDERED and ADJUGED that the petition is dismissed in its entirety.

This decision constitutes the order and judgment of the Court.

Dated: White Plains, New York
December 28, 2018

HON. LARRY J. SCHWARTZ, A.J.S.C.

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January 2nd 2019

TO: All parties by e-filing.

SUPREME COURT OF THE STATE OF NEW YORK
Appellate Division, Fourth Judicial Department

16

CA 19-00612

PRESENT: WHALEN, P.J., CENTRA, LINDLEY, TROUTMAN, AND WINSLOW, JJ.

MAPLE-GATE ANESTHESIOLOGISTS, P.C.,
PLAINTIFF-APPELLANT,

V MEMORANDUM AND ORDER

DEIXY NASRIN AND DOUGLAS BRUNDIN,
DEFENDANTS-RESPONDENTS.

BARCLAY DAMON LLP, BUFFALO (ROBERT J. PORTIN OF COUNSEL), FOR PLAINTIFF-APPELLANT.

HURWITZ & FINE, P.C., BUFFALO (AMBER E. STORR OF COUNSEL), FOR DEFENDANTS-RESPONDENTS.

Appeal from an order of the Supreme Court, Erie County (Frank A. Sedita, III, J.), entered March 22, 2019. The order granted the motion of defendants to dismiss the complaint.

It is hereby ORDERED that the order so appealed from is unanimously affirmed without costs.

Memorandum: Plaintiff commenced this action against defendants, its former employees, alleging that it is entitled to certain proceeds paid to defendants by the Medical Liability Mutual Insurance Company (MLMIC) as a result of MLMIC's conversion from a mutual insurance company to a stock insurance company (demutualization). Pursuant to defendants' employment contracts, plaintiff agreed to provide to defendants the annual premiums for their professional liability insurance as part of their compensation packages. Plaintiff purchased professional liability insurance for defendants and all of its employees through MLMIC. Each defendant was named as the "insured" or "policyholder" on his or her MLMIC policy, and plaintiff was formally designated by defendants as the "Policy Administrator." Defendants assigned certain policyholder rights to plaintiff as the Policy Administrator, namely, the right to receive any dividends and return premiums, and also assigned certain policyholder duties, namely, the duty to pay all premiums.

In 2018, after defendants had left their employment with plaintiff, MLMIC made certain demutualization payments to defendants because of their status as former policyholders. When defendants refused plaintiff's request to pay it 50% of those payments, plaintiff commenced this action, asserting causes of action for conversion and unjust enrichment and alleging that it was the rightful recipient of

the demutualization payments. Thereafter, defendants moved to dismiss the complaint pursuant to, inter alia, CPLR 3211 (a) (1). Supreme Court granted the motion, and we affirm.

"On a motion to dismiss pursuant to CPLR 3211, pleadings are to be liberally construed . . . The court is to accept the facts as alleged in the [pleading] as true . . . [and] accord [the proponent of the pleading] the benefit of every possible favorable inference" (*Baumann Realtors, Inc. v First Columbia Century-30, LLC*, 113 AD3d 1091, 1092 [4th Dept 2014] [internal quotation marks omitted]). "A motion to dismiss pursuant to CPLR 3211 (a) (1) will be granted if the documentary evidence resolves all factual issues as a matter of law, and conclusively disposes of the [plaintiff's] claim[s]" (*Lots 4 Less Stores, Inc. v Integrated Props., Inc.*, 152 AD3d 1181, 1182 [4th Dept 2017] [internal quotation marks omitted]).

Here, contrary to plaintiff's contention, the court properly granted the motion because the documentary evidence established as a matter of law that plaintiff had no legal or equitable right of ownership to the demutualization payments (*see La Barte v Seneca Resources Corp.*, 285 AD2d 974, 976 [4th Dept 2001]; *Di Siena v Di Siena*, 266 AD2d 673, 674 [3d Dept 1999]; *see generally Mandarin Trading Ltd. v Wildenstein*, 16 NY3d 173, 182 [2011]; *Colavito v New York Organ Donor Network, Inc.*, 8 NY3d 43, 49-50 [2006]). Insurance Law § 7307 (e) (3) provides that, when a mutual insurance company converts to a stock insurance company, the plan of conversion: "shall . . . 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 [seeking approval of the conversion] 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." In support of their motion, defendants submitted the MLMIC plan of conversion (plan), which, in accordance with that provision of the Insurance Law, provided that cash distributions were required to be made to those policyholders who had coverage during the relevant period prior to demutualization in exchange for the "extinguishment of their Policyholder Membership Interests." The plan stated that the cash distribution would be made to the policyholder unless he or she "affirmatively designated a Policy Administrator . . . to receive such amount on [his or her] behalf." Additional documentary evidence demonstrated that defendants were the policyholders of the relevant MLMIC policies and that, although defendants had assigned some of their rights as policyholders to plaintiff as Policy Administrator, they had not designated plaintiff to receive demutualization payments. Even assuming, arguendo, that plaintiff could be entitled to the demutualization payments without the express designation contemplated by the plan, we conclude that plaintiff has not alleged any facts or circumstances from which it could be established that it was entitled to any such payments. The mere fact that plaintiff paid the annual premiums on the policies on defendants' behalf does not entitle it to the demutualization payments (*cf. Matter of Schaffer, Schonholz &*

Drossman, LLP v Title, 171 AD3d 465, 465 [1st Dept 2019]).

Entered: April 24, 2020

Mark W. Bennett
Clerk of the Court

Maple-Gate Anesthsiologists, P.C. v. Nasrin

Supreme Court of New York, Erie County

March 22, 2019, Decided

818104/2018

Reporter
63 Misc. 3d 703 *; 96 N.Y.S.3d 837 **; 2019 N.Y. Misc. LEXIS 1173 ***; 2019 NY Slip Op 29075 ****

[**1]** Maple-Gate Anesthsiologists, P.C., Plaintiff against Deixry Nasrin and DOUGLAS BRUNDIN, 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.

Counsel: **[***1]** For Plaintiff: Robert J. Portin and Michael E. Ferdman, of Counsel, HURWITZ & FINE, P.C.

For Defendant: Amber Storr and Andrea Schillaci, of Counsel.

Judges: HON. FRANK A. SEDITA, III, J.S.C.

Opinion by: FRANK A. SEDITA, III

Opinion

[*704] **[**838]** Frank A. Sedita III, J.

The plaintiff is suing the defendants for unjust enrichment and conversion. Before the court is the defendants' pre-Answer motion to dismiss the lawsuit.

The plaintiff is a medical practice. It provides anesthesia services to hospitals and ambulatory surgical centers in Western New York. These facilities require the plaintiff's physicians and Certified Registered Nurse Anesthetists to maintain professional liability insurance.

The defendants are Certified Registered Nurse Anesthetists. Defendant Deixry Nasrin was employed by the plaintiff from March 13, 2012 to April 28, 2017. Defendant Douglas Brundin was employed by the plaintiff from January 1, 2010 to January 6, 2016. Article 3 (c)(ii) of their employment agreements provided that the plaintiff would pay professional liability **[****2]** insurance premiums as an "employment benefit for and on behalf of" the employee. That insurance was secured through the Medical Liability Mutual Insurance Company (MLMIC). The defendants **[***2]** were named as the insured under their individual MLMIC policies. They consequently became policyholders and members of MLMIC.

MLMIC and the defendants entered into a "MLMIC Policy Administrator — Designation & /or Change" agreement, by which the defendants designated the plaintiff as their agent and policy administrator. According its terms, "The Policy Administrator is the agent of all Insureds herein for the paying of premium, requesting changes in the policy, including cancellation thereof and for receiving dividends and any return premiums when due."

Neither the employment agreement nor the MLMIC Policy Administrator — Designation & /or Change agreement contained language indicating that the defendants **[**839]** waived, transferred or assigned their ownership interest in the policy to someone else.

The MLMIC Board of Directors approved a proposed transaction by which MLMIC would demutualize, convert to a stock **[*705]** insurance company, and be acquired by the National Indemnity Company (NICO) for $2.502 billion. The MLMIC Board later adopted a plan of conversion, whereby cash consideration would be paid to policyholders/members in exchange for the extinguishment of the policyholder membership interests. **[***3]** Pursuant to §8.2(a) of the Plan of Conversion (the Plan), "Each Eligible Policyholder (or it's designee) shall receive a cash payment in an amount equal to the applicable conversion." Pursuant to §2.1 of the Plan, an "eligible policyholder" was the person designated as the insured, while a "designee" meant employers or policy administrators, "designated by Eligible Policyholders to receive the portion of the Cash Consideration allocated to such Eligible Policyholders." The Plan did not provide for the policy

administrator to receive cash consideration absent such a designation from the policyholder/member.

The New York Superintendent of Financial Services held a public hearing and approved the Plan. In her September 6, 2018 decision (DFS Decision), the Superintendent wrote: "MLMIC's eligible policyholders will receive cash consideration. *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 explicitly provides that each Eligible Policyholder's equitable share of the purchase price shall be determined **[***4]** based on the amount of the net premiums paid on eligible policies" (DFS Decision, p.4).

The DFS Decision also acknowledged testimony and written comments from medical groups. Nearly identical to the plaintiff's contentions in this case, the medical groups had argued that the cash consideration belonged to them because they had paid the premiums on behalf of the policyholders and/or had acted as the policy administrators. Addressing these arguments, the Superintendent of Financial Services wrote: "*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 **[*706]** 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." Such a claim would be, "decided either by agreement of the parties or by an arbitrator [which must be voluntary] or court" (DFS Decision, p.25).

The plaintiff did not make a claim, or otherwise avail itself of the objection and escrow procedure. MLMIC paid $18,532.60 to defendant Nasrim and $15,546.95 **[***5]** to defendant Brundin **[****3]** on October 4, 2018. Plaintiff's counsel corresponded to both defendants on the very same day. He threatened the defendants with legal action and demanded that they, "execute an [enclosed] Assignment Agreement transferring your right to the cash consideration to the practice."

Much of the foregoing detail is alleged in the plaintiff's complaint. It additionally alleges, inter alia, that the money received by the defendants is "unwarranted" and "rightly belongs to Maple-Gate" (¶29-32); that "it is against equity and good conscience" for defendants to have kept these **[**840]** benefits because the plaintiff paid the premiums (¶40); that the defendants were "unjustly enriched" (¶41); that the, "cash consideration that Defendants received is Maple-Gate's property" (¶45); and, that "by failing and refusing to remit the Benefit that each Defendant received, each Defendant has converted Maple-Gate's property" (¶48).

The defendants filed their motion to dismiss, in lieu of an Answer, on January 6, 2019. Pursuant to *CPLR 3211(a)(7)*, the defendants allege that the complaint fails to state a cause of action. Pursuant to *CPLR 3211(a)(1)*, the defendants also allege that the documentary evidence conclusively establishes **[***6]** that the plaintiff does not have a cause of action. The plaintiff's opposition papers were filed on February 8, 2019. Oral arguments were heard by the court on February 20, 2019.

In support of their motion to dismiss, the defendants principally contend that they were the lawful policyholders and thus possessed an actual and exclusive ownership interest in the cash consideration.

In opposition, the plaintiff principally contends that it is entitled to the cash consideration because it had a virtual ownership interest in the cash consideration; i.e. being designated as the policy administrator, paying the premiums and using any refunds to reduce overall business costs, "vested **[*707]** the Practice w/ virtually all incidents of ownership in the policies" (Plaintiff's Memorandum of Law, p.5). The plaintiff also contends that the Plan and the DFS Decision, "control everything in the case and take precedence over everything in the case" and that, "both expressly recognize the practice's claims to the proceeds and expressly or implicitly, at least, refute the claim that the defendants have to those proceeds as a matter of law" (Transcript of Motions Argument, p.11).

CPLR 3211 authorizes the summary dismissal **[***7]** of a complaint. The court, when considering such a motion, must accept the facts as alleged in the complaint as true, accord the plaintiff the benefit of every possible favorable inference, and determine only whether the facts as alleged fit within any cognizable legal theory. *Leon v. Martinez, 84 NY2d 83, 88, 638 N.E.2d 511, 614 N.Y.S.2d 972*; *Murmane Building Contractors, LLC v. Cameron Hill Construction, LLC, 159 AD3d 1602, 1603, 73 N.Y.S.3d 848*. A cause of action cannot, however, be predicated on mere conclusory statements unsupported by factual

allegations. *Bratge v. Simons, 167 AD3d 1458, 91 N.Y.S.3d 630*; *Miller v. Allstate Indemnity Co., 132 AD3d 1306, 17 N.Y.S.3d 240*. Allegations consisting of bare legal conclusions, as well as claims flatly contradicted by documentary evidence, are not entitled to consideration. *Maas v. Cornell University, 94 NY2d 87, 91, 721 N.E.2d 966, 699 N.Y.S.2d 716*; *Attallah v. Milbank, Hadley, and McCoy, LLP 168 AD3d 1026, 93 N.Y.S.3d 353*. Such a complaint should be dismissed when the documentary evidence conclusively refutes its allegations. *Dominski v. Frank Williams & Son, LLC, 46 AD3d 1443, 848 N.Y.S.2d 791* (*also see, Liberty Affordable Housing Inc. v. Maple Court Apartments, 125 AD3d 85, 998 N.Y.S.2d 543*).

The complaint's allegations are made in support of two causes of action, namely, conversion and unjust enrichment. An actionable conversion takes place when someone, intentionally and without authority, assumes or exercises control over personal property belonging to someone else, interfering with that person's right of possession. *Reeves v. Gianotta, **[****4]** 130 AD3d 1444, 12 N.Y.S.3d 736*. The key elements of conversion are (1) the plaintiff's possessory right or interest in the property and (2) **[**841]** the defendants dominion over the property or interference with **[***8]** it, in derogation of the plaintiff's rights. *Palermo v. Taccone, 79 AD3d 1616, 1619-1620, 913 N.Y.S.2d 859*.

Like conversion, an unjust enrichment claim presupposes that the plaintiff has an ownership interest in the property or benefit it seeks to recover from the defendants (*see, 28 NY Practice, **[*708]** Contract Law* § 4:14; *Roslyn Union Free School Dist. v. Barkan, 71 A.D.3d 660, 661, 896 N.Y.S.2d 406)*. The key elements of unjust enrichment are (1) that the defendants were enriched (2) at the plaintiff's expense and (3) that it is against equity and good conscience to permit the defendants to retain what is sought to be recovered. The doctrine is a narrow one and is not a catchall cause of action to be used when others fail. *E.J. Brooks Company v. Cambridge Security Seals, 31 NY3d 441, 455, 80 N.Y.S.3d 162, 105 N.E.3d 301*. Mere enrichment is not enough to warrant liability and an allegation that the defendants received benefits, standing alone, is insufficient to establish the cause of action. Critical is that the enrichment be unjust (*see, Goel v. Ramachandran, 111 AD3d 783, 791, 975 N.Y.S.2d 428)*.

It is undisputed that the plaintiff received refunds, like returned dividends and premiums, while it was the policy administrator and MLMIC was the insurer. The benefit at issue in this matter is the cash consideration. Unlike a refund, the cash consideration was clearly intended to be in exchange for the extinguishment of the defendants' membership interest in MLMIC.

It is important to note **[***9]** that MLMIC was a mutual insurance company. Generally speaking, a mutual insurance company is a cooperative enterprise in which the policyholders constitute the members for whose benefit the company is organized, maintained, and operated (*68 NY Jur. 2d Insurance § 179*). In this regard, *Insurance Law § 1211(a)*, provides in part, that: "Every domestic mutual insurance corporation shall be organized, maintained and operated for the benefit of its members as a non-stock corporation. Every policyholder shall be a member of such corporation." Thus, when the defendants, at the plaintiff's behest, signed up for professional liability policies issued by MLMIC, they acquired certain rights and benefits, including membership in MLMIC.

It is also important to take note of the demutualization process by which MLMIC was converted from a mutual insurance company into a stock insurance company acquired by NICO. *§7307 of the Insurance Law* governs this process. *Insurance Law §7307(e)(3)*, in relevant part, provides 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 shall be entitled to receive in exchange for such equitable share, without additional payment, **[*709]** consideration payable in voting common **[***10]** shares of the insurer or other consideration, or both." The statute goes on to repeatedly refer to the eligible recipient as the policyholder and sets forth a formula regarding how to calculate the amount of consideration the policyholder would receive as a result of demutualization. The formula takes-into-account the amount of premiums paid. No distinction is made between a policyholder who pays the premium out of his own pocket versus a policyholder whose employer pays the premium as part of an employee compensation package. *Insurance Law §7307* does not confer an ownership interest in the stock or to the to the cash consideration to anyone other than the policyholder.

Being designated as the policy administrator did not make the plaintiff a policyholder, did not make the plaintiff a member **[**842]** of MLMIC and did not entitle the plaintiff to the cash consideration. More was required. Under the Plan, the policyholder was required to designate someone as being entitled to the cash consideration before that person or entity was entitled to

that benefit. The DFS Decision reiterated that it was the policyholder who was entitled to the **[****5]** cash consideration; recognized that such policyholders "may have assigned such **[***11]** legal right to other persons" (DFS Decision, p.25); and, tied eligibility for the objection and escrow process to when the policyholder had, in fact, assigned the right to cash consideration to another person or entity. It appears certain that such a designation or assignment never took place in this case. More to the point, the plaintiff does not allege that such a designation or assignment ever took place. This alone is fatal to the plaintiff's claim that it is entitled to the cash consideration.

As it appears the defendants never had designated the plaintiff to receive the cash consideration, it is no wonder that the plaintiff did not avail itself of the objection and escrow process. The plaintiffs instead demanded that the defendants, "execute an assignment agreement transferring your right to the cash consideration to the Practice." Such an explicit recognition of the defendant's *right* to the cash consideration undermines the claim that the they unlawfully converted it to themselves or that they were unjustly enriched. The transfer demand is also an implicit acknowledgement that the defendants had never designated the plaintiff to receive the cash consideration.

The controlling **[***12]** statutes and the documentary evidence conclusively demonstrate that the defendants had an actual **[*710]** and exclusive ownership interest in the cash consideration. Allegations to the effect that the plaintiff had a legally cognizable ownership interest in the cash consideration is flatly contradicted by the same statutes and evidence. Allegations to the effect that the defendants windfall was unwarranted, or that the defendants converted to themselves that which rightly belonged to the plaintiff, or that the defendants were unjustly enriched, or that it is against equity and good conscience for the defendants to keep their money, are nothing more than bare legal conclusions. Accordingly, the defendants' motion to dismiss the Complaint, pursuant to *CPLR 3211(a)(1)* and *CPLR 3211(a)(7)*, is GRANTED.

The foregoing shall constitute the decision and order of this court.

Dated: March 22, 2019

HON. FRANK A. SEDITA, III, J.S.C.

End of Document

Matter of Schaffer, Schonholz & Drossman, LLP v Title

Supreme Court of New York, Appellate Division, First Department

April 4, 2019, Decided; April 4, 2019, Entered

8892, 1602015/18

Reporter

171 A.D.3d 465 *; 96 N.Y.S.3d 526 **; 2019 N.Y. App. Div. LEXIS 2630 ***; 2019 NY Slip Op 02617 ****; 2019 WL 1473748

[**1]** In the Matter of Schaffer, Schonholz & Drossman, LLP, Petitioner, v Rachel S. Title, M.D., Respondent.

Counsel: **[***1]** Hughes Hubbard & Reed LLP, New York (Amina Hassan of counsel), for petitioner.

Richard A. Klass, Brooklyn, for respondent.

Judges: Concur—Sweeny, J.P., Manzanet-Daniels, Kern, Oing, Singh, JJ.

Opinion

[*465] **[**526]** Upon facts submitted to this Court pursuant to *CPLR 3222 (b) (3)*, it is declared that petitioner is entitled to the cash proceeds resulting from the demutualization of nonparty Medical Liability Mutual Insurance Company (MLMIC). The Clerk of Supreme Court, New York County is directed to enter judgment awarding petitioner said cash proceeds, including interest accrued while the proceeds were in escrow.

Although respondent was named as the insured on the relevant MLMIC professional liability insurance policy, petitioner purchased the policy and paid all the premiums on it. Respondent does not deny that she did not pay any of the annual premiums or any of the other costs related to the policy. Nor did she bargain for the benefit of the demutualization proceeds. Awarding respondent the cash proceeds of MLMIC's demutualization would result in her unjust enrichment (*see Ruocco v Bateman, Eichler, Hill, Richards, Inc., 903 F2d 1232, 1238 [9th Cir 1990]*, *cert denied 498 US 899, 111 S Ct 254, 112 L Ed 2d 212 [1990]*; *Chicago Truck Drivers, Helpers & Warehouse Workers Union [Ind.] Health & Welfare Fund v Local 710, Intl. Bhd. of Teamsters, Chicago Truck Drivers, Helper & Warehouse Workers Union [Ind.] Pension Fund, 2005 U.S. Dist. LEXIS 42877, *10-11, *21-22, 2005 WL 525427, *4, *8 [ND Ill, Mar. 4, 2005, No. 02 C 3115]*). **[***2]** Concur—Sweeny, J.P., Manzanet-Daniels, Kern, Oing, Singh, JJ.

End of Document

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)*

Core Terms

demutualization, rights, policyholders, insureds, proceeds, merger, certificate, mutual, group policy, coverage, employees, bylaws, holder, mutual insurance company, insurance company, summary judgment, conversion, documents, stock, mutual company, discovery, insurance policy, non-movant, membership, Guaranty, terms, parties, trigger, material fact, shares

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 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

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[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).

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 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

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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.

[11] *Id.*, 533.

[12] The process involves filing a resolution adopted by majority

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 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

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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.

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. 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

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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)*.

[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.

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 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 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

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[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).

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 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.

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[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.

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

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[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)*.

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

Mell v. Anthem, Inc.

United States Court of Appeals for the Sixth Circuit

January 20, 2012, Argued; July 25, 2012, Decided; July 25, 2012, Filed

File Name: 12a0230p.06

No. 10-3440

Reporter
688 F.3d 280 *; 2012 U.S. App. LEXIS 15299 **; 2012 FED App. 0230P (6th Cir.) ***; 2012 WL 3023537

RONALD D. MELL, SR., Plaintiff, ESTATE OF FRIEDA M. WILMES; ROBERT K. ESPEL; and JAMES C. MATACIA, on Behalf of Themselves and All Others Similarly Situated, Plaintiffs-Appellants, v. ANTHEM, INC., nka WellPoint, Inc.; ANTHEM INSURANCE COMPANIES, INC.; COMMUNITY INSURANCE COMPANY, fka Community Mutual Insurance Company; and THE CITY OF CINCINNATI, OHIO, Defendants-Appellees.

Prior History: [1]** Appeal from the United States District Court for the Southern District of Ohio at Cincinnati. No. 08-00715—S. Arthur Spiegel, District Judge.

Mell v. Anthem, Inc., 2010 U.S. Dist. LEXIS 19056 (S.D. Ohio, Mar. 3, 2010)

Core Terms

demutualization, policyholder, merger, group policy, employees, rights, certificate, membership, proceeds, insured, insurance company, district court, grandfather, stock, mutual insurance company, insurance policy, Conversion, enrollees, Guaranty, benefits, bylaws, holder, coverage, eligible, membership rights, Policies, summary judgment, healthcare benefits, retirees, mutual

Case Summary

Procedural Posture
Plaintiff insureds sued defendants, a city and its insurer, on behalf of a class of city employees and retirees to recover the current value of shares of common stock the city received from the demutualization of its insurance carrier, claiming breach of contract and tort claims. The United States District Court for the Southern District of Ohio at Cincinnati granted summary judgment to defendants. Plaintiffs appealed.

Overview
Upon receipt of the shares of the stock from the demutualization, the city disposed of its shares on the public market and received $55 million, which it used to fund a variety of city projects. Plaintiffs argued that they should have received the proceeds. Despite plaintiffs' multiple theories suggesting they were entitled to the demutualization proceeds, they could not recover. The city was the policyholder prior to a 1995 merger and maintained its policyholder rights post-merger through a grandfather clause, including any rights to the demutualization proceeds. The 2001 demutualization process did not disrupt the city's membership interests nor did it confer any equity rights to plaintiffs. By virtue of the process of demutualization the court was compelled to conclude that plaintiffs were precluded from recovering any of the proceeds from the demutualization. Moreover, the insurer was an Indiana company at the time of the demutualization and conducted the demutualization process in compliance with the provisions of Ind. Code § 27-15. Under Indiana demutualization law, the city, as the eligible statutory member, was entitled to the demutualization proceeds.

Outcome
The appellate court affirmed the district court's summary judgment order.

LexisNexis® Headnotes

Civil Procedure > Special Proceedings > Class Actions > Class Action Fairness Act

Civil Procedure > ... > Jurisdiction > Diversity Jurisdiction > General Overview

HN1 **Class Actions, Class Action Fairness Act**

The Class Action Fairness Act of 2005 extends the diversity jurisdiction of the federal courts to certain class actions. *28 U.S.C.S. § 1332(d)*.

Civil Procedure > Special Proceedings > Class Actions > Class Action Fairness Act

Civil Procedure > ... > Jurisdiction > Diversity Jurisdiction > General Overview

HN2 **Class Actions, Class Action Fairness Act**

Under the Class Action Fairness Act of 2005, a federal district court may have original jurisdiction of any civil action in which the matter in controversy exceeds the sum or value of $5,000,000, exclusive of interests and costs, and is a class action in which—(A) any member of a class of plaintiffs is a citizen of a State different from any defendant; (B) any member of a class of plaintiffs is a foreign state or a citizen or subject of a foreign state and any defendant is a citizen of a State; or (C) any member of a class of plaintiffs is a citizen of a State and any defendant is a foreign state or a citizen or subject of a foreign state. Pub. L. No. 109-2, 119 Stat. 4 (2005).

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Genuine Disputes

Civil Procedure > Appeals > Summary Judgment Review > Standards of Review

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Legal Entitlement

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Materiality of Facts

HN3 **Entitlement as Matter of Law, Genuine Disputes**

An appellate court reviews a district court's grant of summary judgment de novo. Summary judgment is appropriate if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law. *Fed. R. Civ. P. 56(a)*. The evidence and all reasonable inferences drawn therefrom are viewed in the light most favorable to the nonmoving party.

Business & Corporate Compliance > ... > Insurance Company Operations > Company Ownership > Mutual & Stock Companies

Insurance Law > Claim, Contract & Practice Issues > Policy Interpretation > General Overview

HN4 **Company Ownership, Mutual & Stock Companies**

Under *Ohio Rev. Code Ann. § 3913.20(B)*, a "policyholder" is defined as the person, group of persons, association, corporation, partnership, or other entity named as the insured under a mutual policy of insurance other than life.

Insurance Law > ... > Policy Interpretation > Ambiguous Terms > General Overview

HN5 **Policy Interpretation, Ambiguous Terms**

Under Ohio law, the words in a policy must be given their plain and ordinary meanings, and only where a

contract of insurance is ambiguous and therefore susceptible to more than one meaning must the policy language be liberally construed in favor of the claimant who seeks coverage.

Insurance Law > Claim, Contract & Practice Issues > Group Policies > Agency Relationships

HN6[] Group Policies, Agency Relationships

Under Ohio law, an employer's administration of a group insurance plan does not create an agency relationship between the employer and the insurance carrier since the employer is acting only for the benefit of its employees and the employer's own benefit in promoting better relations between itself and its employees.

Insurance Law > Claim, Contract & Practice Issues > Group Policies > General Overview

HN7[] Claim, Contract & Practice Issues, Group Policies

Ohio Rev. Code Ann. § 3923.12 on group sickness and accident insurance states that the insurer will furnish to the policyholder, for delivery to each employee or member of the insured group, an individual certificate. Ohio revised provisions also do not classify an "insured" as the policyholder of a Group Policy, but rather the insured is defined as the person covered under the Group Policy. Ohio Rev. Code Ann.§§ 3923.13, 3912.121, 3923.123, 3923.381, 3923.38, 3923.44.

Insurance Law > Claim, Contract & Practice Issues > Group Policies > General Overview

HN8[] Claim, Contract & Practice Issues, Group Policies

In Ohio it is generally held that the certificate of coverage merely evidences the employee-member's right to participate and consequently, the provisions of the group policy are controlling over the provisions of the certificate, and the rights of the parties in a group insurance enterprise are dependent upon the group contract.

Business & Corporate Compliance > ... > Insurance Company Operations > Company Ownership > Mutual & Stock Companies

HN9[] Company Ownership, Mutual & Stock Companies

Ind. Code § 27-15 governs the demutualization of Indiana mutual insurance companies. Indiana law allows an Indiana mutual insurance company to convert to a stock company through a plan of conversion.

Counsel: ARGUED: Eric H. Zagrans, ZAGRANS LAW FIRM, LLC, Elyria, Ohio, for Appellants.

Peter R. Bisio, HOGAN LOVELLS US LLP, Washington, D.C., Terrance A. Nestor, CITY SOLICITOR'S OFFICE, Cincinnati, Ohio, for Appellees.

ON BRIEF: Eric H. Zagrans, ZAGRANS LAW FIRM, LLC, Elyria, Ohio, Alphonse A. Gerhardstein, GERHARDSTEIN & BRANCH CO., L.P.A. for Appellants.

Peter R. Bisio, Craig A. Hoover, Adam K. Levin, HOGAN LOVELLS US LLP, Washington, D.C., Glenn V. Whitaker, VORYS, SATER, SEYMOUR and PEASE LLP, Cincinnati, Ohio, Paul A. Wolfla, BAKER & DANIELS LLP, Indianapolis, Indiana, Robert N. Webner, VORYS, SATER, SEYMOUR and PEASE LLP, Columbus, Ohio, Terrance A. Nestor, CITY SOLICITOR'S OFFICE, Cincinnati, Ohio, for Appellees.

Judges: Before: SILER, CLAY, and ROGERS, Circuit Judges.

Opinion by: CLAY

Opinion

[*281] **[***2]** CLAY, Circuit Judge. Plaintiffs, the Estate of Frieda M. Wilmes through its appointed fiduciary, Claudette Schenck, Robert K. Espel, and James C. Matacia (collectively "Plaintiffs"), on behalf of themselves and all other similarly-situated employees and retirees, appeal the district court's **[**2]** order granting summary judgment to Defendants Anthem, Inc., Anthem Insurance Companies, Inc., Community Insurance Company, and the City of Cincinnati (collectively "Defendants") pursuant to *Fed. R. Civ. P. 56*. Plaintiffs seek to recover funds they alleged were owed to them when Anthem Insurance Companies, Inc. demutualized in 2001 and issued 870,021 shares of stock to the City of Cincinnati, Plaintiffs' employer, instead of to Plaintiffs.

For the reasons set forth below, we **AFFIRM** the decision of the district court.

[*282] BACKGROUND

I. Procedural History

On October 15, 2008, Plaintiffs filed a complaint to recover on behalf of themselves and all other similarly-situated employees and retirees of the City of Cincinnati, Ohio (the "City") the current value of the 870,021 shares of Anthem common stock that the City received from the demutualization of Anthem Insurance.[1] In their complaint, Plaintiffs asserted eight claims for breach of contract and four tort claims against Anthem, Inc. n/k/a WellPoint Inc., Anthem Insurance Companies, Inc. ("Anthem Insurance") and Community Insurance Company ("CIC") (collectively, "Anthem").[2] **[***3]** In addition, Plaintiffs brought three breach of contract claims and four **[**3]** tort claims against the City.

On September 1, 2009, Plaintiffs filed a motion for class certification. The district court granted Plaintiffs' motion and certified the proposed class. The class consists of 2,536 employees and retirees of the City who were named as insured persons, or former members of a group of insured persons, covered under a health care group policy from June 18, 2001 through November 2, 2001. The class includes two subsets: "Class A" members were defined as individuals who had an insurance policy with Anthem prior to the merger between Community Mutual Insurance Company ("CMIC") and Anthem in 1995; and "Class B" members were defined as individuals who received a health insurance group policy after the 1995 merger. The district court designated Schenck, Espel, and Matacia to **[**4]** serve as the class representatives of both classes.

The parties proceeded to discovery, after which they filed cross motions for summary judgment. On March 3, 2010, the district court denied Plaintiffs' motion for summary judgment; granted Anthem's cross-motion for summary judgment; granted in part the City's cross-motion for summary judgment; and dismissed the case. Plaintiffs timely appealed.

We have jurisdiction pursuant to *HN1*[↑] the Class Action Fairness Act of 2005, which extends the diversity jurisdiction of the federal courts to certain class actions.[3] *See* *28 U.S.C. § 1332(d)*. We also have appellate jurisdiction under *28 U.S.C. § 1291*.

[*4] II. Factual Background**

A. The City of Cincinnati's Group Health Care

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[1] Demutualization refers to the process of converting an insurance company from mutual ownership to stock ownership. *3 Lee R. Russ & Thomas F. Segalla, Couch on Insurance § 39:43 (3d ed. 2005)*. In the case of Anthem, the company demutualized in 2001, converting Anthem Insurance from an Indiana mutual insurance company to an Indiana stock company.

[2] In 2004, Anthem, Inc. merged with WellPoint, Inc.

[3] *HN2*[↑] Under the Class Action Fairness Act of 2005, a federal district court may have original jurisdiction of:

> any civil action in which the matter in controversy exceeds the sum or value of $5,000,000, exclusive of interests and costs, and is a class action in which—(A) any member of a class of plaintiffs is a citizen of a State different from any defendant; (B) any member of a class of plaintiffs is a foreign state or a citizen or subject of a foreign state and any defendant is a citizen of a State; or (C) any member of a class of plaintiffs is a citizen of **[**5]** a State and any defendant is a foreign state or a citizen or subject of a foreign state. Pub. L. No. 109-2, 119 Stat. 4 (2005).

In this case, the amount in controversy exceeds $5,000,000 and the parties are citizens of diverse states. *See* (R.1: Compl. ¶¶1-3.)

Benefits

In 1986, the City of Cincinnati entered into a Master Group Contract for various **[*283]** group health care benefits with CMIC, a mutual insurance company licensed by Ohio Blue Cross/Blue Shield ("BC/BS"). The Master Group Contract covered both active and retired employees and included such benefits as medical, hospitalization, and, in the case of firefighters, dental coverage. According to the declaration of Andrea Schell, Regional Vice President of Group Underwriting for CMIC, the Master Group Contract granted the City mutual company membership interests (voting and equity rights) in CMIC. Section 1.01 of the CMIC bylaws defined the members of the group insurance plan and stated in relevant part:

> Every policyholder of the corporation, except the holder of a policy or contract of reinsurance, is a member of the corporation while the policy is in force, and is entitled **[**6]** to one vote, and no more, regardless of the amount of insurance held by such policyholder, the number of policies in force in the name of such policyholder or the amount of premiums paid by such policyholder. Policyholder means the person or group of persons identified as the named insured in the declarations page of a policy of insurance of the corporation.... 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 specific provision of such membership....

(R.32-2: Ex. B. CMIC Bylaws § 1.01.) Schell stated that the City's group contract was "renewed each year between 1986 and 1999."

B. The Formation of Anthem Insurance

Anthem Insurance's predecessor was Associated Insurance Companies, Inc. ("Associated"), an Indiana mutual insurance company. In the early 1990s, Associated began acquiring BC/BS licenses in Kentucky (1993) and Ohio (1995). The Ohio BC/BS licensee that was acquired on October 1, 1995 was CMIC. At the time of the 1995 merger between CMIC and Associated, CMIC members received the following:

> **[***5]** (A) An assumption **[**7]** certificate from [CIC] ... that shall provide to [CMIC members] the same medical and health benefits in effect immediately prior to the Effective Time under the terms and conditions of the [CMIC's] insurance policy or health care benefits contract, as the case may be; and
>
> (B) A new Associated guaranty insurance policy/membership certificate which shall grant to that [CMIC member] the following rights:
>
> (1) voting rights on all matters that come before the members of an Indiana domestic mutual insurance company under the Indiana Insurance Law ...;
>
> (2) insurance benefits which shall guarantee the benefits granted under the insurance policy or health care benefits contracts assumed by CIC; and
>
> (3) rights in the events of liquidation, merger, consolidation, or demutualization of Associated as set herein, therein and in Associated's Second Amended and Restated Articles of Incorporation, which rights are intended to be equivalent to the rights such [CMIC member] would have had if such [CMIC member] had owned an insurance policy, issued directly by Associated....

(R.31-23: PTX-20, Page ID # 1560.)

CMIC and Associated jointly petitioned the Ohio Department of Insurance ("Ohio DOI") for approval of **[**8]** the merger. Both **[*284]** companies disclosed to the Ohio DOI that the employers that previously purchased group policies, and not the employees receiving benefits under those policies, were CMIC members. Associated incorporated into the merger agreement a "grandfather" clause which allowed former CMIC members to maintain their membership rights as long as each "grandfathered group" renewed, amended, or replaced its group policy without a lapse in coverage. New customers or those who entered into the contract after the merger would not become members. The joint petition between CMIC and Associated stated the following:

> Group policyholders of [CMIC] . . . are members of [CMIC] and are entitled to one vote on all matters submitted to a vote of the members of CMIC. Group policyholders of [CMIC] also possess certain proprietary rights in CMIC. *The holders of certificates of benefits issued under* **[***6]** *[CMIC's] group polices are not members of [CMIC], are not entitled to vote and do not have proprietary rights in [CMIC]*.
>
> *In order to preserve the existing voting and proprietary rights of [CMIC's] group policyholders*,

> Associated general practice regarding voting and other membership rights relating to group **[**9]** policies will not apply to holders of group polices issued by [CMIC]. *Instead, group holders of Guaranty Policies issued as part of the Merger will be treated as members of Associated and will have membership rights in Associated*. . . .

(R.31-16: PTX-12, Page ID # 1497) (emphasis added).

According to the terms of the merger agreement, the City received a Group Guaranty Policy, which confirmed that it was a member of Associated, and the policy also indicated that City employees who obtained coverage as enrollees in the City's group policy were not members of nor had equity rights in Associated. The Ohio DOI approved the merger and the agreement became effective on October 1, 1995. After the merger, Associated changed its name to Anthem Insurance Companies, Inc.

C. The Demutualization of Anthem Insurance

In 2001, Anthem developed a Plan of Conversion to convert Anthem Insurance from an Indiana mutual insurance company to an Indiana stock insurance company in accordance with Indiana demutualization law under *Indiana Code §27-15-1-1, et seq*. Anthem decided to demutualize in order to increase the company's financial flexibility through improved access to capital. Under the Indiana Demutualization **[**10]** Law, Anthem was required to provide consideration, either in the form of cash or stock, to its eligible statutory members in exchange for their membership interests. During this process, Anthem retained both financial and legal advisors as well as other experts to provide assistance in executing the conversion plan.

On May 18, 2001, Anthem notified the Ohio DOI, as required under *Ohio Rev. Code § 3941.38*, of its plan to convert to an Indiana stock insurance company. Anthem also submitted a Form D Filing to the Ohio DOI, which notified the Ohio DOI of its intent to (1) "discontinue the issuance of any new Guaranty Policies after the effective date of Conversion;" and (2) "cause all issued Guaranty Policies to expire at their **[***7]** anniversary next following the effective date of the Conversion," which would extinguish all membership interests. (R.32-18: Ex. A. Dec. of Marjorie Maginn.) On September 14, 2001, the Ohio DOI approved Anthem's demutualization request.

[*285] Anthem Insurance's board of directors approved a conversion plan in accordance with Indiana demutualization law on June 18, 2001. *See* Ind. Code Ann. § 27-15-2. Anthem submitted its plan for approval to the Indiana Department of Insurance **[**11]** ("Indiana DOI"). The Indiana DOI conducted a full review of Anthem's proposed demutualization, which included a determination of whether particular group policyholders were eligible to retain their membership interests under a "grandfather" clause and therefore become classified as statutory members of Anthem Insurance. Anthem also participated in a public hearing on October 2, 2001 to discuss its conversion plan. Anthem explained at the hearing that individual enrollees in group polices issued by Anthem's Ohio subsidiary prior to the 1995 merger were not eligible statutory members and therefore were not entitled to Anthem's demutualization proceeds. Article XIII of Anthem's Plan of Conversion defined both Statutory and Eligible Statutory members as follows:

> "Statutory Member" shall mean as of any specified date any Person who, in accordance with the records, articles of incorporation and by-laws of Anthem Insurance, is the Holder of an In Force Policy.
>
> "Eligible Statutory Members" shall mean a Person who (a) is a Statutory Member of Anthem Insurance on the Adoption Date and continues to be a Statutory Member of Anthem Insurance on the Effective Date,[4] and (b) has had continuous health **[**12]** care benefits coverage with the same company during the period between those two dates under any Policy or Policies without a break of more than one day.

(R.32-11: Plan of Conversion, Page ID# 2676-77.) No objections to Anthem's position were raised at the public hearing.

On October 25, 2001, the Indiana DOI published its Findings of Fact, Conclusions of Law, and Order, which found that Anthem complied with the **[***8]** requirements set forth under the Indiana demutualization law. The Indiana DOI approved Anthem's Plan of Conversion on October 29, 2001. That same day a majority of Anthem's Statutory Members also voted to approve and adopt the conversion plan. Anthem's demutualization became effective on November 2, 2001, and on that day, Anthem issued 870,021 shares of its common stock to the City. Upon receipt of the shares of the stock from the

[4] The term "Adoption Date" is defined in the Plan of Conversation as June 18, 2001. The "Effective Date" of the Plan of Conversation was November 2, 2001.

demutualization, the City disposed of its shares on the public market and received $55 million. The City used the proceeds to fund a variety of city projects.

On October 15, 2008, Plaintiffs filed this **[**13]** action claiming that the City was not entitled to the $55 million demutualization proceeds and are now seeking to recover that amount.

DISCUSSION

I. Standard of Review

HN3[] We review a district court's grant of summary judgment *de novo*. *White v. Baxter Healthcare Corp., 533 F.3d 381, 389 (6th Cir. 2008)*. Summary judgment is appropriate "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." *Fed. R. Civ. P. 56(a)*. "[T]he evidence and all reasonable inferences drawn therefrom are viewed in the light most favorable to the nonmoving party." *Rodgers v. Monumental Life Ins. Co., 289 F.3d 442, 448 (6th Cir. 2002)* (citing **[*286]** *Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587, 106 S. Ct. 1348, 89 L. Ed. 2d 538 (1986)*).

II. The City was the policyholder of the Group Policy prior to the 1995 merger between CMIC and Associated and possessed grandfather rights as the policyholder after the merger

Plaintiffs argue that the district court erred in concluding that the City obtained rights and interests of the health insurance group policy ("Group Policy") through a "grandfather" clause placed in the pre-merger agreement between CMIC and Associated. **[**14]** Plaintiffs contend that the City was therefore not entitled to receive any proceeds or **[***9]** compensation from the 2001 demutualization of Anthem. Plaintiffs argue that under Ohio insurance law, *Ohio Revised Code §§ 3913.22(A)* and *3913.20(B)*, the City was not "named as the insured" or the "policyholder" of the Group Policy because, according to Plaintiffs, "[a] municipality has no health of its own to insure." Plaintiffs assert that only active and retired employees and their dependents may serve as the "named insureds" or "insureds" or policyholder under the Group Policy. We first address the issue of whether the City was the policyholder of CMIC for purposes of obtaining membership rights under the Group Policy.

The district court correctly held that the statutory definition prohibits Plaintiffs from being classified as an owner of the Group Policy. ***HN4***[] Under Ohio insurance law *§ 3913.20(B)*, a policyholder is defined as the "person, group of persons, association, corporation, partnership, or other entity named as the insured under a mutual policy of insurance other than life ...." The district court interpreted the statute to mean that policyholders are typically "owners" of the group policy. **[**15]** The district court therefore found that Plaintiffs cannot be the owners of the group policy because as employees and retirees Plaintiffs "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." *Mell v. Anthem, Inc., No. 1:08-cv-00715, 2010 U.S. Dist. LEXIS 19056, 2010 WL 796751, at *10 (S.D. Ohio Mar. 3, 2010)*. Moreover, the district court noted that the record provides no evidence that the Group Policy named Plaintiffs as the policyholders of the Group Policy.

Plaintiffs' argument is also incompatible with CMIC's bylaws, which adopted the policyholder definition found under Ohio insurance law. According to CMIC's bylaws, a member was defined as "[e]very policyholder of the corporation" and the "[p]olicyholder means the person or group of persons identified as the named insured in the declarations page of a policy of insurance of the corporation." In the case of the Master Group Contract, the City as the member "shall be the holder of the master policy." CMIC's By-Laws, art I. § 101. The plain language of the bylaws therefore supports the conclusion that even prior to the 1995 merger between CMIC and **[***10]** Associated, **[**16]** the City became a policyholder of the Group Policy by virtue of its contract with CMIC. ***HN5***[] Under Ohio law, "[t]he words in a policy must be given their plain and ordinary meanings, and only where a contract of insurance is ambiguous and therefore susceptible to more than one meaning must the policy language be liberally construed in favor of the claimant who seeks coverage." *Burris v. Grange Mut. Cos., 46 Ohio St. 3d 84, 545 N.E.2d 83, 88 (Ohio 1989)*, overruled on other grounds by *Savoie v. Grange Mut. Ins. Co., 67 Ohio St. 3d 500, 1993 Ohio 134, 620 N.E.2d 809 (Ohio 1993)*. No ambiguity exists in the instant case. Based on a straightforward reading **[*287]** of the statutory language and CMIC's bylaws, Plaintiffs did not possess, nor could they have possessed, any membership interests in Anthem.

Plaintiffs attempt to insert themselves into the contract by arguing that as "named insureds" or "insureds" they became the "policyholders." However, the Master Group Contract in effect established a contractual agreement between the City and CMIC, with Plaintiffs as mere beneficiaries. As beneficiaries, Plaintiffs enjoyed the right to participate in the insurance provided, under the terms and conditions imposed by the Group Policy. Thus, any references to **[**17]** the "named insured" or "insured" simply meant a person covered under a group policy who is entitled to insurance as a benefit of his/her employment. It does not signify the position of policyholder.[5]

To the extent that Plaintiffs argue that an agency relationship exists between CMIC and the employees and retirees, Plaintiffs' argument misconstrues the Ohio statutory language and CMIC's bylaws. ***HN6***[↑] Under Ohio law, "[a]n employer's administration of a group insurance plan does not create an agency relationship between the employer and the **[**18]** insurance carrier since the employer is acting only for the benefit of its employees and the employer's own benefit in promoting better relations between itself and its employees." *Kilbourn v. Henderson, 63 Ohio App. 3d 38, 577 N.E.2d 1132, 1136 (Ohio Ct. App. 1989)* (citing *Hroblak v. Metro. Life Ins. Co., 50 Ohio Law Abs. 395, 79 N.E.2d 360, 364 (Ohio Ct. App. 1947))*. **[***11]** Here, the language of the statute and the bylaws confers an unambiguous contractual relationship between the City and CMIC, so the employee's participation in the Group Policy does not by itself create an agency relationship such that he becomes the policyholder. Plaintiffs' references to unreported Ohio cases and cases outside this Circuit bear no relevance in our analysis and are not controlling authority.[6] Therefore, we are not bound by those decisions. However, the limited authority available on this issue persuades us that the employer and not the employee is the policyholder of an insurance policy. In *Greathouse v. City of East Liverpool*, the Ohio Court of Appeals determined that since the City of East Liverpool purchased health insurance through Anthem on behalf of its employees and exclusively contracted with Anthem, the City and not its employees was **[**19]** therefore the owner of the **[*288]** policy. *159 Ohio App. 3d 251, 2004 Ohio 6498, 823 N.E.2d 539, 544 (Ohio Ct. App. 2004)*. The City was therefore the policyholder of the Group Policy prior to the 1995 merger between CMIC and Associated. And since the City was the policyholder of the Master Group Contract prior to and through the 1995 merger, the City also preserved and protected its rights as a policyholder through the grandfather clause issued by CMIC before the merger.

III. Plaintiffs were not entitled to receive the proceeds from Anthem's demutualization

Plaintiffs argue that they should have received the proceeds from Anthem's demutualization in 2001. Plaintiffs identify "two paths"—Class A and Class B— to show that they are entitled to the demutualization proceeds that are governed by the Ohio demutualization statutes. As we previously stated, "Group A" consisted of the City employees who had full insurance coverage from Anthem at the time of the 1995 merger between Associated and CMIC. Under Plaintiffs' argument that the employees are the **[***12]** policyholders, Plaintiffs contend that the employees in Group A had "grandfathered" rights preserved and guaranteed under Ohio law that would allow them to receive the payments from the 2001 demutualization. Plaintiffs argue that Class members in Group B, who obtained full-coverage from Anthem after the 1995 merger, were entitled to demutualization compensation under Ohio law and Anthem's membership rules where the employee and

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[5] Plaintiffs also claim that the Ohio Health Insurance Guide has adopted the logic that an employer may not be a policyholder. Plaintiffs highlight that the guide defines the term "certificate holder" as "[a]n employee or other insured named under a group health insurance policy" to suggest that the policyholders are the covered employees and insured retirees. (R.31-28: PTX-99 ODI Health Insurance Guide, Page ID # 1683.) Plaintiffs misread the guide, which explicitly states that "your employer [i.e., the City] or trade association is the master policyholder; you and your fellow employees [i.e., Plaintiffs] are certificate holders." (*Id*. at Page ID # 1634.)

[6] We also find unpersuasive Plaintiffs references to Ohio insurance statutes in support of their determination that employees, rather than the employers, are the policyholders of the Group Policy. For example, ***HN7***[↑] *Ohio Revised Code § 3923.12* on group sickness and accident insurance states that the "insurer will furnish to the policyholder, for delivery to each employee or member of the insured group, an individual certificate." Under this provision, CMIC as the insurer furnished to the City, the policyholder, an individual certificate for the employer to furnish to the employee (Plaintiffs). The remaining Ohio revised provisions cited by Plaintiffs also do not classify an "insured" as the policyholder of a Group Policy, but rather the "insured" is defined as the person **[**20]** covered under the Group Policy. *See Ohio Rev. Code §§ 3923.13*, *3923.121*, *3923.123*, *3923.381*, *3923.38*, *3923.44*.

not the employer is the member of the mutual company. Given our finding that **[**21]** employees are not policyholders, Plaintiffs argument with respect to Group A fails. Because Group A members were not policyholders, they accordingly were not covered under the grandfathered clause exception and were not entitled to the demutualization proceeds.

The analysis with respect to Group B members is more complicated. For Group B members—employees who obtained full-coverage from Anthem after the 1995 merger—Plaintiffs claim that the provisions in the 1995 merger agreements and related documents specified that Plaintiffs were entitled to equity rights at the time of the merger, thereby granting them demutualization compensation. Plaintiffs also argue that they are entitled to the stock proceeds by the addition of a fully-insured human organ transplant ("HOT") rider and Certificates of Membership, which triggered a Certificate of Membership from the City that allowed Plaintiffs to receive the demutualization proceeds.

The evidence in the record does not support Plaintiffs' theory. The record indicates that Anthem intended for the City to maintain membership rights. Anthem prepared different documentation for CMIC grandfathered groups than it prepared for group customers that contracted **[**22]** with Anthem for the first time after the merger. Specifically, for CMIC grandfathered groups, Anthem prepared a Guaranty Policy that confirmed that the policyholders had membership rights. Not only did this Guaranty Policy differentiate between the employer "member" and the employee "enrollee" under the employer's policy, it also explained that "[n]o Enrollee or dependent of an Enrollee shall receive any equity rights by virtue of being an Enrollee or dependent of an Enrollee."

[*13]** In contrast, Anthem did not make a distinction between "members" and "enrollees" in the guaranty policies prepared for Plaintiffs' Group B members. Rather, those guaranty policies defined a "member" as "each person who has enrolled for insurance of health care benefits and who was eligible to enroll for such benefits **[*289]** under the Community Contract because of the person's status as an employer of the Policyholder, if the Policyholder is an employer." Post-merger enrollees received a Certificate of Membership for purposes of defining the enrollees whereas the grandfathered groups received a Summary of Benefits. However, the presence or absence of a certificate does not change the underlying facts that dictated the **[**23]** membership determinations made in connection with the CMIC/Associated merger and the Anthem demutualization. The record established that the Certificates of Membership did not by themselves create membership rights and are not relevant for membership determinations. *See*, e.g., *Talley v. Teamsters, Chauffers, Warehousemen, and Helpers, Local No. 377, et al., 48 Ohio St. 2d 142, 357 N.E.2d 44, 46 (Ohio 1976)* (**HN8**[↑] "It is generally held that the certificate of coverage merely evidences the employee-member's right to participate ... [and] [c]onsequently, the provisions of the group policy are controlling over the provisions of the certificate, and the rights of the parties in a group insurance enterprise are dependent upon the group contract.").

The district court properly concluded that Plaintiffs' interpretation of the merger document for Class B members is incorrect. The district court found that the merger document does not state that new insurance is the "triggering event." *Mell, 2010 U.S. Dist. LEXIS 19056, 2010 WL 796751, at *10*. The merger document states in pertinent part:

> The Associated guaranty insurance policy/membership certificate shall continue in effect as long as (a) the insurance policy or health care benefits contract assumed **[**24]** 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 ...

(*Id.*) Accordingly, by virtue of the process of demutualization we are compelled to conclude that Plaintiffs are precluded from recovering any of the proceeds from Anthem's demutualization. Based on the reading of the merger documents, it is clear **[***14]** that Anthem did not create new membership rights for employees enrolled post-merger. Therefore, the Class B members were not eligible policyholders under the Anthem plan and were thus not entitled to receive Anthem's demutualization proceeds.

IV. Indiana law governs the demutualization of Anthem

Plaintiffs also improperly apply Ohio law when the demutualization process was governed by Indiana law.[7]

[7] We also note that Plaintiffs' attorney conceded at oral argument that Indiana law governed the demutualization of

Anthem was an Indiana mutual insurance company at the time of demutualization in 2001 and conducted the demutualization process in compliance with the provisions of HN9[↑] Indiana Code § 27-15, which governs the demutualization of Indiana mutual insurance companies. *See* Ormond v. Anthem, Inc., 799 F. Supp. 2d 910, 912 (S.D. Ind., 2011) **[**25]** (stating that Indiana law allows "an Indiana mutual insurance company to convert to a stock company through a plan of conversion"); *see also 3 Russ & Segalla, Couch on Insurance § 39:43 (3d ed. 2005)*. As required by Indiana law, Anthem submitted documentation of its plan to demutualize and also held a public hearing. Anthem's demutualization process was then approved by the Indiana DOI, which recognized that the City was an "eligible member" to receive **[*290]** the proceeds from the demutualization. *See* Ind. Code Ann. § 27-15-2-2.

To now apply Ohio law would disrupt the entire demutualization process in which the Indiana demutualization law vested exclusive authority in the Indiana DOI to approve the conversion plan. If this Court were to adopt Plaintiffs' argument that Ohio demutualization law applied, Anthem's entire application for conversion would be discredited. It also would undo the 1995 merger agreement. Under the 1995 agreement, Anthem, an Indiana based mutual insurance company, acquired CMIC, which was an Ohio insurance company. At no point did Anthem become **[**26]** subject to Ohio law. As a result of the merger, all of the mutual company members of the Ohio company became mutual company members of the Indiana company with voting and equity interests in the Indiana company. After the merger, what remained in Ohio was an Ohio stock insurance company, not an Ohio mutual insurance company. Under Indiana **[***15]** demutualization law, however, the City, as the eligible statutory member, was entitled to the demutualization proceeds. *See* Ind. Code Ann. § 27-15-1-7.

CONCLUSION

Despite Plaintiffs' multiple theories suggesting that they are entitled to the Anthem demutualization proceeds, Plaintiffs cannot recover any of the demutualization compensation. The evidence in the record indicates that the City was the policyholder prior to the 1995 merger between CMIC and Associated. The documents also clearly establish that the City maintained its policyholder rights post-merger through a grandfather clause, including any rights to the demutualization proceeds. The 2001 demutualization process did not disrupt the City's membership interests nor did it confer any equity rights to Plaintiffs. Thus, Plaintiffs are not entitled to the demutualization proceeds.

For the foregoing **[**27]** reasons we **AFFIRM** the district court's order granting summary judgment to Defendants.

End of Document

Anthem in 2001.

Matter of New Surfside Nursing Home, LLC v Daines

Supreme Court of New York, Appellate Division, Second Department

February 6, 2013, Decided

2010-10100

Reporter
103 A.D.3d 637 *; 958 N.Y.S.2d 782 **; 2013 N.Y. App. Div. LEXIS 750 ***; 2013 NY Slip Op 745 ****; 2013 WL 440641

[**1]** In the Matter of New Surfside Nursing Home, LLC, et al., Appellants, v Richard F. Daines et al., Respondents. (Index No. 10185/10)

Subsequent History: Affirmed by *Matter of New Surfside Nursing Home, LLC v. Daines, 2014 N.Y. LEXIS 97 (N.Y., Jan. 21, 2014)*

Core Terms

audit, patients, regulations, sheets, reimbursement, Neurobiological, revised, petitioners', binding, determinations, ambiguity, reimbursement rate, enforcing, circumstances, annulling

Case Summary

Procedural Posture
Petitioner nursing facilities filed a hybrid proceeding pursuant to CPLR art. 78 to review respondent New York State Department of Health's (DOH) determinations that sought a judgment annulling the audit results, enjoining DOH from implementing and enforcing the revised Medicaid rate sheets, and directing DOH to issue new revised Medicaid rate sheets based upon the original Restorative Therapy/Heavy Rehabilitation designations.

Overview
The Supreme Court, Queens County, New York, denied the petition. The facilities appealed. The appellate court held that DOH's enforcement of the audit results controverting the facilities' patient review instrument submission designations through the issuance of the revised Medicaid rate sheets was not arbitrary and capricious. Under *10 NYCRR 86-2.30(e)(5)* and *86-2.11(a)*, DOH was required to correct the facilities' case mix indexes in accordance with audit results and to adjust payments to reflect changes. DOH was not estopped from exercising these duties by any delay in issuing the revised Medicaid rate sheets. The facilities' challenges to the audit results were untimely. The facilities understood the implication of DOH's ruling upon receipt of the results. DOH's decision to apply existing regulations in conducting the audits was not arbitrary and capricious. The claims that a DOH official and an independent contractor represented that the facilities would be permitted enhanced reimbursement not provided for in existing regulations did not establish an enforceable agreement between DOH and the facilities, and estoppel could not prevent DOH from discharging its statutory duties.

Outcome
The judgment was affirmed.

LexisNexis® Headnotes

Administrative Law > Judicial Review > Standards of Review > Abuse of Discretion

Administrative Law > Judicial Review > Standards of Review > Arbitrary & Capricious Standard of Review

Administrative Law > Judicial Review > Standards of Review > Unlawful Procedures

Administrative Law > Separation of Powers > Legislative Controls > Explicit Delegation of Authority

HN1 **Standards of Review, Abuse of Discretion**

In a proceeding in which the petitioners challenge an agency determination that was not made after a quasi-judicial hearing, the appellate court must consider whether the 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 (*CPLR 7803(3)*). In such a proceeding, courts examine whether the action taken by the agency has a rational basis and will overturn that action only where it is taken without sound basis in reason or regard to the facts or where it is arbitrary and capricious. Further, courts must defer to an administrative agency's rational interpretation of its own regulations in its area of expertise.

Public Health & Welfare Law > ... > Providers > Payments & Reimbursements > Nursing Facilities

HN2 **Payments & Reimbursements, Nursing Facilities**

By regulation, the New York State Department of Health (DOH) is required to correct a facility's case mix indexes (CMI) in accordance with audit results, and to adjust payments to reflect changes in the facility's CMI (*10 NYCRR 86-2.30(e)(5)*, *10 NYCRR 86-2.11(a)*). The DOH cannot be estopped from exercising these duties by any delay in issuing the revised Medicaid rate sheets.

Administrative Law > Agency Rulemaking > Rule Application & Interpretation > Binding Effect

HN3 **Rule Application & Interpretation, Binding Effect**

The rules of an administrative agency, duly promulgated, are binding upon the agency as well as upon any other person who might be affected.

Public Health & Welfare Law > ... > Providers > Payments & Reimbursements > Nursing Facilities

HN4 **Payments & Reimbursements, Nursing Facilities**

A facility is not entitled to Medicaid reimbursements sought in violation of applicable regulations, even where the services were properly rendered.

Administrative Law > Separation of Powers > Legislative Controls > Explicit Delegation of Authority

HN5 **Legislative Controls, Explicit Delegation of Authority**

Estoppel cannot be invoked to prevent the New York State Department of Health from discharging its statutory duties.

Headnotes/Summary

Headnotes

Health—Medicare Reimbursement Payments

Health—Medicare Reimbursement Payments—Timeliness of Audit

Counsel: **[***1]** Hamburger, Maxson, Yaffe, Knauer & McNally, LLP, Melville, N.Y. (David N. Yaffe, Richard Hamburger, and William P. Caffrey, Jr., of counsel), for

appellants.

Eric T. Schneiderman, Attorney General, New York, N.Y. (Richard Dearing and Sudarsana Srinivasan of counsel), for respondents.

Judges: THOMAS A. DICKERSON, J.P., CHERYL E. CHAMBERS, LEONARD B. AUSTIN, ROBERT J. MILLER, JJ. DICKERSON, J.P., CHAMBERS and MILLER, JJ., concur.

Opinion

[*638] [783]** In a hybrid proceeding pursuant to CPLR article 78, inter alia, to review two determinations of the Commissioner of the New York State Department of Health, both dated March 30, 2010, enforcing audit results of the petitioners/plaintiffs' patient review instrument submissions for certain years, and action for declaratory relief, the petitioners/plaintiffs appeal, as limited by their brief, from so much of a judgment of the Supreme Court, Queens County (Kelly, J.), dated September 15, 2010, as, upon a decision of the same court dated August 9, 2010, denied the petition and dismissed the proceeding.

Ordered that the judgment is affirmed insofar as appealed from, with costs.

The petitioners/plaintiffs (hereinafter the petitioners) run nursing homes in Queens. **[***2]** In 1998, the petitioner New Surfside Nursing Home, LLC (hereinafter New Surfside), instituted a Neurobiological Program to provide care to mentally ill and brain-injured patients. The program accepted patients discharged from facilities licensed by the New York State Office of Mental Health (*see generally* Hirschfeld v [**784] Teller, 14 NY3d 344, 927 NE2d 1042, 901 NYS2d 558 [2010]). The Neurobiological Program later expanded to other nursing homes under related ownership, including the petitioner Meadow Park Rehabilitation and Health Care Center, LLC (hereinafter Meadow Park).

As part of the process of Medicaid reimbursement, the petitioners semiannually submitted patient review instrument (hereinafter PRI) data to the New York State Department of Health (hereinafter the DOH) (*see 10 NYCRR 86-2.11 [b]*). PRI submissions provide information assessing each patient's medical diagnosis, treatment, and care (*see 10 NYCRR 86-2.30*; Matter of Terrace HealthCare Ctr., Inc. v Novello, 54 AD3d 643, 644, 865 NYS2d 37 [2008]). Each patient is placed into 1 of 16 "resource utilization" groups, and assigned a case mix index (hereinafter CMI) number (*see 10 NYCRR Appendix 13-A*). The weighted average of all patients' CMI values is a nursing home's CMI, upon which a **[***3]** portion of the facility's Medicaid reimbursement is based (*see 10 NYCRR 86-2.10 [a] [5]*; *[c] [6]*). The petitioners classified the patients in the Neurobiological Program in the highest category of "Restorative Therapy/Heavy Rehabilitation." **[****2]**

In February 2003, the DOH completed an audit of New Surfside's July 2000 PRI submission, and in July 2004 it completed an audit of Meadow Parks's May 2000 PRI submission (*see 10 NYCRR 86-2.30 [e]*). Subsequent audits were completed for PRI submissions for subsequent years. In the audit results, the DOH controverted the petitioners' "Restorative **[*639]** Therapy/Heavy Rehabilitation" designation of the patients in the Neurobiological Program, thereby reducing the Medicaid reimbursements to which the petitioners were entitled. The petitioners nevertheless continued to classify the patients in the Neurobiological Program in the highest category of "Restorative Therapy/Heavy Rehabilitation." In letters dated March 30, 2010, the DOH sent the petitioners revised Medicaid rate sheets implementing the changes to the petitioners' PRI submissions made in the audits. The DOH alleged that the petitioners made substantial profits of $14.2 million (New Surfside) and $6.2 million **[***4]** (Meadow Park) during the years in question.

The petitioners commenced this hybrid proceeding pursuant to CPLR article 78 to review the DOH's determinations controverting their PRI submission designations for patients in the Neurobiological Program and enforcing the results of the audits, and action for declaratory relief. They sought a judgment, inter alia, annulling the audit results, enjoining the respondents from implementing and enforcing the revised Medicaid rate sheets, and directing the respondents to issue new revised Medicaid rate sheets based upon the original Restorative Therapy/Heavy Rehabilitation designations. The Supreme Court, inter alia, denied the petition and dismissed the proceeding. The petitioners appeal, and we affirm the judgment insofar as appealed from.

HN1[↑] In this proceeding in which the petitioners challenge an agency determination that was not made

after a quasi-judicial hearing, we must consider whether the 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 (*see* CPLR 7803 [3]; *Matter of Halperin v City of New Rochelle, 24 AD3d 768, 770, 809 NYS2d 98 [2005]*). In such a proceeding, courts **[***5]** "examine whether the action taken by the agency has a rational basis" and will overturn that action only "where it is 'taken without sound basis in reason' or 'regard to the facts' " (*Matter of Wooley v New York State Dept. of Correctional Servs., 15 NY3d 275, 280, 934 NE2d 310, 907 NYS2d 741 [2010]*, quoting *Matter of Peckham v **[**785]** Calogero, 12 NY3d 424, 431, 911 NE2d 813, 883 NYS2d 751 [2009]*; *see Matter of Pell v Board of Educ. of Union Free School Dist. No. 1 of Towns of Scarsdale & Mamaroneck, Westchester County, 34 NY2d 222, 232, 313 NE2d 321, 356 NYS2d 833 [1974]*), or where it is "arbitrary and capricious" (*Matter of Deerpark Farms, LLC v Agricultural & Farmland Protection Bd. of Orange County, 70 AD3d 1037, 1038, 896 NYS2d 126 [2010]*). Further, courts must defer to an administrative agency's rational interpretation of its own regulations in its area of expertise (*see Matter of Peckham v Calogero, 12 NY3d 424, 431, 911 NE2d 813, 883 NYS2d 751 [2009]*; *Matter of Nazareth Home **[*640]** of the Franciscan Sisters v Novello, 7 NY3d 538, 544, 858 NE2d 1131, 825 NYS2d 426 [2006]*; *Matter of Manko v New York State Div. of Hous. & Community Renewal, Off. of Rent Admin., 88 AD3d 719, 930 NYS2d 72 [2011]*; *Matter of Jennings v Commissioner, N.Y.S. Dept. of Social Servs., 71 AD3d 98, 109, 893 NYS2d 103 [2010]*).

Here, the DOH's enforcement of the audit results through issuance of the revised Medicaid rate sheets was not arbitrary and capricious. ***HN2***[⬆] By **[***6]** regulation, the DOH is required to correct a facility's CMI in accordance with audit results, and to adjust payments to reflect changes in the facility's CMI (*see 10 NYCRR 86-2.30 [e] [5]*; *86-2.11 [a]*). The DOH cannot be estopped from exercising these duties by any delay in issuing the revised Medicaid rate sheets (*see Matter of Frye v Commissioner of Fin. of City of N.Y., 62 NY2d 841, 844, 466 NE2d 151, 477 NYS2d 611 [1984]*).

The petitioners' challenges to the audit results themselves are untimely, as they were not brought within four months after the petitioners' receipt of the audit results (*see* CPLR 217 [1]; *Matter of Terrace HealthCare Ctr., Inc. v Novello, 54 AD3d 643, 865 NYS2d 37 [2008]*; *Concourse Rehabilitation & Nursing Ctr., Inc. v Novello, 45 AD3d 366, 367, 846 NYS2d 25 [2007]*). The cases relied upon by the petitioners, cited by our dissenting colleague for the proposition that the audit results were not final and binding until revised Medicaid rate sheets were issued in 2010, do not involve audit results and do not compel a different result (*see New York State Assn. of Counties v Axelrod, 78 NY2d 158, 165, 577 NE2d 16, 573 NYS2d 25 [1991]*; *Matter of Westmount Health Facility v Commissioner of N.Y. State Dept. of Health, 205 AD2d 991, 613 NYS2d 965 [1994]*; *Matter of New York State Health Facilities Assn. v Axelrod, 199 AD2d 752, 753, 605 NYS2d 497 [1993]*, **[***7]** *revd sub nom. Matter of Consolation Nursing Home v Commissioner of N.Y. State Dept. of Health, 85 NY2d 326, 648 NE2d 1326, 624 NYS2d 563 [1995]*). Furthermore, contrary to our dissenting colleague's position, the petitioners "fully understood the implication of DOH's determination" upon receipt of those results (*Matter of Alterra Healthcare Corp. v Novello, 306 AD2d 787, 788, 761 NYS2d 707 [2003]*). **[****3]** Indeed, New Surfside commenced an article 78 proceeding within four months of receiving its audit results in 2003, but it failed to pursue the matter, which was eventually marked off the calendar.

In any event, the DOH's determination to apply existing regulations in conducting the audits was not arbitrary and capricious. ***HN3***[⬆] "The rules of an administrative agency, duly promulgated, are binding upon the agency as well as upon any other person who might be affected" (*Matter of Frick v Bahou, 56 NY2d 777, 778, 437 NE2d 277, 452 NYS2d 18 [1982]*; *see Matter of Henn v Perales, 186 AD2d 740, 588 NYS2d 653 [1992]*). ***HN4***[⬆] A facility is not entitled to Medicaid reimbursements sought in violation of applicable regulations, even where the services were **[*641]** properly rendered (*see Matter of Cornerstone of Med. Arts Ctr. Hosp. v Novello, 304 AD2d 445, 758 **[**786]** NYS2d 627 [2003]*; *Matter of A.R.E.B.A. Casriel v Novello, 298 AD2d 134, 748 NYS2d 547 [2002]*). The assertions made by the **[***8]** managing member and a former administrator of New Surfside that, sometime in 1998, a DOH official and an independent contractor represented that the petitioners would be permitted enhanced reimbursement not provided for in existing regulations, even if credited, do not establish an enforceable agreement between the DOH and the petitioners. Furthermore, to the extent that the petitioners allege that they relied upon any such representations, ***HN5***[⬆] estoppel cannot be invoked to prevent the DOH from discharging its statutory duties (*see Matter of Schorr v New York City Dept. of Hous. Preserv. & Dev., 10 NY3d 776, 779, 886 NE2d 762, 857 NYS2d 1 [2008]*; *Matter of New York State Med. Transporters Assn. v Perales, 77 NY2d 126, 130, 566*

NE2d 134, 564 NYS2d 1007 [1990]; Matter of Miney v Donovan, 68 AD3d 876, 878, 890 NYS2d 616 [2009]).

The petitioners' remaining contentions are either without merit or not properly before this Court. Dickerson, J.P., Chambers and Miller, JJ., concur.

Dissent by: AUSTIN

Dissent

Austin, J., dissents, and votes to reverse the judgment insofar as appealed from, on the law, reinstate the petition, and grant the petition to the extent of annulling the determinations of the Commissioner of the New York State Department of Health dated **[***9]** March 30, 2010, annulling the audit results enforced by those determinations, and directing the respondents to reimburse the petitioners in accordance with the last audited Medicaid reimbursement rate sheets submitted by the petitioners in 2000, and otherwise deny the petition, in accordance with the following memorandum: On March 30, 2010, the New York State Department of Health (hereinafter the DOH) issued some eight years of previously withheld revised Medicaid reimbursement rate sheets to the petitioners all in one fell swoop. These revised rate sheets were predicated upon several audits which were left to languish unenforced for years, despite regulatory obligations mandating periodic adjustment by the DOH. During this lengthy interregnum, the DOH actively injected ambiguity and uncertainty into whether the subject audits were intended to be final and binding determinations, and did not treat them as such until the issuance of the revised rate sheets. It was only at that point that the petitioners, New Surfside Nursing Home, LLC (hereinafter New Surfside), and Meadow Park Rehabilitation and Health Care Center, LLC (hereinafter Meadow Park), were notified that they were required **[***10]** to repay excess reimbursement sums of $14,516,679.15 and $12,683,074.91, respectively.

To affirm the Supreme Court's determination that the **[*642]** petitioners' challenges to the DOH's audit results were time-barred would be to allow the DOH to inequitably penalize the petitioners for the ambiguity it created.

While invocation of the doctrine of estoppel against a governmental agency is generally foreclosed in order to avoid fraud, it is not absolutely precluded and is available in exceedingly rare circumstances (*see* Matter of New York State Med. Transporters Assn. v Perales, 77 NY2d 126, 130, 566 NE2d 134, 564 NYS2d 1007 [1990]; Matter of Parkview Assoc. v City of New York, 71 NY2d 274, 282, 519 NE2d 1372, 525 NYS2d 176 [1988], *cert denied 488 US 801, 109 S Ct 30, 102 L Ed* ***2d*** *9 [1988]*). I believe that this case is one of those rare circumstances.

For this reason and the additional reasons herein set forth, I respectfully dissent, **[**787]** and vote to reverse the Supreme Court's judgment and grant the petition to the extent of annulling the challenged determinations of the DOH so as to reinstate the last audited rate sheets submitted by the petitioners in 2000. **[****4]**

"An article 78 proceeding must be commenced within four months after the administrative determination to be reviewed becomes 'final and binding upon **[***11]** the petitioner' " (Matter of Yarbough v Franco, 95 NY2d 342, 346, 740 NE2d 224, 717 NYS2d 79 [2000], quoting CPLR 217 [1]; *see* New York State Assn. of Counties v Axelrod, 78 NY2d 158, 165, 577 NE2d 16, 573 NYS2d 25 [1991]; Matter of Village of Westbury v Department of Transp. of State of N.Y., 75 NY2d 62, 72, 549 NE2d 1175, 550 NYS2d 604 [1989]; Matter of Brown v New York State Racing & Wagering Bd., 60 AD3d 107, 112, 871 NYS2d 623 [2009]). However, the finality of any DOH determination that affects a facility's Medicaid reimbursement rates is impugned when the DOH injects "ambiguity and uncertainty as to when and whether the determination became—or was intended to be—final and binding" (New York State Assn. of Counties v Axelrod, 78 NY2d at 166). "[W]hen an administrative body itself creates ambiguity and uncertainty . . . affected [parties] and their counsel should not have to risk dismissal for prematurity or untimeliness by necessarily guessing when a final and binding determination has or has not been made. Under these circumstances, 'the courts should resolve any ambiguity created by the public body against it in order to reach a determination on the merits and not deny a party his [or her] day in court' " (Mundy v Nassau County Civ. Serv. Commn., 44 NY2d 352, 358, 376 NE2d 1305, 405 NYS2d 660 [1978], quoting Matter of Castaways Motel v Schuyler, 24 NY2d 120, 126-127, 247 NE2d 124, 299 NYS2d 148 [1969]).

A **[***12]** determination is not final and binding until its consequences are ascertainable and its impact can be accurately assessed (*see* New York State Assn. of Counties v Axelrod, 78 NY2d at 165; Matter of New York State Health Facilities Assn. v Axelrod, 199 AD2d

752, 753, 605 NYS2d 497 [1993], *revd sub nom. on other* ***[*643]*** *grounds Matter of Consolation Nursing Home v Commissioner of N.Y. State Dept. of Health, 85 NY2d 326, 648 NE2d 1326, 624 NYS2d 563 [1995]*). Thus, the triggering act for a CPLR article 78 proceeding to challenge an ambiguous "final" administrative determination pertaining to Medicaid reimbursement is commonly the facility's receipt of a rate recomputation notice apprising it of its actual reimbursement rates (*see Matter of New York State Health Facilities Assn. v Axelrod, 199 AD2d at 753*; *Matter of Consolation Nursing Home v Commissioner of N.Y. State Dept. of Health, 194 AD2d 149, 152, 605 NYS2d 493 [1993]*, *revd on other grounds 85 NY2d 326, 648 NE2d 1326, 624 NYS2d 563 [1995]*; *Matter of Westmount Health Facility v Commissioner of N.Y. State Dept. of Health, 205 AD2d 991, 993, 613 NYS2d 965 [1994]*).

The holdings of the Appellate Division, First Department, pertaining to the general finality of audits in *Matter of Terrace HealthCare Ctr., Inc. v Novello (54 AD3d 643, 643, 865 NYS2d 37 [2008])* and *Concourse Rehabilitation & Nursing Ctr., Inc. v Novello (45 AD3d 366, 367, 846 NYS2d 25 [2007])*, **[***13]** as relied upon by the majority, differ factually from the instant case and, thus, are distinguishable.

Unlike *Terrace HealthCare* and *Concourse Rehabilitation*, the record here demonstrates that the DOH did not treat the results of the audits as final and binding against the petitioners until its issuance **[**788]** of revised Medicaid rate sheets in 2010, years after its last audit was forwarded to the petitioners. Instead, DOH officials acknowledged to the petitioners the inadequacy of existing regulations, worked on altering the basis for the audit determinations, and, despite downward adjustment in the subject audits, permitted categorization of neurobiological patients in the highest category while those officials endeavored to promulgate new regulations.

Not only did the DOH abstain from enforcing the subject audits, the earliest of which was performed in 2003, until 2010, but, throughout that time, the DOH continued to reimburse the petitioners based upon their pre-audit rate schedules from 2000. The DOH evidently did so acknowledging that the audits were predicated upon outmoded regulations which were not designed to address the needs of neurobiological patients. During this extended period **[***14]** of time, the DOH ignored several of its own regulations requiring it to periodically adjust the Medicaid reimbursement rates (*see e.g. 10 NYCRR 86-2.11 [a]*, *[d]* [mandating periodic rate adjustment "to reflect changes in the case mix of facilities" and the "number of patients in each patient classification group"]). Such a substantial delay in enforcement lent itself to the petitioners' reasonable view that the audit results were nonbinding and created uncertainty as to their actual impact when taken in conjunction with repeated assurances **[*644]** from various DOH officials proffering operational and reimbursement cures to the admitted inadequacies inherent in the existing regulations in addressing neurobiolgical patients.

Unlike the circumstances in *Matter of Alterra Healthcare Corp. v Novello (306 AD2d 787, 761 NYS2d 707 [2003])*, where the alleged injection of ambiguity by the DOH regarding the finality of its decision was **[****5]** predicated upon a single meeting and overwhelmed by consistent and repeated reaffirmations of the DOH's asserted position (*see id. at 788-789*), here the DOH consistently and repeatedly undermined the finality of its determination with regard to determining the appropriate Medicaid reimbursement **[***15]** rates for the petitioners' neurobiological patients.

Upon receiving the first disputed audit result in 2003, New Surfside commenced a proceeding pursuant to CPLR article 78 against certain DOH officials challenging the results, though the matter was subsequently marked off the calendar. Shortly thereafter, the DOH's Director of the Office of Health Systems Management (hereinafter the Director) and several other high-level DOH officials convened with an attorney representing the petitioners. At that meeting, "[a] commitment was made that the [DOH] would review the staffing requirements for these [Neurobiological Program] residents and put forward reimbursement regulations for a new discrete rate category." Moreover, the Director "agreed that the DOH would move forward with regulations to establish a new reimbursement category for neuro-biological residents." Thereafter, DOH officials did work on analyzing and preparing new operational regulations and reimbursement provisions, while simultaneously refraining from enforcing the subject audit results against the petitioners. Written communications in 2003 and 2005 from the former Director of the DOH Bureau of Long Term Care Reimbursement **[***16]** stated that a commitment had been made that the DOH would review staffing requirements and move forward with proposed regulations. Proposed operational regulations for neurobiological units were published for public comment in 2008, although ultimately they were not adopted.

Through the actions and assertions of its officials, the DOH injected ambiguity and **[**789]** uncertainty as to when and whether the audit results were intended to be final and binding. Contrary to the DOH's contention, the financial impact of the audits was not objectively "inevitable" under the circumstances. The finality of the audits did not become unequivocal until the DOH ultimately issued revised rate sheets to the petitioners in 2010. This proceeding was commenced within four months of the petitioners' receipt of those rate sheets. Therefore, it was timely.

[*645] On the merits, upon annulment of the challenged audit results and the determinations enforcing those results, the petitioners are entitled to rely upon the last audited rate sheets that they submitted in 2000.

Accordingly, I would reverse the Supreme Court's judgment insofar as appealed from, and grant the petition to the extent indicated herein.

People v. Hobson

Court of Appeals of New York

February 20, 1976, Argued ; May 4, 1976, Decided

No Number in Original

Reporter
39 N.Y.2d 479 *; 348 N.E.2d 894 **; 384 N.Y.S.2d 419 ***; 1976 N.Y. LEXIS 2673 ****

The People of the State of New York, Respondent, v. Henry Cornelius Hobson, Appellant

Prior History: [**1]** *People v Hobson, 47 AD2d 716.*

Appeal, by permission of an Associate Judge of the Court of Appeals, from an order of the Appellate Division of the Supreme Court in the Second Judicial Department, entered February 24, 1975, which affirmed a judgment of the Suffolk County Court (Ernest L. Signorelli, J.), convicting defendant, upon his plea of guilty, of robbery in the third degree.

Disposition: Order reversed, etc.

Counsel: *Gerald J. Callahan, John F. Middlemiss, Jr.*, and *Leon J. Kesner* for appellant. I. The People violated the constitutional rights of appellant in questioning him without his attorney being present. *(* People v Arthur, 22 NY2d 325; **[****4]** People v Vella, 21 NY2d 249; People v Donovan, 13 NY2d 148.) II. The trial court had insufficient evidence presented to determine that appellant waived his constitutional rights. *(* Blyden v Hogan, 320 F Supp 513; Inmates of Attica Correctional Facility v Rockefeller, 453 F2d 12; People v Horowitz, 21 NY2d 55; *People v Custis, 32 AD2d 966.*)

Henry F. O'Brien, District Attorney (Charles M. Newell of counsel), for respondent. I. Appellant's confession was not rendered inadmissible by the fact that it was made in the absence of his attorney. *(* People v Huntley, 15 NY2d 72; People v Valerius, 31 NY2d 51; People v Leonti, 18 NY2d 384, 19 NY2d 922, 389 U.S. 1007; Blackburn v Alabama, 361 U.S. 199; People v Stephen J. B., 23 NY2d 611; People v Chaffee, 42 AD2d 172; People v Paulin, 25 NY2d 445; People v Arthur, 22 NY2d 325; People v Gunner, 15 NY2d 226; People v McIntyre, 31 AD2d 964, 41 AD2d 776, 36 NY2d 10.) II. The record contains ample evidence that appellant freely and knowingly waived his constitutional rights and made a voluntary confession. *(* Blyden v Hogan, 320 F Supp 513; Miranda v Arizona, 384 U.S. 436; **[****5]** People v Cerrato, 24 NY2d 1, 397 U.S. 940; People v Huntley, 15 NY2d 72; People v Fairley, 32 AD2d 976; Johnson v Zerbst, 304 U.S. 458; People v Jennings, 40 AD2d 357, 33 NY2d 880; United States ex rel. Stephen J. B. v Shelly, 430 F2d 215; People v Tanner, 30 NY2d 102; People v Anthony, 24 NY2d 696.)

Judges: Judges Jones, Wachtler, Fuchsberg and Cooke concur with Chief Judge Breitel; Judge Jasen concurs in a separate opinion; Judge Gabrielli concurs in result in another separate opinion.

Opinion by: BREITEL

Opinion

[*481] [896] [***420]** Defendant, following denial of a motion to suppress his incriminating statements, was convicted, after a guilty plea, of third degree robbery (Penal Law, § 160.05). He was sentenced to seven years' imprisonment. His conviction was affirmed, and he appeals.

The issue is whether a defendant in custody, represented by a lawyer in connection with criminal charges under investigation, may validly, in the absence of the lawyer, waive his right to counsel.

There should be a reversal. Once a lawyer has entered a criminal proceeding representing a defendant in connection with criminal charges under investigation, the **[****6]** defendant in custody may not waive his right to counsel in the absence of the lawyer *(* People v Arthur, 22 NY2d 325, 329). Any statements elicited by an agent of the State, however subtly, after a purported "waiver" obtained without the presence or assistance of counsel, are inadmissible. Since the purported "waiver" of defendant's right to counsel was obtained in the absence of his lawyer, who had represented him at a just-completed lineup in connection with the criminal charges, his **[*482]** statements were inadmissible and should have been suppressed.

The facts are undisputed. On February 7, 1973, at approximately 8:30 p.m., defendant entered a delicatessen in Central Islip in Suffolk County. After asking for directions from the owner, George Gundlach, defendant drew a gun and demanded all the cash in the register. After he had received the cash and a number of packages of cigarettes, defendant left.

When the police arrived shortly thereafter, Mr. Gundlach described the robber to Suffolk County Detective Dolan. He then accompanied the detective to the police station, where he eventually identified photographs of defendant as those of the culprit. Mr. Gundlach did state, **[****7]** however, that to be **[***421]** positive he would have to see defendant in person.

Nine months later, on September 26, 1973, defendant was being held in the Suffolk County Jail on charges unrelated to the delicatessen robbery. He was not under arrest for the robbery at that time, although he was a photograph-identified suspect. Defendant was placed in a five-man lineup. Because defendant had requested counsel, Samuel McElroy, a Legal Aid lawyer, was assigned and present to represent him. Mr. Gundlach identified defendant as the robber. Mr. McElroy then left.

After Mr. McElroy left, a Sheriff's deputy asked Detective Dolan if he desired to speak to defendant. Despite his admitted knowledge that defendant was now represented by counsel on the robbery charge, Dolan replied that he would. The detective had not told Mr. McElroy that he was going to speak to defendant, nor did he make any effort to reach counsel before seeing defendant. At the deputy's request, defendant signed an undescribed form of "waiver" (which Dolan testified he had never seen) and agreed to speak to Dolan. Defendant was then brought to an "interview" room in the jailhouse.

Detective Dolan read to defendant **[****8]** the standard preinterrogation warnings and asked him if he understood. Defendant said that he did. The detective then asked defendant "Do you wish to contact a **[**897]** lawyer?" Defendant shook his head, indicating "No". The detective then asked "Having these rights in mind, do you wish to talk to me now without a lawyer?" Defendant replied "Yes".

Defendant then inquired of Dolan whether he had been identified by Mr. Gundlach, and the detective told him that he **[*483]** had. Expressing a desire to "clear up everything", defendant in effect confessed to the robbery.

In *People v Arthur (22 NY2d 325, 329, supra)*, the court held: "Once an attorney enters the proceeding, the police may not question the defendant in the absence of counsel unless there is an affirmative waiver, in the presence of the attorney, of the defendant's right to counsel *(People v. Vella, 21 N Y 2d 249)*. There is no requirement that the attorney or the defendant request the police to respect this right of the defendant." The rule of the *Arthur* case has been restated many times (see *People v Hetherington, 27 NY2d 242, 244-245*; *People v Paulin, 25 NY2d 445, 450*; *People v McKie [****9] , 25 NY2d 19, 26*; *People v Miles, 23 NY2d 527, 542*, cert den *395 U.S. 948*; cf. *People v Stephen J. B., 23 NY2d 611, 616)*.

This unequivocal and reiterated statement of the law in this State is no mere "dogmatic claim" or "theoretical statement of the rule" (see, contra, *People v Robles, 27 NY2d 155, 158*, cert den *401 U.S. 945*, thus characterizing the rule). It is, instead, a rule grounded in this State's constitutional and statutory guarantees of the privilege against self incrimination, the right to the assistance of counsel, and due process of law (see *People v Arthur, 22 NY2d 325, 328, supra; People v Failla, 14 NY2d 178, 180*; *People v Donovan, 13 NY2d 148, 151*; Richardson, Evidence [10th ed], § 545, at p 546). Indeed, the rule resisted narrow classification of defendants entitled to its protection; it is applicable to a defendant when taken into custody, whether as an "accused", a "suspect", or a "witness" (cf. *People v Sanchez, 15 NY2d 387, 389)*.

Of course, as with all verbalizations of constitutional principles, the rule of **[***422]** the *Arthur* case *(supra)* is not an absolute. Thus, the fact that a defendant is represented by counsel **[****10]** in a proceeding unrelated to the charges under investigation is not sufficient to invoke the rule (see *People v Hetherington, 27 NY2d 242, 245, supra; People v Taylor, 27 NY2d 327, 331-332)*. The rule applies only to a defendant who is in custody; it does not apply to noncustodial interrogation *(People v McKie, 25 NY2d 19, 28, supra)*. Moreover, the rule of the *Arthur* case *(supra)* does not render inadmissible a defendant's spontaneously volunteered statement *(People v Kaye, 25 NY2d 139, 144*; cf. *People v Robles, 27 NY2d 155, 159*, cert den *401 U.S. 945, supra)*.

The *Donovan* and *Arthur* cases *(supra)* extended constitutional protections of a defendant under the State Constitution **[*484]** beyond those afforded by the Federal Constitution (compare *People v Arthur, 22 NY2d 325, 329, supra*; and *People v Donovan, 13 NY2d*

148, 151, *supra*; with Miranda **[**898]** v Arizona, 384 U.S. 436, 475; and Escobedo v Illinois, 378 U.S. 478, 486-487; see Richardson, Evidence [10th ed], *op. cit.*, at pp 548-549; but cf., e.g., Massiah v United States, 377 U.S. 201, 205-206; United States v Thomas, 474 F2d 110, 112, **[****11]** cert den *412 U.S. 932*; United States ex rel. Lopez v Zelker, 344 F Supp 1050, 1054, affd 465 F2d 1405, cert den *409 U.S. 1049*, dealing with the right to counsel after the commencement of adversary judicial proceedings).

Notwithstanding that warnings alone might suffice to protect the privilege against self incrimination, the presence of counsel is a more effective safeguard against an involuntary waiver of counsel than a mere written or oral warning in the absence of counsel (see United States v Massimo, 432 F2d 324, 327 [Friendly, J., dissenting], cert den *400 U.S. 1022*; compare ALI, Model Code of Pre-Arraignment Procedure [Tent Draft No. 6, 1974], § 140.8, subd [2]; Miranda v Arizona, 384 U.S. 436, 475, *supra)*. The rule that once a lawyer has entered the proceedings in connection with the charges under investigation, a person in custody may validly waive the assistance of counsel only in the presence of a lawyer breathes life into the requirement that a waiver of a constitutional right must be competent, intelligent and voluntary (see People v Witenski, 15 NY2d 392, 395; Matter of Bojinoff v People, 299 NY 145, 151-152; Johnson v Zerbst, 304 **[****12]** U.S. 458, 464). Indeed, it may be said that a right too easily waived is no right at all.

Moreover, an attempt to secure a waiver of the right of counsel in a criminal proceeding in the absence of a lawyer, already retained or assigned, would constitute a breach of professional ethics, as it would be in the least-consequential civil matter (see ABA Code of Professional Responsibility, DR7-104, subd [A], par [1]; People v Robles, 27 NY2d 155, 162 [Fuld, Ch. J., dissenting], cert den *401 U.S. 945*, *supra;* United States v Thomas, 474 F2d 110, 111-112, cert den *412 U.S. 932*, *supra;* United States v Springer, 460 F2d 1344, 1355 [Stevens, J., dissenting], cert den *409 U.S. 873*; United States v Durham, 475 F2d 208, 211 [Swygert, Ch. J.]; Coughlan v United States, 391 F2d 371, 376 [Hamley, J., dissenting], cert den *393 U.S. 870*; Drinker, Legal Ethics, p 202; Broeder, *Wong Sun v United States*: A Study in **[***423]** Faith and Hope, 42 Neb L Rev 483, 601; cf. People v Lopez, 28 NY2d 23, 29 [dissenting opn], cert **[*485]** den *404 U.S. 840*). Since the Code of Professional Responsibility is applicable, it would be grossly incongruous for the courts to **[****13]** blink its violation in a criminal matter.

Of course, it would not be rational, logical, moral, or realistic to make any distinction between a lawyer acting for the State who violates the ethic directly and one who indirectly uses the admissions improperly obtained by a police officer, who is the badged and uniformed representative of the State. To do so would be, in the most offensive way, to permit that to be done indirectly what is not permitted directly. Indeed, in each of the cases cited above the rejected "waiver" was secured by investigators and not by lawyers.

Moreover, the principle is not so much, important as that is, to preserve the civilized decencies, but to protect the individual, often ignorant and uneducated, and always in fear, when faced with the coercive police power of the State. The right to **[**899]** the continued advice of a lawyer, already retained or assigned, is his real protection against an abuse of power by the organized State. It is more important than the preinterrogation warnings given to defendants in custody. These warnings often provide only a feeble opportunity to obtain a lawyer, because the suspect or accused is required to determine his **[****14]** need, unadvised by anyone who has his interests at heart. The danger is not only the risk of unwise waivers of the privilege against self incrimination and of the right to counsel, but the more significant risk of inaccurate, sometimes false, and inevitably incomplete descriptions of the events described. Surely, the need for and right to a lawyer at an identification lineup is insignificant compared to the need in an ensuing interrogation. If Dick the Butcher said, "The first thing we do, let's kill all the lawyers", the more zealous policeman in the station or jailhouse may well say, "The first thing we do, let's get rid of all the lawyers" (Shakespeare, Henry VI, pt II, act IV, sc ii).

The rule to be applied in this case would be evident, unquestionably evident, on the basis of what has been discussed thus far, but for one significant circumstance. Between September, 1970 and September, 1972 three cases were decided in this court which departed from the evident rule. The reasons for the departure were never made explicit, but nice distinctions were used, if the fact of departure was mentioned at all. On the other hand, the line of cases out of which the *Arthur* case **[****15]** *(supra)* arose, as well as the *Arthur* case itself, was an elaborated legal development, consciously evolved as **[*486]** such, stretching back at least to 1960 (see People v Di Biasi, 7 NY2d 544; and People v Spano, 4 NY2d 256, 264-267 [Desmond J., dissenting], revd 360 U.S. 315). It was not a string of happenstances (see People v Lopez, 28 NY2d 23, 26-28 [dissenting opn], cert den *404 U.S. 840*, *supra*, for a

detailed analysis of the development of the right to counsel in this State; but see, in contrast, *People v Robles, 27 NY2d 155, 158-160*, cert den *401 U.S. 945*, *supra)*. The three cases were *People v Robles (supra)*; *People v Lopez (28 NY2d 23*, cert den *404 U.S. 840*, *supra)*, and *People v Wooden (31 NY2d 753*). The *Wooden* case simply relied on the *Lopez* case, without opinion, three Judges concurring on constraint of the *Lopez* case. The *Robles* case involved an egregiously brutal and unnatural double murder. The *Lopez* case also involved a murder. That is perhaps the best that one can speculate about what moved the court, reminiscent of the adage about the influence of "hard cases".

[*424]** In the *Robles* **[****16]** case (p 158), the *Arthur* rule was discussed as "merely a theoretical statement" and it was said that "this dogmatic claim is not the New York law" citing *People v Kaye (25 NY2d 139*, *supra)* and *People v McKie (25 NY2d 19*, *supra)*, cases which applied as exceptions to the right to counsel doctrine spontaneous statements and noncustodial interrogation. There was further discussion of cases quite beside the issue, turning on coercion, trickery, and the like, as conditions which would require exclusion of interrogations of uncounseled defendants.

Actually the stability of these odd cases has already been undermined, albeit collaterally. The hapless Lopez, defeated in the State courts, went to the Federal courts. There the District Court in an extensive opinion by Judge Marvin Frankel granted habeas corpus relief, adopting the reasoning of the dissenters in the State court as **[**900]** a statement of Federal constitutional principles *(United States ex rel. Lopez v Zelker, 344 F Supp 1050, 1054*, *supra)*. The Court of Appeals for the Second Circuit affirmed unanimously from the Bench, without opinion (*465 F2d 1405*, cert den *409 U.S. 1049*). (See, also, *People **[****17]** v Santos, 85 Misc 2d 602, 608* [NYLJ, March 24, 1976, at p 8, col 6], declining to follow the *Lopez* case, *supra.)* As for the *Robles* case *(supra)*, the Richardson treatise is unsure of its effect on the *Arthur* line of cases (Richardson, Evidence [10th ed], *op. cit.*, at pp 547-548, listing five unanswered questions). Nor were the distinguished Justices in the Appellate Division for the Fourth Department able to agree (see *People v Pellicano, **[*487]** 40 AD2d 169* [opn by Mr. Justice Del Vecchio and dissenting opn by Mr. Justice Cardamone]).

The problem this departure from a deliberately elaborated line of cases raises is: What is required of a stable court in applying the eminently desirable and essential doctrine of *stare decisis*. Which is the *stare decisis*: The odd cases or the line of development never fully criticized or rejected?

Frankfurter, a stalwart for stability and systemic values in a jurisprudence, and no evanescent impulsive innovator, answered the question rather succinctly. In *Helvering v Hallock (309 U.S. 106, 119)* he said: "We recognize that *stare decisis* embodies an important social policy. It represents an **[****18]** element of continuity in law, and is rooted in the psychologic need to satisfy reasonable expectations. But *stare decisis* is a principle of policy and not a mechanical formula of adherence to the latest decision, however recent and questionable, when such adherence involves collision with a prior doctrine more embracing in its scope, intrinsically sounder, and verified by experience."

The *Di Biasi-Arthur* line of cases, stretching over almost two decades, represents "a prior doctrine more embracing in its scope, intrinsically sounder, and verified by experience". The three odd cases of uncertain root, present recency in time, but surely are in collision with the "prior doctrine", and in each instance decided by the closest possible margin in the court. They do not merit application of "a mechanical formula of adherence", just because of their recency.

Stare decisis, if it is to be more than shibboleth, requires more subtle analysis. Indeed, the true doctrine by its own vitality should not, perversely, give to its violation strength and stability. That would be like the parricide receiving mercy because he is an orphan. The odd cases rode roughshod over *stare decisis* **[****19]** and now would be accorded *stare decisis* as their legitimate right, whether or not they express sound, good, or acceptable doctrine.

There are many thinkers in the law whose comments on *stare decisis* bear directly on the problem in this case. Invariably, the concern is with the exercise of restraint in overturning established well-developed doctrine and, on the other hand, the justifiable rejection of archaic and obsolete **[***425]** doctrine which has lost its touch with reality (see, e.g., *Heyert v Orange & Rockland Utilities, 17 NY2d 352, 360-361* [Van Voorhis, J.], and cases and materials cited). But one comment **[*488]** by Mr. Justice Von Moschzisker, as long ago as 1924, is especially useful. He said: "From the very nature of law and its function in society, the elements of certainty, stability, equality, and knowability are necessary to its success, but reason and the power to advance justice must always be its chief essentials; and the principal

cause for standing by precedent is not to be found in the inherent probable virtue of a judicial decision, it 'is to be drawn from a consideration of the nature and object of law itself, considered as a system or **[****20]** a science'." (Von Moschzisker, Stare Decisis in Courts of Last Resort, 37 Harv L Rev 409, 414.)

[901]** The nub of the matter is that *stare decisis* does not spring full-grown from a "precedent" but from precedents which reflect principle and doctrine rationally evolved. Of course, it would be foolhardy not to recognize that there is potential for jurisprudential scandal in a court which decides one way one day and another way the next; but it is just as scandalous to treat every errant footprint barely hardened overnight as an inescapable mold for future travel.

While this case involves a narrow issue of the right to counsel in a criminal matter, it necessarily turns on what appears to be binding precedent, and hence, the doctrine of *stare decisis*. It is not sufficient to limit the discussion of the doctrine to its application to this case. There is the danger, otherwise, of a misunderstanding of the doctrine's role in the larger perspective in which this case is but an isolated instance. Indeed, this case is another example in which a treatment of the particular requires treatment of the universal under which it falls.

Distinctions in the application and withholding **[****21]** of *stare decisis* require a nice delicacy and judicial self-restraint. At the root of the techniques must be a humbling assumption, often true, that no particular court as it is then constituted possesses a wisdom surpassing that of its predecessors. Without this assumption there is jurisprudential anarchy. There are standards for the application or withholding of *stare decisis*, the ignoring of which may produce just that anarchy.

For one, in this case the court deals with constitutional limitations contained in the Bill of Rights. Legislative correction is confined. Although the limitations are designed to protect the individual against the encroachments of a transitory majority, the principle is well established that in cases interpreting the Constitution courts will, nevertheless, if convinced **[*489]** of prior error, correct the error (see, e.g., *Glidden Co. v Zdanok, 370 U.S. 530, 543*; *Smith v Allwright, 321 U.S. 649, 665-666*; *Burnet v Coronado Oil & Gas Co., 285 U.S. 393, 406-407* [Brandeis, J., dissenting]; Von Moschzisker, 37 Harv L Rev 407, 420-421). But the conviction of error must be imperative.

Tort cases, but especially personal injury cases, **[****22]** offer another example where courts will, if necessary, more readily re-examine established precedent to achieve the ends of justice in a more modern context (see, e.g., *Victorson v Bock Laundry Mach. Co., 37 NY2d 395*; *Goldberg v Kollsman Instrument Corp., 12 NY2d 432*; *Bing v Thunig, 2 NY2d 656*; *Woods v Lancet, 303 NY 349*). Significantly, in these cases the line of precedent, although well established, was found to be analytically unacceptable, and, more important, out of step with the times and the reasonable expectations of members of society.

Always critical to justifying adherence to precedent is the requirement that those who engage in transactions based on the **[***426]** prevailing law be able to rely on its stability. This is especially true in cases involving property rights, contractual rights, and property dispositions, whether by grant or testament (see, e.g., *United States v Title Ins. Co., 265 U.S. 472, 486-487*; *Heyert v Orange & Rockland Utilities, 17 NY2d 352, 360, 362-363*, *supra* [property rights]; *United States v Flannery, 268 U.S. 98, 105* [commercial transactions]; *Matter of Eckart, 39 NY2d 493*, decided herewith; Douglas, **[****23]** Stare Decisis, 49 Col L Rev 735-736 [wills]; cf. *Endresz v Friedberg, 24 NY2d 478, 488-489* [wrongful death **[**902]** action under *EPTL 5-4.1*]; *Matter of Brown, 362 Mich 47, 52* [statute pertaining to the descent and distribution of property]). The absence of such factors, on the other hand, makes easier the reassessment of aberrational departures from precedents and accepted principles.

Precedents involving statutory interpretation are entitled to great stability *(* *Matter of Schinasi, 277 NY 252, 265-266*; see 20 Am Jur 2d, Courts, § 198). After all, in such cases courts are interpreting legislative intention and a sequential contradiction is a grossly aggrogated legislative power. Moreover, if the precedent or precedents have "misinterpreted" the legislative intention, the Legislature's competency to correct the "misinterpretation" is readily at hand. (See, e.g., *People v Butts, 32 NY2d 946, 947*; *People v Cicale, 35 NY2d 661, 662*, concurred in on constraint and decided on authority of *People v Carter, 31 NY2d 964*.)

There is a more rarely recognized principle, a sort of exception **[*490]** to the general rule about the interpretation of statutes **[****24]** by courts. There are statutes drawn in such general terms that it is evident that the legislative intention is that the courts, by their interpretation, indeed construction, fill in, by a case-by-case approach, the skeletal outlines. Those are statutes which apply general and therefore flexible

standards. The classic example is that of the antitrust statutes, Federal and State, which apply "rules of reason". In such cases the degree of flexibility in handling statutory precedents is that much the greater, but still not unlimited. (See Breitel, The Lawmakers, 65 Col L Rev 749, 761.)

There are obviously other principles that do not now come to mind but most likely would share the rationale of those already discussed. Throughout, however, a precedent is less binding if it is little more than an ipse dixit, a conclusory assertion of result, perhaps supported by no more than generalized platitudes. On the contrary, a precedent is entitled to initial respect, however wrong it may seem to the present viewer, if it is the result of a reasoned and painstaking analysis. Indeed, that constitutes one of the bases for treating the *Robles* and *Lopez* cases as overruled in principle, **[****25]** just because they did not satisfy the rational test when compared to the line of reasoned and consciously developed cases which a bare majority in the *Lopez* and *Robles* cases found unsatisfactory.

The closeness of a vote in a precedential case is hardly determinative *(Semanchuck v Fifth Ave. & 37th St. Corp., 290 NY 412, 420*; see 21 CJS, Courts, § 189, at p 307). It certainly should not be. Otherwise, every precedent decided by a bare majority is a nonprecedent -- one to be followed if a later court likes it, and not to be followed if it does not like it. In the *Semanchuck* case, Chief Judge Lehman stated the rule precisely: "Three judges, including the writer of this opinion, dissented from the decision in the earlier case, insofar as it held that the general contractor was not, under the contract, entitled to indemnity from the subcontractor. The controversy over the applicable rule to be followed in the construction of **[***427]** the indemnity agreement has been resolved by that decision. The authoritative force of a decision as a precedent in succeeding cases is not determined by the unanimity or division in the court. The controversy settled by a decision **[****26]** in which a majority concur should not be renewed without sound reasons, not existing here. All the judges of the court accept the **[*491]** decision in the *Walters* case *[Walters v Rao Elec. Equip. Co., 289 NY 57]* and the rules which form the basis for that decision as guides in analogous cases."

[903]** Similarly, the accident of a change of personalities in the Judges of a court is a shallow basis for jurisprudential evolution *(Simpson v Loehmann, 21 NY2d 305, 314* [concurring opn]; see *Minichiello v Rosenberg, 410 F2d 106, 109* [Friendly, J.], cert den *396 U.S. 844*). In the *Simpson* case, the troublesome precedent was all but mint-new; its symmetrical conformance to prior law was facially absent. Nevertheless, the precedent was followed just because it would have been scandalous for a court to shift within less than two years because of the replacement of one of the majority in the old court by one who now intellectually would have preferred to have voted with the old minority and the new one.

The ultimate principle is that a court is an institution and not merely a collection of individuals; just as a higher court commands superiority over a lower **[****27]** not because it is wiser or better but because it is institutionally higher. This is what is meant, in part, as the rule of law and not of men.

Accordingly, the order of the Appellate Division should be reversed, the plea vacated, and the statements of defendant suppressed.

Concur by: JASEN; GABRIELLI

Concur

Jasen, J. (concurring). Convinced as I am that the reasoning which prompted the holdings in the *Robles* and *Lopez* cases has failed to produce a stable and recognized rule, I concur in the majority opinion and particularly for the respect it accords to the doctrine of *stare decisis* and the limited exceptions which it would allow.

Gabrielli, J. (concurring). I concur in the result reached by the majority. In doing so, however, I am unable to join in overruling *People v Lopez (28 NY2d 23*). I would adhere to the established view that, until counsel is assigned or retained by a defendant in a criminal action, he is perfectly free, after suitable and proper admonitions, to waive his right to the presence and assistance of counsel and make voluntary statements *(People v Bodie, 16 NY2d 275*; cf. *People v Meyer, 11 NY2d 162, 165)*. It is always the task of the courts, **[****28]** of course, to assure that such a waiver is knowingly and intelligently made and that statements following a waiver are voluntarily given.

We succinctly stated in *People v Bodie* (*supra, p 279*) that **[*492]** "since the right to counsel also imports the right to refuse counsel, we hold that a defendant may effectively waive his right to an attorney." This holding is qualified, of course, in the situation where counsel has

been assigned or retained in which case we have held that a defendant may not be interrogated without the presence or consent of counsel *(People v Arthur, 22 NY2d 325*; *People v Vella, 21 NY2d 249*; *People v Donovan, 13 NY2d 148*). Under the circumstances of the instant case, it is this rule which is applicable as the majority ably demonstrates. To reach the result in the case before us, it is unnecessary to consider *People v Lopez (supra)*. As noted in the majority opinion, defendant Hobson was represented by counsel at the time of the interrogation, while, in *Lopez*, the defendant decided to forego representation by counsel.

[*428]** While the rule in the Federal courts may be unsettled, several of them have recognized the admissibility **[****29]** of postindictment statements made after a waiver of right to counsel. Thus, in *United States ex rel. O'Connor v State of New Jersey (405 F2d 632, 636)* the Third Circuit Court of Appeals, focusing on the quality of the waiver, stated that "only a clear, explicit, and **[**904]** intelligent waiver may legitimate interrogation without counsel following indictment" (see, also, *United States v Crisp, 435 F2d 354, 358-359*. And, in *United States v Garcia (377 F2d 321, 324*, cert den *389 U.S. 991*), the Second Circuit indicated that"*Massiah [v United States, 377 U.S. 201]* does not immunize a defendant from normal investigation techniques after indictment".

In the landmark decision of *Massiah v United States (377 U.S. 201, 206*, *supra)*, the United States Supreme Court held that the defendant "was denied the basic protections of that guarantee [Sixth Amendment right to counsel] when there was used against him at his trial evidence of his own incriminating words, which federal agents had deliberately elicited from him after he had been indicted and in the absence of his counsel." In *Massiah*, the defendant had retained counsel before the statements were elicited **[****30]** from him and, significantly, the court noted that "it was entirely proper to continue an investigation of the suspected criminal activities of the defendant * * * even though the defendant had already been indicted" *(supra, p 207*).

I do not view the Federal District Court decision in *United States ex rel. Lopez v Zelker (344 F Supp 1050*, affd *465 F2d [*493] 1405*) as requiring a contrary result. The essence of Judge Frankel's decision in the *Lopez* habeas corpus proceeding was that defendant's waiver of the right to counsel was not knowingly and intelligently rendered because he was not aware of the outstanding indictment against him for the crime of murder. The decision, therefore, is predicated upon a view of the facts which is divergent from the facts as developed in the proceedings against Lopez in our State courts. The majority of this court in *Lopez* observed that "[defendant] does not dispute either the waiver or the sufficiency of the evidence to find that it was intelligently and understandingly made" *(supra, p 25*). The trial court in *Lopez*, affirmed by an unanimous Appellate Division, found, following a suppression hearing, that "the People **[****31]** have proven beyond a reasonable doubt that the defendant intelligently understood the warnings and knowingly expressed his waiver of Constitutional rights," and we held that there was evidence in the record to sustain such a finding (p 25). Thus, three New York courts found that Lopez made voluntary statements following a knowing and intelligent waiver of the right to counsel.

I would only add that adopting the position proposed by the majority would bar the admissibility of any statements which a defendant might wish to tender in response to any police inquiry, no matter how knowingly and intelligently made, following the commencement of any criminal action by the filing of an accusatory instrument even so minor as a simplified traffic information. *

End of Document

* *CPL 1.20* (subd [1]) defines an accusatory instrument as "an indictment, an information, a simplified traffic information, a prosecutor's information, a misdemeanor complaint or a felony complaint."

Rhine v. New York Life Ins. Co.

Supreme Court of New York, Appellate Division, First Department

June 23, 1936

No Number in Original

Reporter
248 A.D. 120 *; 289 N.Y.S. 117 **; 1936 N.Y. App. Div. LEXIS 6089 ***

Artrude L. Westerheide Rhine, Plaintiff, v. New York Life Insurance Company, Defendant

Prior History: [*1]** Submission of a controversy upon an agreed statement of facts pursuant to section 546 of the Civil Practice Act.

Disposition: Judgment unanimously directed in favor of the defendant, without costs. Settle order on notice.

Core Terms

disability, dividends, surplus, disability benefits, policies, premium, policyholders, disability policy, apportionment, life insurance, calculated, equitable, mortality, insurance company, non-disability, provisions, expenses, insured, disability insurance, mutual life, ascertained, annually, zero, mathematical, losses, life insurance policy, annual premium, similar policy, death benefit, principles

Case Summary

Procedural Posture
Plaintiff brought suit against defendant asserting that defendant violated its contractual and statutory duty in applying a negative disability factor in connection with the apportionment of dividends to its disability policies.

Overview

Plaintiff brought suit against defendant asserting that defendant violated its contractual and statutory duty in applying a negative disability factor in connection with the apportionment of dividends to its disability policies. The court granted judgment in defendant's favor holding that all the policyholders of disability benefits were treated alike in the apportionment of dividends, and all policyholders without disability benefits were treated alike in the apportionment. According to the court, the apportionment made by an insurance company was regarded prima facie as an equitable apportionment, and the plaintiff must allege and prove facts showing that the apportionment was not equitable or was based upon erroneous principles. The court also held that in the absence of any allegation of wrongdoing or mistake, the directors' determination of the apportionment must be treated as proper. The court then found there was no violation of N.Y. Ins. Law §§ 89 and *108*.

Outcome
The court granted judgment in defendant's favor holding that all the policyholders of disability benefits were treated alike in the apportionment of dividends, and all policyholders without disability benefits were treated alike in the apportionment.

LexisNexis® Headnotes

Insurance Law > Claim, Contract & Practice Issues > Premiums

HN1[] Claim, Contract & Practice Issues, Premiums

Each participant should be benefited in proportion to the excess of his payments over and above the actual cost of insurance.

Insurance Law > Claim, Contract & Practice Issues > Premiums

HN2[] Claim, Contract & Practice Issues, Premiums

The difference between the sum of his credits and the sum of his debits determines the overpayment or contribution from the policy proper.

Insurance Law > Claim, Contract & Practice Issues > Premiums

HN3[] Claim, Contract & Practice Issues, Premiums

The contribution method is the recognized standard for dividend distribution throughout the world.

Insurance Law > Types of Insurance > Life Insurance > General Overview

Labor & Employment Law > ... > Conditions & Terms > Duration of Employment > General Overview

Insurance Law > Claim, Contract & Practice Issues > Premiums

HN4[] Types of Insurance, Life Insurance

In the creation of any mutual life insurance company's surplus the factors employed by every mutual life insurance company in the ascertainment and apportionment of its divisible surplus are "positive" or "negative" or "zero," as follows: If the mortality is less than the mortality table employed, or the interest is greater than the rate assumed, or the expenses are less than assumed in the calculation of the premium, or the disability claims are less than in the disability table employed, then the respective elements of mortality interest, expense or disability are positive, otherwise, such respective elements are negative. In any case where the mortality, interest, expense or disability experience equals the tabular rate the element is zero, indicating by such descriptive mathematical term, no contribution, either positive or negative, to the divisible surplus from the particular source to which the zero factor refers, that is, no divisible profit or loss is indicated from such element in the determination of the dividend.

Insurance Law > Claim, Contract & Practice Issues > Premiums

HN5[] Claim, Contract & Practice Issues, Premiums

N.Y. Ins. Law § 83.

Business & Corporate Compliance > ... > Industry Practices > Unfair Business Practices > Discrimination

Insurance Law > Types of Insurance > Life Insurance > General Overview

Constitutional Law > Equal Protection > Nature & Scope of Protection

Insurance Law > Claim, Contract & Practice Issues > Premiums > Refunds

HN6[] Unfair Business Practices, Discrimination

N.Y. Ins. Law § 89.

Business & Corporate Compliance > ... > Industry Practices > Unfair Business Practices > Discrimination

Constitutional Law > Equal Protection > General Overview

Insurance Law > Types of Insurance > Life Insurance > General Overview

HN7 **Unfair Business Practices, Discrimination**

N.Y. Ins. Law § 108.

Business & Corporate Compliance > ... > Insurance Company Operations > Company Ownership > Mutual & Stock Companies

Insurance Law > Types of Insurance > Life Insurance > General Overview

Constitutional Law > Equal Protection > General Overview

Insurance Law > Claim, Contract & Practice Issues > Premiums

Insurance Law > ... > Insurance Company Operations > Company Ownership > General Overview

HN8 **Company Ownership, Mutual & Stock Companies**

The relation between a policyholder and a mutual insurance company is not that of trustee and cestui que trust, but is the relationship of debtor and creditor; that in the absence of wrongdoing or mistake the amount of divisible surplus to be apportioned as determined by the company is final and conclusive on all policyholders; that the apportionment of surplus earnings of an insurance company must be equitably made; that, prima facie, the apportionment made by the company should be regarded as equitable, since under the terms of the policy the duty of making it is cast upon the company, and it ought to be presumed that the company has performed its duty instead of presuming that it has failed to do so; but that on proper allegations of fact showing the apportionment made by the company is not equitable or has been based upon erroneous principles, the policyholder and all others similarly situated have a right to make proof of such allegations.

Insurance Law > Types of Insurance > Life Insurance > General Overview

Insurance Law > Claim, Contract & Practice Issues > Premiums

HN9 **Types of Insurance, Life Insurance**

A policyholder has a right to share in an equitable distribution of the company's accumulated surplus, but, until a distribution is made by the officers or managers of the company, a policyholder has no such title to any part of the surplus as would enable him to maintain an action at law for its recovery.

Constitutional Law > Equal Protection > General Overview

Insurance Law > Types of Insurance > Life Insurance > General Overview

HN10 **Constitutional Law, Equal Protection**

An equitable and fair classification includes in one class all policies issued upon the same plan so that participation in profits may be uniform to all the members of that single branch of the mutual enterprise, and that a further classification among such holders of uniform policies depending only upon the accidents of age and date of issue ought not to be made and must not be made when such subdivision is into such small units as will necessarily result in inequitable inequalities among members holding the same kind of policies.

Insurance Law > Contract Formation

HN11 **Insurance Law, Contract Formation**

The essential test to determine whether a number of promises constitute one contract or more than one is simple. It can be nothing else than the answer to an inquiry whether the parties assented to all the promises as a single whole, so that there would have been no bargain whatever, if any promise or set of promises were struck out.

Constitutional Law > Equal Protection > General Overview

Insurance Law > Types of Insurance > Life Insurance > General Overview

HN12 **Constitutional Law, Equal Protection**

The statutory test is whether the apportionment is equitable or whether it unfairly discriminates between individuals of the same class.

Constitutional Law > Equal Protection > General Overview

Insurance Law > Types of Insurance > Life Insurance > General Overview

Business & Corporate Law > ... > Directors & Officers > Scope of Authority > Discretion

Civil Procedure > Appeals > Standards of Review > Clearly Erroneous Review

Insurance Law > Claim, Contract & Practice Issues > Premiums

HN13[] **Constitutional Law, Equal Protection**

To succeed, plaintiff must show that the principle on which the apportionment is based is so clearly erroneous as to be beyond the exercise of any reasonable discretion on the part of the company's directors.

Headnotes/Summary

Headnotes

Insurance -- life insurance -- mutual life insurance company properly separately and differently classified, for purpose of distribution of dividends, policies which contain in addition to usual agreement to pay stipulated sum on death, incorporated in all policies of insurer contemporaneously issued, agreement to pay, on receipt of proof of disability, certain disability benefits (Insurance Law, §§ 83, 89, *108*) -- policy containing such disability provisions constitutes single integral agreement, not two separate agreements -- terms divisible contract, severable contract and entire contract, distinguished -- statutory test of propriety of distribution of surplus, stated -- apportionment of surplus, as made by company, will be regarded prima facie as equitable.

Syllabus

A mutual life insurance company properly separately and differently classified, for purpose of distribution of dividends, policies which contain in addition to the usual agreement to pay a stipulated **[***2]** sum on the death of the assured incorporated in all the policies of life insurance contemporaneously written by the insurer, an agreement to pay, on receipt of proof that the assured is totally and permanently disabled, certain disability benefits (Insurance Law, §§ 83, 89, *108*).

A policy of life insurance which contains, in addition to the usual agreement to pay a stipulated sum on the death of the assured incorporated in all the policies of life insurance contemporaneously written by the insurer, an agreement to pay, on receipt of proof that the assured is totally and permanently disabled, certain disability benefits, and which provides for a single total premium covering both life insurance and disability benefits, though an amount is stated by which the total premium will be reduced in the event of discontinuance of the disability coverage, constitutes a single integral contract, and not two separate and complete agreements of insurance, where the disability benefits were not separately obtainable and cannot be continued in force independently of the death benefit in the policy, and the provisions relating to disability insurance standing by themselves will not spell out a separate **[***3]** contract.

Terms divisible contract, severable contract and entire contract, distinguished. The essential test to determine whether a number of promises constitute one contract or more than one, is the answer to an injury whether the parties assented to all the promises as a single whole, so that there would have been no bargain whatever if any promise or set of promises were struck out.

The statutory test for the propriety of distribution to policyholders of surplus in the form of dividends is whether the apportionment is equitable or whether it unfairly discriminates between individuals of the same class (Insurance Law, §§ 83, 89, *108*).

The apportionment of surplus, as made by the company, will be regarded *prima facie* as an equitable

apportionment, and a complaining policyholder who alleges abuse of discretion or the application of an erroneous principle will be required affirmatively to establish such allegations by proof. The plaintiff must show, to succeed, that the principle on which the apportionment is based is so clearly erroneous as to be beyond the exercise of any reasonable discretion on the part of the company's directors.

Counsel: *John Gerdes* of counsel [**[***4]** *Wilson E. Tipple* and *Everett Lewy* with him on the brief; *Tipple & Plitt*, attorneys], for the plaintiff.

Wm. Marshall Bullitt of counsel [*Louis H. Cooke* with him on the brief; *Root, Clark, Buckner & Ballantine*, attorneys], for the defendant.

Judges: Dore, J. Martin, P. J., Townley, Glennon and Untermyer, JJ., concur.

Opinion by: DORE

Opinion

[*121] **[**118]** Plaintiff, as holder of one of defendant's insurance policies containing both life and disability insurance, sues under section 195 of the Civil Practice Act on behalf of herself and all other holders of similar policies issued by defendant between 1917 and 1934. The question presented is whether, during the years 1931 to 1935, the defendant failed to apportion equitably its divisible surplus among its policies or made an unlawful discrimination when it paid smaller dividends on its policies providing life and disability insurance than on policies, otherwise similar, providing only life insurance.

[119]** While the amount in dispute between the parties is trivial, the vast majority of New York Life policies contain disability benefits, approximately 1,600,000, as against 1,000,000 providing life insurance only; hence, if **[***5]** a legal wrong was done to plaintiff a similar wrong was done to the 1,600,000 holders of similar policies, and this alleged wrongful discrimination against her and all other holders of similar disability policies involves, for the years in question alone, approximately $ 15,000,000 in dividends.

The agreed statement of facts contains, in two volumes, a vast mass of detailed information regarding the types of policies involved; the basis, nature and principles of mutual life insurance; the history and experience of the company; the basis, elements and factors in the computation of premiums, the creation and ascertainment of divisible surplus and the apportionment of dividends, with specific illustrations of the application of such factors over a wide range of experience; the company's detailed policy records, long tables of figures, statistics and actuarial computations, etc. Such broad and complicated factual basis cannot, within reasonable compass, be discussed in any detail in a judicial opinion. Accordingly, the court will give only such summary of the salient facts as is necessary intelligently to present and discuss the issues, before pronouncing the conclusion of the court **[***6]** thereon.

Plaintiff originally had a $ 2,000 life plus disability policy issued by defendant on June 13, 1927. Subsequently, she surrendered this policy for two policies of $ 1,000 each, on one of which premiums are payable annually, and on the other semi-annually. For convenience **[*122]** in making comparisons and contrasts with other policies, plaintiff's $ 1,000 twenty-payment policy providing both life insurance and disability insurance, for a total annual premium of $ 30.30, will be called herein the "disability policy;" and a policy issued at the same time and the same age and under generally the same conditions, but providing *only* life insurance and without provisions for disability, will be called the "non-disability policy."

Plaintiff's disability policy contains: (1) Life insurance, *i. e.*, the company's promise to pay $ 1,000 on the death of the insured (and the terms and conditions relating to such life insurance are identical with those contained in all other similar life insurance agreements made at the same time by defendant, whether in policies providing only life insurance or in policies providing both life and disability insurance); and, in addition, **[***7]** (2) disability benefits under the terms of which, on receipt of proof that the insured is totally and permanently disabled before sixty, the company agrees to pay **[**120]** the insured ten dollars per month each month (*i. e.*, one per cent of the face of the policy each month) and also agrees to waive payment of premiums falling due during the period of disability. The annual premium

is stated to be $ 30.30. This total premium includes the life insurance and the disability benefits. The policy expressly provides:

"The total premium stated on the first page hereof includes an annual premium of $ 2.96 for Disability Benefits.

"Any premium due on or after the anniversary of the policy on which the age of the Insured at nearest birthday is sixty, will be reduced by the amount of premium charged for Disability Benefits. Upon written request signed by the Insured and upon return of this policy for proper indorsement, the Company will terminate this provision and thereafter the premium shall be reduced by the amount charged for Disability Benefits."

Under these terms, on termination of the disability benefits, plaintiff's premium would accordingly be reduced to $ 27.34, the exact amount **[***8]** of the premium on a similar non-disability policy.

The policy's provision as to dividends reads as follows:

"Participation in Surplus -- Dividends

"The proportion of divisible surplus accruing upon this Policy shall be ascertained annually. Beginning at the end of the second insurance year, and on each anniversary thereafter, such surplus as shall have been apportioned by the Company to this Policy shall at the option of the Insured be either" paid in cash; applied toward payment of premiums; applied to purchase of participating paid-up addition to the sum insured; or left to accumulate as a dividend deposit.

[*123] No default has occurred in plaintiff's performance of the terms and conditions of her policies, and such policies are in full force and effect.

The defendant New York Life Insurance Company (hereinafter referred to as "the Company") is and has been since its inception in 1845 a mutual life insurance company with no capital stock, engaged in the insurance business in what is called the co-operative or mutual plan. Under such mutual plan, all the members pay regular fixed sums or premiums into the company fund, the sums being based on age and character of **[***9]** insurance desired; the company's officers manage the money, investing and reinvesting, paying out death and disability claims, matured endowments, surrender values, loans, taxes, expenses, etc., and set aside as a reserve fund the amount required by law, calculated mathematically, to be held **[**121]** for future protection of the members, and after setting aside funds sufficient to cover other liabilities (such as unpaid death and disability claims and other amounts embraced in a contingency reserve), return what is left over to the members annually, as their equitable share of divisible surplus. The share so distributed is called a dividend.

Since 1845 the company has issued policies covering over 6,000,000 policyholders whose lives have been insured in sums aggregating over $ 18,000,000,000, and it has paid to the policyholders nearly $ 3,000,000,000 in death and disability claims, matured endowments and surrender values, and over $ 1,000,000,000 in cash dividends. During the past eight years (1927 to 1934, inclusive), the company paid to its policyholders (1) over $ 1,100,000,000 in death, disability and other policy claims, and (2) about $ 480,000,000 in dividends; and it apportioned **[***10]** to pay to its policyholders in 1935 about $ 46,000,000 in dividends. In 1935 the company had over 2,000,000 policyholders, insured to the extent of about $ 6,661,000,000, who receive dividends annually.

Under the mutual plan, in order to provide for unforeseen contingencies, the premium to be paid by a member is fixed by the company at an amount somewhat in excess of that which the company anticipates will be necessary to cover the cost of the insurance. The member pays that amount in advance, but later receives such excess payment, if any, as a dividend, and thus gets the insurance at cost.

The premium to be paid for each age and type of policy is first determined by a purely mathematical calculation based strictly on specified mortality or disability tables and on a specific assumed rate of interest (*e. g.*, three per cent) expected to be earned on the company's funds. As the purely mathematical calculation of the **[*124]** net premium does not cover expenses, taxes, losses in investments, univested funds, and possible excessive mortality or disability, the company adds to the net premium an amount called the "Loading" (*i. e.*, an additional amount calculated to be **[***11]** sufficient to cover such expenses, taxes, losses, idle money, etc.), which "Loading," plus the mathematical net premium, constitute the actual premium paid by the policyholder.

To offset the unavoidable increase in death and disability rates which arise from the yearly advance in age of members insured, the company must accumulate out of premiums a fund required by law to be held by

every life insurance company, and known as "Reserve." **[**122]** The amount of reserve on any policy for any given age, plan, and time in force is a matter of mathematical calculation and is exactly the same when calculated by any actuary, depending on the particular mortality table, disability table and interest rate assumed.

As a practical matter, no company can tell in advance exactly what its interest earnings, death and disability claims or expenses will be. Yet if its interest earnings unexpectedly decrease (as has been the case to an enormous extent in every company since 1931), or if substantial financial losses befall (as has also been the case in the years 1931-1934), or if epidemics sweep the country (as influenza did in 1918) causing abnormal death losses, or if disability claims greatly increase **[***12]** (as has been notably the case since the depression), the company cannot increase the annual premiums to meet such losses. Therefore, in order to attain the highest degree of security, so that, in the distant years to come, members or their beneficiaries will surely receive the insurance at maturity, death, or disability, the company, in fixing the premium, has assumed four things:

(1) That the death rate will be precisely that of the specified mortality table (whereas, by careful medical selection, the death rate is usually less than that given in the table);

(2) That, in the case of disability policies, the payment of disability benefits will be precisely in accordance with the specified disability table (whereas, it was believed that the actual payments for disability benefits would probably be less than that indicated by such table);

(3) That the company will earn the specified rate of interest on its funds (whereas, in fact it will probably earn more than such assumed rate); and

(4) That the company's expenses, taxes and extraordinary losses will be the exact amount of the loading (whereas, in fact the expenses, etc., are ordinarily less than the loading).

[*125] **[***13]** Consequently, there are four, and only four sources of surplus or profit to a mutual life insurance company:

1. Mortality savings. If the mortality is deferred beyond the period calculated on the basis of the mortality table used, instead of the company paying death losses at the time it provided for doing so, it keeps the money at interest longer and receives more premiums than expected. The resulting profit from such favorable mortality experience is called mortality savings.

[123]** 2. Disability benefits. By careful selection of the risks insured, fewer persons may receive disability benefits, and for a shorter time, than was assumed in the disability table.

3. Interest. The company generally derives from interest a higher net rate than it assumed in mathematically calculating the premium; and to the extent that it earns more than the rate assumed, such excess interest is a profit.

4. Expenses. By economical management, the company may keep its aggregate expenses within the aggregate of all its loading. If so, then to that extent, the difference between the aggregate expenses and the aggregate loading is a profit.

There is a subsidiary element which was formerly a source **[***14]** of profit, to wit, lapsed and surrendered policies; but with annual dividend policies the element of lapses and surrenders is too small a factor to be calculated each year, and is calculated periodically.

Accordingly, from these four sources, mortality savings, disability benefits, interest, and expenses, the company accumulates funds in excess of legal reserves; and the excess of the funds on hand over such reserves (and other liabilities) constitutes the company's surplus.

By the application of these so-called dividend factors, the company's various annual dividend rates are ascertained.

An "economic adjustment" factor has been also added as a fifth dividend factor in connection with recent numerous and unanticipated losses arising from defaults in interest on bond and mortgage investments, depreciation of assets, default in interest payments, and reduced interest rates.

As the policyholders in a mutual life insurance company have paid in more than was necessary, they are entitled to a return of such overpayments. The dividends of a mutual life insurance company are, accordingly, strictly speaking, not profits as in the case of an ordinary corporation, but really constitute **[***15]** a return to the policyholder of the amount he has been overcharged for his insurance. In life insurance companies operating on the mutual plan the whole of the divisible surplus is distributed among the members annually as equally as

may be in the proportions in which they have contributed to it.

[*126] Life insurance is based upon the principle of averages, and hence no company can consider an individual policy by itself and determine whether there has been an overcharge in its premiums, but every company must first determine the aggregate amount of all **[**124]** overcharges in premiums before it can decide how to arrive at what each individual policy shall receive back as dividend. The aggregate of all overcharges constitutes what is called the divisible surplus.

When the divisible surplus for any year has been ascertained, the company must determine how it shall be apportioned among all the policyholders, and for this purpose every mutual life insurance company divides its policies into a large number of homogeneous classes. In a "class" consisting of similar policies issued at the same time, under the same conditions, at the same age, with the same dividend distribution period, **[***16]** upon the same plan of insurance, and calling for the same annual premium per $ 1,000 face amount of the policy, there is not, even in the largest companies, a sufficient number of persons to give a true average rate of mortality. Accordingly, every life insurance company doing business upon the mutual plan applies to such group or "class," not the individual experience of such "class" by itself, but some ratio representing the average result of the company's experience (1) as a whole; or (2) in some portion of its business sufficiently large to eliminate the effect of any accidental variations. The company thereby obtains for each of such "classes" substantially the same result that would have been obtained had the "class" contained as many persons in it as the company contains as a whole.

By a series of actuarial mathematical calculations covering its ninety years' experience with over six million policyholders, the company determines from time to time its average experience with respect to mortality, disability, interest, expenses, lapses and surrenders, and this average experience is then used to determine the annual dividend rate, calculated in accordance with what is called **[***17]** the "contribution" method of ascertaining dividends; *i. e.*, the distribution of divisible surplus to the different sources from which it is derived, so that as near as may be it is returned to the policyholders in the proportion in which they have contributed thereto. The "contribution" method was published more than seventy years ago by Sheppard Homans, actuary of the Mutual Life Insurance Company (The Assurance Magazine and Journal of the Institute of Actuaries, October, 1863, Vol. 11, p. 121 *et seq.*), and has since been followed with its principles and basic characteristics unchanged. Homans stated the fundamental principle as follows: "Each HN1[↑] participant should be benefited in proportion to the excess **[*127]** of his payments over and above the actual cost of insurance. * * * The first point * * * will be to determine what the actual cost of insurance, and consequently the overpayment, has been in any and **[**125]** every case." He analyzed the mutual life insurance business; gave the intricate mathematical formulae of his proposed method for determining the contribution or overpayment of any policy, and then summed up the results as follows: "The HN2[↑] difference between the sum of **[***18]** his credits and the sum of his debits determines the overpayment or contribution from the policy proper."

Daniel H. Wells, a distinguished American actuary, stated, in 1892, the basis of the contribution method as follows: "It is of the very essence of the contribution method that no member or class of members shall be made to pay for the insurance furnished to any other member or class of members; that the cost of insurance shall not be increased to any individual or class because of the insurance of any other individual or class." (Papers and Transactions Actuarial Society of America, Vol. II, p. 361.)

HN3[↑] The contribution method has been used since by practically every American and Canadian company, and is the recognized standard for dividend distribution throughout the world.

The company's application of the contribution method is based upon keeping a debit and credit account with each "class" of homogeneous policies as an independent unit. It gives to the "class" -- not the actual experience of the class itself -- but an average experience which would have obtained if the class had been sufficiently numerous to produce average results.

HN4[↑] In the creation of any mutual life insurance **[***19]** company's surplus the factors employed by every mutual life insurance company in the ascertainment and apportionment of its divisible surplus are "positive" or "negative" or "zero," as follows: If the mortality is less than the mortality table employed, or the interest is greater than the rate assumed, or the expenses are less than assumed in the calculation of the premium, or the disability claims are less than in the disability table employed, then the respective elements

of mortality interest, expense or disability are positive, otherwise, such respective elements are negative. In any case where the mortality, interest, expense or disability experience equals the tabular rate the element is zero, indicating by such descriptive mathematical term, no contribution, either positive or negative, to the divisible surplus from the particular source to which the zero factor refers, that is, no divisible profit or loss is indicated from such element in the determination of the dividend.

[*128] As the controversy between plaintiff and defendant arises from defendant's use of the disability factor in calculating plaintiff's dividend, the use of this factor must be referred to in some **[***20]** detail. **[**126]** In 1910 the company began to issue, for the first time, life insurance policies with both death and disability benefits. From time to time, between 1910 and the present time, the company issued life insurance policies (1) with death benefits only, and (2) with death benefits and varying forms of disability benefits, providing in the earlier years of issue only for a waiver of the premium during the continuance of disability; and in later years also providing for payment to the insured of a certain annual or monthly income during disability.

From 1912 to 1917, inclusive, in the calculation of dividends, the disability factor was positive and the company paid larger dividends on its disability policies than it paid on its non-disability policies; in 1918 and 1919 the disability factor was (1) positive for certain forms of disability policies and (2) zero for other forms, depending on the year of issue and the type of benefit conferred; from 1920 to 1930, inclusive, the disability factor was zero and the company paid the same dividends on both kinds of policies; from 1931 to 1934, inclusive, the disability factor was (1) zero for policies with certain forms of disability benefits, **[***21]** and (2) negative for other forms, depending upon the year of issue and the type of benefit conferred.

In 1912-1917 -- during which period there were apparently gains to the company's surplus from the disability policies -- the company applied positive disability factors to all its various homogeneous classes of disability policies. Other policies taken out in the same years but without disability benefit provisions, had contributed nothing to surplus from disability provisions, and were not given any participation in the surplus created from such disability provisions.

During the years 1920-1930, when the company used a zero disability factor with respect to all its homogeneous "classes" of disability policies, the fluctuations were such that the company did not definitely settle whether certain adverse experiences were due to accidental variations in disability claims, or whether they represented a permanent trend of a greater number of persons being disabled. During the latter portion of such 1920-1930 period, not only had there ceased to be an apparent contribution to surplus from disability provisions, but the officers and directors of the company gradually realized that **[***22]** there was a serious possibility of a very large and utterly unanticipated drain upon the company's contingency reserve, as a result of such disability provisions in its life insurance policies.

[*129] **[**127]** Beginning in 1931, the directors and officers of the company became convinced that, although the premiums received by the company over a series of years for the disability benefits in its life insurance policies exceeded the actual cash disbursements on account of disabled policyholders, such provisions were not contributing to the surplus; and in the exercise of their reasonable and best judgment they decided that, while the experience of the prior eleven years (1920-1930) was not conclusive, they should no longer continue to use a zero factor; and, therefore, they decided that the company should use, and thereafter it did use, a negative disability factor in the ascertainment and apportionment of divisible surplus among those disability policies. No notice, however, of the change made in 1931 in the company's method of distributing divisible surplus was given to the policyholders.

In 1932 the company ceased to issue any policies with the former one per cent monthly income **[***23]** disability benefits, and greatly reduced the rate of income payments. Subsequently, it ceased to issue, and does not now issue, any policies with disability benefits providing for the payment of any kind of income.

The Insurance Department of the State of New York has approved the company's practices in the distribution of dividends to its policyholders as equitable and as in conformity with the laws of the State of New York and the rulings of such department. In 1930, before the company adopted a negative disability factor in the apportionment of its divisible surplus to disability policies, it took the matter up with the Insurance Department of the State of New York and that department, after thorough consideration, approved the application of a proposed negative disability factor and the rate thereof by which the disability policies would

have applied to them such negative factor of disability experience, while similar policies without disability benefits would not have any disability factor applied to them.

If, from January 1, 1931, to January 1, ***1936***, the company's surplus had been apportioned so that non-disability policies received the same dividends per $ 1,000 face amount **[***24]** of the policy as similar policies containing disability benefits, the disability policies would have received in dividends about $ 15,000,000 more and the non-disability policies would have received about $ 15,000,000 less than they actually received.

On these and other facts detailed and amplified and expressly stipulated to by the parties in the agreed statement of facts, the plaintiff claims (1) that the disability policies are divided into *two* **[**128]** separate and distinct contracts -- (a) one for death benefits, and **[*130]** (b) the other for total and permanent disability benefits -- for which separate and independent premiums were paid; and (2) that the company has discriminated in favor of non-disability policies and against the disability policies, by paying on the former a larger dividend (per $ 1,000 face amount of insurance) than it paid on the latter, although the policies were exactly similar, except for the disability benefits, and that such difference was solely on account of the losses which the company sustained because of such disability benefits.

On the same facts the company claims (1) that all its disability policies are life insurance policies, *i. e., not* **[***25]** *two contracts but one*, with both (a) death benefits, and (b) total and permanent disability benefits; that such disability policies belong, for the ascertainment and apportionment of dividends, to a "class" different from the "class" to which non-disability policies belong; and (2) that the company, in the light of its prior experience, had the right, since 1931, to pay on non-disability policies larger dividends than it paid on otherwise similar policies containing disability benefits.

The question for the court to decide is whether the company had such right, or whether it violated any contractual or statutory duty in so doing and in applying a negative disability factor in connection with the apportionment of dividends to its disability policies, and whether such negative factor can be so employed in any proper application of the contribution method.

The statutes relied on by the respective parties are the following sections of the Insurance Law:

HN5[↑] " § 83. Distribution of surplus to policyholders. * * * every domestic life insurance corporation * * * shall provide in every policy * * * that the proportion of the surplus accruing upon said policy shall be ascertained and distributed **[***26]** annually and not otherwise. Upon the thirty-first day of December of each year * * * every such corporation shall well and truly ascertain the surplus earned by such corporation during said year. After setting aside from such surplus * * * a contingency reserve not in excess of the amount prescribed in this article, every such corporation shall apportion the remaining surplus equitably to all other policies entitled to share therein."

HN6[↑] "§ 89. Discriminations prohibited. No life insurance corporation * * * shall make or permit any discrimination between individuals of the same class or of equal expectation of life, in the amount of payment or return of premiums or rates charged for **[**129]** policies of insurance * * * or in the dividends or other benefits payable thereon, or in any of the terms and conditions of the policy."

[*131] ***HN7***[↑] "*§ 108*. Discriminations under accident or health policies prohibited. No insurance corporation * * * shall make or permit any discrimination between individuals of the same class in the amount of premiums, policy fees, or rates charged for any policy of accident or health insurance, or in the benefits payable thereunder, or in any of the terms or conditions **[***27]** of such insurance contract, or in any other manner whatsoever."

Counsel have been unable to find any decision in this State passing upon the precise issues submitted, or to cite any decision of a court of record whose opinions are published in any other State passing upon such precise issues. Certain rules, however, concerning policyholders' rights with regard to divisible surplus and the apportionment of dividends have been judicially determined.

In *Uhlman v. New York Life Ins. Co. (109 N. Y. 421* [1888]) it was held that ***HN8***[↑] the relation between a policyholder and a mutual insurance company is not that of trustee and *cestui que trust*, but is the relationship of debtor and creditor; that in the absence of wrongdoing or mistake the amount of divisible surplus to be apportioned as determined by the company is final and conclusive on all policyholders; that the apportionment of surplus earnings of an insurance company must be equitably made; that, *prima facie*, the apportionment made by the company should be regarded as equitable,

since under the terms of the policy the duty of making it is cast upon the company, and it ought to be presumed that the company has performed **[***28]** its duty instead of presuming that it has failed to do so; but that on proper allegations of fact showing the apportionment made by the company is not equitable or has been based upon erroneous principles, the policyholder and all others similarly situated have a right to make proof of such allegations and, if proved, the court will declare a proper principle upon which the apportionment is to be made so as to become an equitable apportionment.

In *Greeff v. Equitable Life Assurance Society (160 N. Y. 19* [1899]) it was held that ***HN9***[↑] a policyholder has a right to share in an equitable distribution of the company's accumulated surplus, but, until a distribution is made by the officers or managers of the company, a policyholder has no such title to any part of the surplus as would **[**130]** enable him to maintain an action at law for its recovery. The court said: "We think the principles which control the disposition of the surplus earnings of a stock corporation are applicable here. In those cases it has often been held that until dividends have been declared a stockholder has no right of action at law to recover any part of the fund applicable to that purpose, and that when directors **[***29]** have exercised their discretion in regard thereto **[*132]** the courts will not interfere unless there is bad faith, or wilful neglect, or abuse of such discretion." (Citing authorities.)

Equitable Life Assurance Society v. Brown (213 U.S. 25 [1909]) reiterated the rulings of the *Uhlman* and *Greeff* cases that the insurance company is not a trustee of its policyholders, and that discretion rests with the officers of the company as to what amount of surplus shall be retained and distributed and when the distribution shall be made. The court said: "The complainant's contention, as above stated, that there is such a trust in the fund mentioned has never been regarded as the law in the State of New York [*Cohen v. New York Mutual Life Insurance Company, 50 N. Y. 610*; *People v. Security Life, etc., Co., 78 N. Y. 114*; *Bewley v. Equitable Life, etc., 61 How. Pr. 344*; *Uhlman v. New York Life Ins. Co., 109 N. Y. 421*; and, to the same effect, *Greeff v. Equitable Life Assurance Society, 160 N. Y. 19]*, nor anywhere else so far as any case has been cited on the subject." And in overruling another contention of the complainant in the **[***30]** case the United States Supreme Court summarized the *Uhlman* and *Greeff* cases as follows: "We think that neither the *Uhlman* nor the *Greeff* case decides any such principle as is asserted by the complainant. After holding, as already stated, that there was no trust existing between a policyholder and even a purely mutual company, reference was made in the former case to the contention of the defendant that the apportionment made by it, or under its direction, was absolutely and, at all events, conclusive upon the policyholders, it was said in the opinion that that was not an accurate statement, and that the plaintiff and others similarly situated had the right, upon proper allegations, of showing that the apportionment made by the defendant was not equitable, or had been based upon erroneous principles, and he had the right to a trial and to make proof of such allegations, and if true the court could declare the proper principles upon which **[**131]** the apportionment was to be made so as to become an equitable apportionment. The *Greeff* case simply adopted that statement in the course of the opinion, which is chiefly devoted to the discussion of other matters.

"There is nothing **[***31]** in either case to show that any other wrongdoing or fraud was in contemplation of the court than that above mentioned, viz., that the proposed or actual distribution of the money as between the policyholders themselves was not equitable, or was based on erroneous principles."

In *Miller v. New York Life Ins. Co. (179 Ky. 246*; *200 S. W. 482* [1918]) the plaintiff contended that because the defendant, a mutual life insurance company, had not classified its policies with others issued in the same year, at the same age, and upon the same plan, **[*133]** and had not treated such "classes" or groups as independent units, the defendant had made no classification whatever. The court held that ***HN10***[↑] an equitable and fair classification includes in one class all policies issued upon the same plan so that participation in profits may be uniform to all the members of that single branch of the mutual enterprise, and that a further classification among such holders of uniform policies depending only upon the accidents of age and date of issue ought not to be made and must not be made when such subdivision is into such small units as will necessarily result in inequitable inequalities among **[***32]** members holding the same kind of policies.

On the facts stipulated and on the statutory and contractual obligations before us and under the rules of law applicable, we now determine the issues presented for adjudication.

Running through the whole of plaintiff's argument and as

the basis on which that argument ultimately reposes is the contention that the policy in question is a severable, divisible or separate contract; that there are in fact in such policy two complete agreements of insurance, one a complete agreement of life insurance for a specified premium ($ 27.34), and the other a complete agreement of disability insurance for another specified premium ($ 2.96); that plaintiff and all other holders of similar policies have the same rights under each of the several "agreements" as they would have if each such "agreement" was contained in a separate policy; that a reduction in dividends paid on the "agreement" of life insurance, merely because the policy also contains an "agreement" of disability insurance, is to the extent of such reduction an illegal exaction of an additional premium for the disability insurance; and that **[**132]** the portion of divisible surplus earned on "agreements" **[***33]** of life insurance must be divided as dividends under such "agreements," while the portion of divisible surplus earned on "agreements" of disability insurance must be divided as dividends under such "agreements." Plaintiff compares her policy with a similar non-disability policy, and maintains that the life insurance agreement is identical in her policy with similar life insurance agreements issued at the same time in policies without agreements of disability insurance, and that the annual premium in both instances is $ 27.34 for "the agreement" of life insurance.

After consideration of the record and briefs, we conclude that this basic contention of the plaintiff, that the policy is severable and divisible in the sense that it is in legal form two separate agreements, cannot be sustained. We reach the conclusion that the policy is one agreement, a single policy, with both death and disability benefits so interwoven as to constitute a single integral **[*134]** insurance contract. While the amount charged for disability is specifically set forth (and must be so specified pursuant to the regulations of the New York State Insurance Department), the policy itself provides for one **[***34]** premium, $ 30.30, and the statement on page 2 that the "total premium stated on the first page hereof includes an annual premium of $ 2.96 for disability benefits," is to meet the provision that plaintiff, at any time while the policy is in effect, may drop the disability benefits, in which event the premium is automatically reduced to $ 27.34. In that sense the disability feature of the policy is, indeed severable, but it is severable for the purpose of being terminated, and until the privilege of dropping the disability benefit is exercised (or has been rescinded for any proper reason), the policy with the various promises therein contained is a single policy and may for dividend purposes be dealt with as a whole.

In its physical aspect, the policy is one instrument. A consideration of the provisions for disability benefits makes it clear that if all of these provisions were taken together apart from the rest of the policy, it would be impossible to spell out a separate contract for disability insurance; there would be no identifiable company, no identifiable sum to be paid (for the disability benefits cannot be obtained without the death benefit), and no identifiable person **[***35]** to receive the payment. The provisions for disability benefits are so intimately dependent upon and unintelligible without the death benefit provisions as to be by themselves impossible of constituting a separate contract. There was one application for the policy, not **[**133]** two, and provision is made for one premium. Throughout the policy the single number is invariably used, never the plural; it is referred to as "this policy," "the policy," "this contract," "the contract," "the entire contract;" the policy thus describes itself about seventy-four times in the singular. The following provision is also significant: "The Contract. -- The policy and the application therefor, copy of which is attached hereto, constitute the entire contract. * * * No agent is authorized to make or modify this contract."

A single set of promises arising in connection with life insurance and with disability insurance are closely interwoven and dependent one upon the other. The disability benefits are issued only when the terms thereof are printed in a life insurance policy, they cannot be obtained separately, and cannot be continued in force independently of the death benefit in the policy. When the annual **[***36]** premium became due, if plaintiff tendered the $ 2.96 specified as the amount for the disability benefits, she could not compel **[*135]** the defendant to continue the disability benefits unless the balance of the premium was paid.

From all the above it follows that the policy is a single contract containing various provisions and various promises, severable and divisible in one sense as a remedial measure for enforcement, but the policy cannot be taken, as plaintiff contends, as the equivalent of two separate policies, one the exact equivalent of a policy of life insurance with merely a death benefit, and the second an independent contract or policy covering disability benefits.

Williston points out that the words "divisible" and "severable," as applied to contracts, are often misleading: "Some confusion has arisen from the inexact use of the terms 'divisible contract' and

'severable contract' on the one hand, and 'entire contract' on the other. * * * Sometimes the words entire or indivisible are used as meaning that there is one contract as distinguished from several contracts, and at other times the words are used as meaning more than this, namely, that there is a contract **[***37]** which is not divisible. A divisible contract, using that term properly, is always one contract and not several contracts. It differs in one respect only from other contracts -- namely, that on performance of one side of each of its successive divisions, the other party becomes indebted for the agreed price of the division." (2 Williston Cont. [1920 ed.] § 861, pp. 1646, 1648, 1649.) He adds (§ 863, pp. 1652, 1653): "The HN11[] essential test to determine whether a number of promises constitute one contract or more than one is simple. It can be nothing else than the answer to an inquiry whether the parties assented **[**134]** to all the promises as a single whole, so that there would have been no bargain whatever, if any promise or set of promises were struck out. * * * The question essentially is one of fact: Did the parties give a single assent to the whole transaction or did they assent separately to several things?"

Applying that test to the policy under review, were the life insurance provision stricken out at the outset there would have been no contract whatever, as disability benefits are issued only when the terms thereof are printed in a life insurance policy; they cannot be separately **[***38]** obtained.

Hence we conclude that it cannot be said that the directors of the defendant company violated either a contractual or statutory duty when, for dividend purposes, they treated the policy as a whole and considered the contribution to surplus of the whole policy, not the contribution of some portion of the policy, as the basis for determining how much of the divisible surplus should be returned in the form of a dividend upon the policy.

[*136] HN12[] The statutory test is whether the apportionment is equitable or whether it unfairly discriminates between individuals of the same class. (Insurance Law, §§ 83, 89, 108, *supra*.) No fraud, bad faith, willful neglect or mistake of fact is here claimed. The alleged wrong is an abuse of discretion or the application of an erroneous principle, *i. e.*, the use since 1931 of the negative disability factor. As indicated by the authorities cited above, the apportionment, as made by the company, must be regarded *prima facie* as an equitable apportionment, and the plaintiff must allege and prove facts showing that the apportionment is not equitable or has been based upon erroneous principles, and in the absence of any allegation **[***39]** of wrongdoing or mistake, the directors' determination of the question must be treated as proper. (*Uhlman* v. *New York Life Ins. Co., Greeff* v. Equitable Life Assurance Society, Equitable Life Assurance Society v. Brown, *supra*.)

HN13[] To succeed, plaintiff must show that the principle on which the apportionment is based is so clearly erroneous as to be beyond the exercise of any reasonable discretion on the part of the company's directors. The author of the contribution method has stated that the difference between the sum of the policyholder's "credits" and the sum of his "debits" determine the overpayment or contribution from the policy proper. (Homans, *supra*, p. 124.) The negative factor was, of course, not used in connection with the policy as a whole, for otherwise the policy would not be entitled to **[**135]** any distribution of surplus. Its contested use is only in connection with the disability element. The "debits" arising from that element are set off against the "credits" arising from other elements before determining the net overpayment or contribution from the *policy as a whole*. This is the company's procedure with regard to the homogeneous "classes" in **[***40]** question, namely, the classes of disability policies. A class of policies, viz., a disability class, that entails such debits on its disability benefits cannot be said to contribute *as a class* to surplus in the same degree as another class of policies (non-disability) that does not entail such debits.

It is true that the plaintiff is the holder of a disability policy on which no claims have been made. But the plaintiff and all persons holding the 1,600,000 disability policies issued and outstanding possess and have received disability protection. To those who have become disabled the disability benefits have accrued. To those who, like plaintiff, have fortunately never become disabled, the disability benefit is a matter of protection, as is all other insurance. That being so, it cannot be said that the policyholders who possess that valuable protection as an integral part of their insurance should receive precisely the same dividend treatment **[*137]** as holders of non-disability policies who have never received any such disability protection.

The record shows that from 1910 to 1919 disability benefits were a source of surplus in the defendant's business and received **[***41]** all the surplus from that source. The non-disability policies were not permitted to share in the surplus derived from that source because

they had in no way contributed to its creation. From 1912 to 1919 the non-disability policies received a smaller dividend than the disability policies. From 1920 to 1930 the defendant, acting under the belief that the disability experience was approximately equal to that which had been assumed in the calculation of the premiums, and that any adverse experience was a mere accidental temporary variation due to chance, to be taken care of by the company's contingency fund, employed what is referred to as a zero factor as to disability policies. From 1931 to 1935, as the result of its experience, the defendant, instead of using a zero factor, employed a negative factor on its disability policies, causing the dividend on the disability classification to be less than on similar policies containing no disability provision. There is thereby no discrimination, and particular classes are uniformly treated. All the policyholders of disability benefits have been treated alike in the **[**136]** apportionment of dividends, and all policyholders without disability benefits **[***42]** have been treated alike in such apportionment.

On the facts stipulated and limiting our decision strictly to these facts, including the particular experience of the company in question, we cannot say that the use of the negative disability factor since 1931 is erroneous, inequitable, beyond the exercise of the directors' reasonable discretion, or a breach of statutory or contractual obligation.

Judgment should accordingly be entered in favor of defendant, but without costs.

RLJCS Enters. v. Prof'l Benefit Trust, Inc.

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

June 15, 2006, Decided ; June 15, 2006, Filed

No. 03 C 6080

Reporter
438 F. Supp. 2d 903 *; 2006 U.S. Dist. LEXIS 44131 **; 38 Employee Benefits Cas. (BNA) 1368

RLJCS ENTERPRISES, INC., et al., Plaintiffs, v. PROFESSIONAL BENEFIT TRUST, INC., et al., Defendants.

Subsequent History: Affirmed by *Rljcs Enters. v. Prof'l Benefit Trust Multiple Emplr. Welfare Benefit Plan & Trust Multiple Emplr. Welfare Ben. Plan & Trust, 2007 U.S. App. LEXIS 10125 (7th Cir. Ill., May 2, 2007)*

Prior History: *RLJCS Enters. v. Prof'l Benefit Trust, Inc., 2005 U.S. Dist. LEXIS 27250 (N.D. Ill., Nov. 8, 2005)*

Counsel: **[**1]** For RLJCS Enterprises, Inc., R Leldon Sweet, Mitchell A. Toups PC, Mitchell A Toups, Gail C. Jenkins PC, Gail C Jenkins, Gilbert I. Low Ltd, Gilbert I Low, R. Lyn Stevens, P.C., R Lyn Stevens, Hubert Oxford III PC, Hubert Oxford, III, David A Bosse MD PA, M.D. David A Bosse, SG/SW Bourque Management, Inc., Stephen G Bourque, Stacy Bourque, Script Care Management, Inc., James F Brown, Stephen N Cherewaty, M.D. Stephen N Cherewaty, Christopher's Copy Service, Inc., Monty Christopher, Larry P Ducharme Inc, Larry P Ducharme, Joseph M. Finley & Associates, M.D., P.A., MD Joseph M Finley, Mehmet Gurgun MD PA, MD Mehmet Gurgun, Cleveland Management, Inc., Claude Cleveland, E. Linn Heartfield M.D., P.A., MD E Linn Heartfield, JLH Enterprises, Inc, MD J Leonard Hilliard, Michael G. Keller D.O. P.A., DO Michael G Keller, B A King Jr MD PA, MD B A King, Jr, Brent L. Mainwaring M.D. P.A., MD Brent L Mainwaring, Wayne S. Margolis M.D. P.A., MD Wayne S Margolis, PWM Enterprises, Inc., Phil W Meaux, Vida K. Riston, R.N. C.N.M. P.C., Vida K Riston, Daniel R. Roubein, M.D. P.A., MD Daniel R Roubein, Rodney D. Anderson, M.D. P.A., MD Rodney D Anderson, Miguel Castellanos MD PA, MD Miguel Castellanos, **[**2]** Mark A Wilson MD PA, MD Mark A Wilson, Plaintiff: Paul Ethan Slater, Sperling & Slater, Chicago, IL; Richard Lyle Coffman, Richard L. Coffman, P.C., Beaumont, TX.

For Professional Benefit Trust, Inc, Defendant: Douglas Spears Robson, Handler, Thayer, & Duggan LLC, Chicago, IL;

For Professional Benefit Trust Multiple Employer Welfare Benefit Trust Plan and Trust, Defendant: Columbus R. Gangemi, Jr., Romy Elisabeth Carr, Timothy John Rooney, Winston & Strawn, Chicago, IL.

For 1st Fidelity Trust Co., Ltd, Defendant Professional Benefit Trust, Ltd., Defendant: Richard D Hart, Handler, Thayer, & Duggan LLC, Chicago, IL; Columbus R. Gangemi, Jr., Cheryl Tama Oblander, Romy Elisabeth Carr, Timothy John Rooney, Winston & Strawn, Chicago, IL.

For Sunderlage Resource Group, Inc., Professional Benefit Trust, Administration, LLC, Tracy L Sunderlage, Carey L Sunderlage, Defendant: Richard D Hart, Douglas Spears Robson, Handler, Thayer, & Duggan LLC, Chicago, IL.

For Canada Life Financial Corporation, Canada Life Assurance Corporation, Defendant: David Joseph Novotny, Chittenden, Michael Brian Galibois, Murday & Novotny, LLC, Chicago, IL; Stephen James Jorden, Jorden Burt, **[**3]** LLP., Washington, DC.

For Sun Life Financial Services of Canada Inc, Sun Life Assurance Company of Canada, Defendant: Mark E Schmidtke, Robert L. Clark, Schmidtke Hoeppner Consultants LLP, Valparaiso, IN; F Joseph Jaskowiak, Hoeppner Wagner & Evans, Valparaiso, IN.

For Professional Benefit Trust, Ltd., Counter Claimant: Richard D Hart, Handler, Thayer, & Duggan LLC, Chicago, IL; Columbus R. Gangemi, Jr., Cheryl Tama Oblander, Timothy John Rooney, Winston & Strawn, Chicago, IL.

For Professional Benefit Trust Multiple Employer Welfare Benefit Trust Plan and Trust, Counter Claimant: Columbus R. Gangemi, Jr., Cheryl Tama Oblander, Timothy John Rooney, Winston & Strawn, Chicago, IL.

For RLJCS Enterprises, Inc., R Leldon Sweet, Mitchell A. Toups PC, Mitchell A Toups, Gail C. Jenkins PC, Gail C Jenkins, Gilbert I. Low Ltd, Gilbert I Low, R. Lyn Stevens, P.C., R Lyn Stevens, Hubert Oxford III PC, Hubert Oxford, III, David A Bosse MD PA, M.D. David A Bosse, SG/SW Bourque Management, Inc., Stephen G

Bourque, Stacy Bourque, Script Care Management, Inc., James F Brown, Stephen N Cherewaty, M.D. Stephen N Cherewaty, Christopher's Copy Service, Inc., Monty Christopher, Larry **[**4]** P Ducharme Inc, Larry P Ducharme, Joseph M. Finley & Associates, M.D., P.A., MD Joseph M Finley, Mehmet Gurgun MD PA, MD Mehmet Gurgun, Cleveland Management, Inc., Claude Cleveland, E. Linn Heartfield M.D., P.A., MD E Linn Heartfield, JLH Enterprises, Inc, MD J Leonard Hilliard, Michael G. Keller D.O. P.A., DO Michael G Keller, B A King Jr MD PA, MD B A King, Jr, Brent L. Mainwaring M.D. P.A., MD Brent L Mainwaring, Wayne S. Margolis M.D. P.A., MD Wayne S Margolis, PWM Enterprises, Inc., Phil W Meaux, Vida K. Riston, R.N. C.N.M. P.C., Vida K Riston, Daniel R. Roubein, M.D. P.A., MD Daniel R Roubein, Rodney D. Anderson, M.D. P.A., MD Rodney D Anderson, Miguel Castellanos MD PA, MD Miguel Castellanos, Mark A Wilson MD PA, MD Mark A Wilson, Counter Defendant: Paul Ethan Slater, Sperling & Slater, Chicago, IL; Richard Lyle Coffman, Richard L. Coffman, P.C., Beaumont, TX.

Judges: John E. Grady, United States District Judge.

Opinion by: John E. Grady

Opinion

[*904] MEMORANDUM OPINION

Before the court are the parties' cross-motions for summary judgment on the issue of stock ownership and plaintiffs' motion to strike certain of defendants' statements of material fact and supporting affidavits and documents. **[**5]** For the reasons explained below, the motions are treated as motions for partial summary judgment; defendants' motion is granted, and plaintiffs' motion is denied. Plaintiffs' motion to strike is denied.

BACKGROUND

We will repeat here a brief summary of the facts of this case from an earlier opinion:

> Plaintiffs are former employer and employee participants in a multiple-employer benefits trust ("the Trust"). The employers participated in the Trust for the sole purpose of providing death benefits for their participating employees. These death benefits were funded by life insurance policies that were purchased by the Trust with contributions made by the employers. The Trust was designed to be a qualifying trust under *section 419A(f)(6) of the Internal Revenue Code*, which allows employers to realize a tax deduction for contributions made to certain employee benefit plans. See *I.R.C. § 419A(f) (6)*.

At the heart of this dispute are life insurance policies purchased by the Trust from Canada Life and Sun Life on behalf of participating employees. When these policies were issued, Canada Life and Sun Life were both mutual **[**6]** insurance companies, or, "insurer[s] whose policyholders are its owners, as opposed to a stock insurance company owned by outside shareholders." BLACK'S LAW DICTIONARY 1041 (7th ed. 1999). However, Canada Life and Sun Life, in 1999 and 2000 respectively, "demutualized," which is "[t]he process of converting a mutual insurance company (which is owned by its policyholders) to a stock insurance company (which is owned by outside shareholders). . . ." Id. at 445.

As a result of these demutualizations, the Trust received shares of Canada Life and Sun Life stock (together, "the Demutualized Stock"). Then, in or around September 2000, the trustee of the Trust liquidated the Demutualized Stock for approximately $ 5,000,000, which the Trust has retained. Effective December 31, 2002, plaintiffs terminated their participation in the Trust. Upon their withdrawal, the Trust distributed to the participating employees their respective Canada Life and Sun Life insurance policies and their *pro rata* share of other related Trust assets. The distribution, however, did not include any of the sales proceeds from the Demutualized Stock.

This action followed. Plaintiffs have brought a 73-page, **[**7]** sixteen-count complaint alleging violations of civil RICO, *18 U.S.C. §§ 1961, et seq.*, and ERISA, *29 U.S.C. §§ 1001, et seq.*, as well as various common law breach of contract, fiduciary duty and fraud-based claims. The crux of the complaint is that the participating employees had an ownership interest in the Demutualized Stock and that defendants -- the Trust and several related entities and individuals -- unlawfully **[*905]** deprived the employees of that interest when their *pro rata* shares of the sales proceeds were not included in their distributions.

*RLJCS Enters., Inc. v. Professional Benefit Trust, Inc., 2004 U.S. Dist. LEXIS 17769, No. 03 C 6080, 2004 WL 2033067, at *1 (N.D. Ill. Sept. 2, 2004)* (footnote omitted). [1]

In our opinion of September 2, 2004, we indicated that much of the complaint **[**8]** hinges on the narrow question of ownership of the Demutualized Stock and therefore put that question on the front burner. Shortly thereafter, we instructed the parties to conduct discovery on the question of stock ownership, with a view to preparing dispositive motions on the issue. We later set a briefing schedule on cross-motions for summary judgment. After the parties filed their initial briefs, defendants filed a motion to strike plaintiffs' expert reports, and we stayed briefing on the summary judgment motions pending a ruling on the motion to strike. After we granted the motion to strike in most respects, briefing on the summary judgment motions resumed. Those motions have been fully briefed for some time now, but at a late stage of the briefing, plaintiffs filed a motion to strike various of defendants' documents and statements. We decided to take that motion along with the summary judgment motions, and the motion to strike was then briefed. All the motions are now fully briefed.

A few initial observations are in order. The first is that the summary judgment briefs and exhibits are ridiculously voluminous. Upon reviewing the briefs, we are unable to understand why each side **[**9]** wanted to file its own summary judgment motion instead of briefing a single motion. After seeing the huge stack of papers devoted to these motions, one would be surprised to learn that the issue is simple: who is entitled to this windfall of Demutualized Stock? Each side merely had to set forth its supporting arguments for the contention that it is entitled to the proceeds. Instead, the parties, particularly plaintiffs, have briefed many other issues that are somewhat factually related, but ultimately of very little use in determining the legal issue of ownership.

We also are compelled to remark that the briefs, chiefly those of plaintiffs, are marked by pettiness and a lack of civility. [2] The same sort of incivility creeps into defendants' briefs at points. Our colleague, Judge Kennelly, confronted the problem of incivility and prudently remarked:

> It goes without saying that the parties on both sides of high-stakes civil cases often find their veracity, integrity, competence, and reputation under attack, not to mention their economic well-being. It is understandable that the parties in such cases sometimes take it personally and react negatively. But taking **[*906]** it personally **[**10]** is not the role of counsel. The lawyer's office does not include acting as the channeler of the client's anger and frustration. To put it another way, a lawyer is not, contrary to the colloquialism, a "mouthpiece" for his client. A lawyer representing a client can and must represent the client zealously. Sometimes, to be sure, this involves striking hard blows. But the punches must be thrown fairly. And personal attacks of the type made by the attorneys who filed the papers quoted above are rarely, if ever, justified. Our system of justice does not work, or at least does not work well, if lawyers act like professional wrestlers hyping the next match rather than as members of. the honorable profession to which they belong.

*Daniels v. Bursey, 2004 U.S. Dist. LEXIS 9665, No. 03 C 1550, 2004 WL 1144046, at *2 (N.D. Ill. May 19, 2004)*. Counsel are advised to refrain from using inflammatory language in future filings.

[11]** The parties' unreasonable contentiousness is also displayed in their multiple motions and requests to strike various documents or statements. The briefing on the summary judgment motions was delayed by the filing of the first such motion by defendants. The motion was granted in large part. Plaintiffs then sent the court a letter calling our attention to their own request, which had been included within their response to defendants'

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[1] It appears that plaintiffs are seeking both stock proceeds and stock that was not sold. We will simply refer to the proceeds and the stock as the "stock" for convenience.

[2] In their reply brief regarding their motion for summary judgment, plaintiffs characterize defendants as (1) "danc[ing] a little sidestep" (curiously quoting from the movie "The Best Little Whorehouse in Texas," and providing a footnote to that effect, as if plaintiff's counsel is proud of the flippant remark); (2) "say[ing] what they need to say when they need to say it in order to make a point;" (3) "employing the fine art of shading and wordsmithing;" (4) "hid[ing] behind" the Plan documents. (Plaintiffs' Reply in Support of Summary Judgment Motion at 2, 5.) In their reply in support of their motion to strike, plaintiffs provide another abrasive quotation -- "Those who know the least know it the loudest" -- and accuse defendants of "ignor[ing] the cold hard facts, ignor[ing] the law and say[ing] what they have to say." (Plaintiffs' Reply in Support of Motion to Strike at 1.) These are just a few examples of the general snide tone that pervades many of plaintiffs' briefs.

motion to strike, to strike the legal opinions and testimony of one of defendants' witnesses, Thomas J. Handler. Thereafter, we issued a minute order stating in relevant part:

> Defendants state that the "memoranda and documents authored by Handier and/or the Handler law firm are offered exclusively as *transactional* documents, issued *to the PBT Plan and its participants at the time of and as part of the transactions at issue*. These documents establish the very history of the facts of the case and are relevant as facts in the case." (Reply at 10.) Accordingly, these materials will not be stricken because they may assist the court on factual issues. Of course, to the extent that they do not bear on the *facts* of the case and contain legal **[**12]** analysis and conclusions that would usurp the province of the court, the legal analyses will be disregarded. At this juncture, though, it would be a waste of time to sift through each exhibit identified by plaintiffs to assess which portions are fact and which portions are legal opinion. Plaintiffs can rest assured that, when ruling on the motions for summary judgment, the court will disregard legal analysis and conclusions whether those analyses and conclusions are offered by plaintiffs or by defendants.

(Minute Order of December 1, 2005.) It is puzzling to us how this order could be construed as an invitation or suggestion to file another motion to strike, but a week after we issued the order, plaintiffs did just that. Plaintiffs move to strike (1) the affidavit of Tracy L. Sunderlage, one of the defendants; (2) the affidavit of Thomas J. Handler (whose testimony was the very subject of the minute order); and (3) certain excerpts of Sunderlage and Handler's deposition testimony; and (4) over 150 of defendants' Rule 56.1 statements of material fact. Plaintiffs have even submitted a proposed order seeking individual rulings on each and every paragraph in the affidavits to which **[**13]** they object, and on each and every fact statement. The same day plaintiffs filed their motion to strike, defendants filed a response to plaintiffs' Rule 56.1 Statement arguing that the entire Statement should be stricken.

Motions to strike are generally disfavored except when they serve to expedite. See *Heller Fin., Inc. v. Midwhey Powder Co., 883 F.2d 1286, 1294 (7th Cir. 1989)*. These motions and requests to **[*907]** strike do not serve to expedite or streamline matters here; rather, the motions are unnecessary clutter and have only delayed briefing on the substantive motions. We need not and will not wade through the Sunderlage and Handler affidavits, or through their deposition testimony, to provide a detailed analysis of why each paragraph or statement is or is not improper legal opinion, or conclusory, or based on hearsay. We have found it unnecessary to even consider the statements in the affidavits and the deposition testimony to which plaintiffs object because they are not material to our ruling today. Similarly, we need not and will not provide individual rulings on over 150 of defendants' statements of fact for relevance or hearsay objections, or dozens of plaintiffs' **[**14]** statements of fact. We will say as a general matter that many of plaintiffs' statements of "fact" do appear to contain inappropriate legal argument, and that plaintiffs' relevancy objections to many of defendants' statements of fact are unfounded.

Perhaps individualized rulings on some of the evidence or statements would have been necessary were the issue here not so simple. But the only question before us at this point is ownership of the stock, and the relevant undisputed facts -- which are far fewer than the facts that the parties have deemed relevant -- will be set forth in our discussion infra. It will be clear from our discussion and analysis which facts are relevant to the issues. Plaintiffs' motion to strike and defendants' request to strike will be denied. [3]

DISCUSSION

Summary judgment "shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, **[**15]** 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)*. In considering such a motion, the court construes the evidence and all inferences that reasonably can be drawn therefrom in the light most favorable to the nonmoving party. See *Pitasi v. Gartner Group, Inc., 184 F.3d 709, 714 (7th Cir. 1999)*. "Summary judgment should be denied if the dispute is 'genuine': 'if the evidence is such that a reasonable jury could return a verdict for the nonmoving party.'" *Talanda v. KFC Nat'l Mgmt. Co., 140 F.3d 1090, 1095 (7th Cir. 1998)* (quoting *Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986)*). The court will

[3] One wonders what amounts of needless attorneys' fees have been generated by the creation of this mound of paper.

enter summary judgment against a party who does not "come forward with evidence that would reasonably permit the finder of fact to find in [its] favor on a material question." *McGrath v. Gillis, 44 F.3d 567, 569 (7th Cir. 1995)*.

A. Additional Material Facts

Defendant Professional Benefit Trust Multiple **[**16]** Employer Welfare Benefit Plan and Trust (the "Trust") was established in 1989. It has provided specified employee welfare benefits for sixteen years and currently provides benefits for over 2500 employee participants in 300 employer groups. The Trust is governed by the Professional Benefit Trust ("PBT") Multiple Employer Welfare Benefit Plan and Trust document, which has been amended from time to time. Defendant Professional Benefit Trust, Ltd. ("PBTL") is the entity that is the Managing Trustee of the Trust, and defendant Tracy Sunderlage is CEO and Chairman of PBTL. [4]

Plaintiffs began participating in the Trust during the mid-1990s for the sole **[*908]** purpose of securing death benefits, but not severance, long-term care, or medical benefits. In late 1997, the Trust amended the governing Trust document by issuing the PBT Third Amended and Restated Multiple Employer Welfare Benefit Plan and Trust ("the Third Amended Document"). The employer plaintiffs **[**17]** were provided copies of the Third Amended Document, a Summary Plan Description, and a 47-page legal opinion prepared by counsel for the Trust that addressed the operation of and participation in the Trust and the federal income tax and estate tax consequences. Each employer plaintiff executed an Adoption Agreement formally agreeing to the Third Amended Document.

The Trust was designed to operate as follows. Covered employees, those whose employers participated in the Trust, would be entitled to a death benefit in an amount (relative to the employee's compensation) that was selected by the employer in the Adoption Agreement. The Trust funded these benefits primarily through the purchase of investment-grade insurance policies on the lives of the employees. The employers contributed to the Trust by paying the premiums on these life insurance policies; the Trust then paid the premiums to the life insurance companies.

[4] There are other related defendants whom we need not discuss.

The language of the Third Amended Document indicates that the Trust was intended to comply with *§ 419A(f) (6) of the Internal Revenue Code*, *26 U.S.C. § 419A(f)(6)*, which would allow the employers to claim federal income tax **[**18]** deductions for their contributions. In a *§ 419A(f) (6)* plan, the Trust must be the owner of the insurance policies, even though the policies are written on the employee participants' lives. Moreover, *§ 419A(f)(6)* requires that there be a single plan, not an aggregation of individual plans, and that all plan assets be available for all employee participants instead of allocated to specific employers.

Most of the life insurance policies were purchased from The Canada Life Assurance Company ("Canada Life"), and one policy was purchased from Sun Life Assurance Company of Canada ("Sun Life"). In 1999 and 2000, respectively, Canada Life and Sun Life demutualized. The Trust had never experienced a demutualization, and evidently Sunderlage and his advisors were initially unsure about how to treat the stock windfall. There is no dispute that at the time of the demutualizations, the Third Amended Document was the governing Trust document. The Third Amended Document does not contain the words "demutualized stock" or include any provisions pertaining to the treatment of demutualized stock specifically. Plaintiffs' position was that they alone were entitled to the stock, and there were extensive **[**19]** discussions between plaintiffs' representatives and the Trust. The parties also obtained legal opinions concerning treatment of the stock. Eventually, the stock proceeds were deposited in the "Surplus Account" of the Trust, [5] and plaintiffs did not **[*909]** receive the stock or stock proceeds. The Trust

[5] Pursuant to the terms of the Third Amended Document, the "Surplus Account" receives "all experience gains" of the Trust. The Third Amended Document does not define the term "experience gain." It does refer, however, to some occurrences that are treated as experiences gains. It provides that after certain triggering events, if an employee or the beneficiary of the employee's death benefit does not purchase the insurance policy, the proceeds of the sale or surrender of the policy "shall be treated as an experience gain" and shall be governed by § 11.4 of the Document, which provides that experience gains are to be deposited in the Surplus Account. (App. to Defendants' Rule 56.1 Statement, Vol. I, Ex. 4, Third Amended Document, § 5.4.) The Third Amended Document also provides that unclaimed benefits become a part of the Surplus Account, and that excess assets remaining in the Trust after certain conditions are satisfied following an employer's withdrawal shall be treated as experience gains and credited to the Surplus Account. (Id., §§ 12.2, 12.3(b).)

reasoned that the stock was an "experience gain" that must be retained by the Trust in keeping with the Third Amended Document and *§ 419A(f)(6)*.

[20]** Beginning in late 2002, the employer plaintiffs began to request to withdraw from the Trust; all but two of the employer plaintiffs withdrew effective December 31, 2002. [6] According to the Third Amended Document, when an employer withdrew from the Trust, the participant employees were entitled to receive their pro rata share of Trust assets, exclusive of the Surplus Account. Upon withdrawal, plaintiffs elected to keep their life insurance policies and "roll them over" to another account, and so the policies were distributed to the employee plaintiffs, along with excess funds that had been deposited in the Trust that temporarily had been invested in tax-free municipal bonds. Because this distribution was largely in-kind (consisting of the life insurance policies) instead of in cash, plaintiffs claim that the Trust did not actually make a calculation of their pro rata shares. In plaintiffs' view, the Trust did not comply with *§ 419A(f) (6)* because it did not divvy up the Trust assets on a pro rata basis based on mathematical calculations. Defendants admit that they did not perform actuarial calculations when plaintiffs withdrew from the Trust, but state that the relevant calculations **[**21]** of the cash surrender values had already been made by the insurance companies that issued the policies. Defendants contend that when plaintiffs received the insurance policies, plaintiffs had actually"purchased" them by having their pro rata shares reduced by the cash surrender values of the policies.

B. Demutualized Stock Ownership

The parties' briefs, voluminous as they are, fail to provide a framework for deciding the question of entitlement to the Demutualized Stock. Instead, the parties plunge directly into their reasons why they believe they are entitled to the stock, without indicating why these factors matter in the overall equation. Defendants contend that (1) the Trust was created and intended to comply with *§ 419A(f) (6)*, which requires that the value of the stock be held by the Trust for all ongoing participants; (2) defendants were authorized by the terms of the governing **[**22]** Trust documents to deposit the proceeds of the Demutualized Stock in the Surplus Account for the benefit of all Trust participants; and (3) plaintiffs are estopped from claiming any right to the stock because they accepted the Trust's welfare benefits and tax benefits and expressly agreed to the terms of the Trust documents. Plaintiffs, on the other hand, argue that they are entitled to the stock because (1) Sunderlage "repeatedly promised" to distribute it to plaintiffs when they terminated their participation in the Trust; (2) the Trust is a collection of individual welfare benefit plans instead of a single Trust of pooled assets that complies with *§ 419A(f)(6)*; and (3) the stock is not an "experience gain" that the Trust was required to allocate to its Surplus Account under the terms of the trust documents or the law.

The proper framework for our analysis is provided in an opinion cited in plaintiffs' reply brief in support of their motion, *Chicago Truck Drivers, Helpers & Warehouse Workers Union (Independent) Health & Welfare Fund v. Local 710, International Brotherhood of Teamsters, No. 02 C 3115, 2005 U.S. Dist. LEXIS 42877, 2005 WL 525427 (N.D. Ill. **[*910]** Mar. 4, 2005)* (Guzman, J.). Chicago **[**23]** Truck Drivers involved four employee-benefit plans that held insurance policies purchased from companies that demutualized. The issues were whether the demutualization proceeds were plan assets, and if so, whether the compensation reverted to the employees or to the employers. The court noted that ERISA does not define "plan assets," but that the Department of Labor [7] has issued advisory opinions concerning the treatment of demutualization compensation by benefit plans. An agency's advisory opinions are not binding authority, but they are entitled to deference if reasonable. See *2005 U.S. Dist. LEXIS 42877, [WL] at *3*.

A side note before plunging into our analysis. The instant case is unusual because the former employer and employee Trust participants are not adversaries; **[**24]** they have aligned themselves on the same side because the employer plaintiffs are the wholly-owned professional corporations of the employee plaintiffs. In the typical scenario, as in Chicago Truck Drivers, the question would be whether the demutualized stock reverts to the employers or to the employees. Here, plaintiffs -- both employers and employees -- claim that the stock is not a plan asset and that they are entitled to the stock to the exclusion of the other participants in the

[6] As for the remaining two employers, one withdrew on December 31, 2001, and the other withdrew on December 31, 2003.

[7] "The Department of Labor shares enforcement responsibility for ERISA with the Department of the Treasury." *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank, 510 U.S. 86, 107 n.14, 114 S. Ct. 517, 126 L. Ed. 2d 524 (1993)* (citing *29 U.S.C. § 1204(a)*).

Trust. [8]

According to the Department of Labor, "the assets of a plan generally are to be identified on the basis of ordinary notions of property rights under non-ERISA law. This identification process includes consideration of any contract or other legal instrument involving the plan, including the plan documents. It also requires the consideration **[**25]** of the actions and representations of the parties involved." Dep't of Labor Advisory Op. 92-02A, at 2 (Jan. 17, 1992). A more recent advisory opinion stated: "The proceeds of the demutualization will belong to the plan if they would [sic] 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 received by the policyholder in connection with a demutualization would constitute plan assets." Dep't of Labor Advisory Op. 2001-02A, at 5-6 n.2 (Feb. 15, 2001) (emphasis added).

In Chicago Truck Drivers, the court analyzed, among other plans, a life insurance plan that met ERISA's definition of an employee welfare benefit plan. [9] The court found that because the employers made all of the contributions to the plan and because **[*911]** there was nothing in the language of the plan to suggest that demutualization compensation was intended to be a plan asset, the demutualization compensation was not a plan asset and reverted to the employers. *2005 U.S. Dist. LEXIS 42877, 2005 WL 525427, **[**26]** at *8*.

Plaintiffs maintain that under **[**27]** the analysis of Chicago Truck Drivers, they are entitled to the Demutualized Stock because the employers made the contributions to the Trust and because the Third Amended Document does not mention demutualized stock. We disagree. The life insurance plan in *Chicago Truck Drivers* is distinguishable in two very important ways. First, the policy at issue in that case was a group policy owned by the employers. Here, the policies were owned by the Trust pursuant to the express language of the Third Amended Document:

> Each application for a policy, and the policies themselves, shall designate the Trustee as sole owner, with the right reserved to the Trustee to exercise any right or option contained in the policies, subject to the terms and provisions of this Agreement. The Trustee shall be the named beneficiary.
>
> Subject to the right of a Participant Employee to make a Beneficiary [10] designation (and change such designation from time to time) the Trustee shall have full and complete control over any insurance policy as set forth in Section 14.4(k) hereof.
>
> [T]he Trustee is authorized and empowered . . . [t]o apply for and own any life insurance policy of the Insurer **[**28]** held as an asset of the Trust Fund, and to exercise any option, privilege or benefit in connection therewith, including, without limitation, the right to collect and receive the cash surrender value proceeds and all dividends or other distributions thereof. . . .

(Third Amended Document, §§ 3.1, 5.2(a), 14.4(m).) In compliance with the language of the Third Amended Document, the policies on the employee plaintiffs' lives were titled to the Trust and named the Trust as beneficiary. The Adoption Agreements that the employer plaintiffs executed (in which they formally agreed to the Third Amended Document) stated: "All insurance policies and bond funds will be titled (owned) by TTEE, Independent Trust Company FBO

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[8] Plaintiffs do not seek to recover any share of demutualized stock that may have been issued with respect to life insurance policies insuring the lives of other Trust participants.

[9] There is no genuine dispute that the Trust is an "employee welfare benefit plan" under ERISA, *29 U.S.C. § 1002(1) (A)*, because it provides benefits in the event of death. The Trust documents contemplate a single plan, not a collection of plans. But plaintiffs argue, without authority, that the Trust is a collection of hundreds of individual employee welfare benefit plans instead of a single employee welfare benefit plan. This position is relevant to their contention that the Trust did not operate in compliance with *§ 419A(f)(6) of the Internal Revenue Code*. However, for our purposes, the characterization "employee welfare benefit plan" is an ERISA determination that is independent of the Trust's status for tax purposes. Indeed, plaintiffs themselves argue that the employee welfare benefit plan at issue in Chicago Truck Drivers is analogous to the Trust. (Plaintiffs' Reply in Support of Summary Judgment Motion at 6.)

[10] "Beneficiary" is defined by the Third Amended Document as "the person or persons or entity designated by a Participant Employee to receive the Death Benefit, if any, payable under the Plan." (Third Amended Document, § 1.1(d).) So, the Third Amended Document uses the term "beneficiary" in two different ways: uncapitalized, it refers to the named beneficiary of the life insurance contract, which was the Trust; capitalized, the term refers to the person or entity who was designated to receive the death benefit from the Trust pursuant to the terms of the Third Amended Document.

Professional Benefit Trust." (App. to Defendants' Rule 56.1 Statement, Vol. II, Ex. 16, Sample Adoption Agreement, art. XVI.)

[29]** A second distinguishing factor is that in *Chicago Truck Drivers*, there was nothing in the language of the plan at issue to suggest how to treat demutualization compensation. The plan document was silent in regard to possible assets such as dividends. In this case, however, there are indicia in the language of the Third Amended Document that demutualization compensation should be treated as assets of the Trust for the benefit of all Trust participants, not just plaintiffs. Because "ordinary notions of property rights" govern, first and foremost is the above-quoted language stating that the Trust owned the policies and had full and complete control over the policies. In contrast to Chicago Truck Drivers, the Third Amended Document **[*912]** contains a provision concerning dividends; the Trustee has "the right to collect and receive the cash surrender value proceeds and all dividends or other distributions thereof." (Third Amended Document, § 14.4(m).) Moreover, the following additional provisions giving the Trustee broad ownership and control, and disclaiming any ownership or control by employers or employees, support the treatment of the Demutualized Stock as an asset of the Trust:

> . **[**30]** Upon termination of employment, the participant employees do not have the right to purchase the insurance policies; rather, the Trustee "may permit" them to purchase the policies for their cash surrender value. (§ 5.4)
> . "The Employer shall have no right, title or interest in and to the contributions made by it to the Trust; and, no part of the Trust property, or res, nor any income attributable thereto, ever shall revert to the Employer or be used for, or be diverted to, purposes other than for the exclusive benefit of the Participant Employees or for the payment of taxes and expenses of administration of the Trust. No Participant Employee shall have any right, title or interest in and to any contributions to the Trust by the Employer, any portion of the Trust res, nor any portion of any income attributable to the Trust, except as may otherwise be provided herein. (§ 8.3)
> ."[N]o Participant Employee shall have any right, title or interest in any specific assets of the Trust Fund." (§ 10.3(i))
>
> . "[T]he Trustee is authorized and empowered" to manage, convey, and "otherwise deal with all property" "on such terms and conditions as the Trustee shall decide," in **[**31]** addition to other broad rights. (§ 14.4)

Because the Trust owned the policies, it follows that the Trust owned the Demutualized Stock that flowed from the policies.

Plaintiffs argue in the alternative that even if the plaintiff employers are not entitled to the Demutualized Stock under a Chicago Truck Drivers analysis, the plaintiff employees are entitled to the stock pursuant to *Ruocco v. Bateman, Eichler, Hill, Richards, Inc., 903 F.2d 1232 (9th Cir. 1990)*. In Ruocco, the Ninth Circuit affirmed the district court's holding that demutualized stock reverted to the employee participants in a long-term disability insurance plan under a "balancing of the equities" test. The court found that allowing the compensation to revert to the employers would give the employers an undeserved windfall because the plan contributions had been made by the employees.

We see no reason to apply *Ruocco* here. Like Chicago Truck Drivers, Ruocco involved a group policy evidently owned by the employer. Furthermore, we decline to "balance the equities" because in the instant case, there was a contract that governed the administration of the Trust, and that contract **[**32]** stated that the Trust, not the plaintiffs, owned the policies. Plaintiffs decided to become participants in the Trust and agreed to its terms, knowing from the outset that they would not own the policies, and indeed why they would not own the policies. The Trust had to be structured in that way so that it would comply with *§ 419A(f)(6)*, and so the employers would therefore receive tax benefits.

Given that the benchmark of our analysis is "ordinary notions of property rights" (pursuant to Chicago Truck Drivers, a case cited by plaintiffs themselves), plaintiffs' contentions -- that defendants are "hiding behind" the Third Amended Document and that we should disregard the **[*913]** language of that document -- are absurd. In our view, the language of the Third Amended Document is clear and controlling. Plaintiffs make much of their experts' legal opinions and of a private letter ruling by the IRS to the effect that in practice, the Trust did not actually comply with all of the requirements of *§ 419A(f)(6)* at certain points in time. Defendants strenuously argue that it did, and the parties devote much of their briefs to the ins and outs of pooled assets, experience gains, and other esoteric **[**33]** characteristics of *§ 419A(f)(6)* plans.

We do not believe that the plan's compliance with *§*

419A(f)(6) bears on the issue of ownership. Whether the Trust was required to treat the Demutualized Stock as an "experience gain" is also beside the point; whether the Trust could do so because it owned the Stock is the relevant issue. We look to what the parties intended at the outset, and that intent is evidenced in the governing Trust document. The plaintiffs contracted for death benefits; they did not contract for ownership of the life insurance policies or other assets. Plaintiffs cite no authority whatsoever to support their argument that we should ignore the language of the Third Amended Document and focus instead on the Trust's compliance with tax regulations.

Plaintiffs also assert that they are entitled to the stock because Sunderlage "repeatedly promised" to distribute the stock to them when they terminated their participation in the Trust. (It is disputed whether Sunderlage actually made any "promise," but we will assume for purposes of this discussion that he did.) The argument, however, stops at "he promised"; plaintiffs fail to explain what the legal effect of such **[**34]** a "promise" was. And as with their arguments concerning tax compliance, plaintiffs fail to cite any authority at all to support their position. Again, what is relevant is what the parties intended regarding ownership of the policies at when they agreed to the terms of the governing documents, not what occurred years later when the Demutualized Stock was distributed.

Under ordinary notions of property rights, the Trust owned the policies. And it is not as if ownership by the Trust was some sort of decision made by a coin flip. Because they contemplated receiving (and did in fact receive) tax benefits, plaintiffs agreed to a welfare benefit plan structure in which the Trust was the policyholder. Because the Trust owned the policies, we hold that the Trust also owned the Demutualized Stock that was issued in relation to those policies.

A final note regarding the nature of our ruling. The parties have titled their cross-motions as simple motions for summary judgment. They are really motions for "partial" summary judgment on the issue of ownership because the parties have not identified which claims or counterclaims are affected by our ruling. It appears that our ruling today will dispose **[**35]** of most, if not all, of the case, but it is unclear exactly what is left of the claims and counterclaims. Therefore, the parties are directed to file cross-memoranda by June 23, 2006 and cross-responses by July 7, 2006, stating their views as to the effect of today's ruling on the claims and counterclaims in the case.

CONCLUSION

For the foregoing reasons, the cross-motions of the parties are treated as motions for "partial" summary judgment on the question of ownership of the Demutualized Stock. Defendants' motion for partial summary judgment is granted, and plaintiffs' motion for partial summary judgment is denied. Plaintiffs' motion to strike certain of defendants' statements of **[*914]** material fact and supporting affidavits and documents is denied.

DATE: June 15, 2006

ENTER:

John E. Grady, United States District Judge

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Rodriguez v. Perales

Court of Appeals of New York

April 25, 1995, Argued ; June 14, 1995, Decided

No. 131

Reporter
86 N.Y.2d 361 *; 657 N.E.2d 247 **; 633 N.Y.S.2d 252 ***; 1995 N.Y. LEXIS 1143 ****

In the Matter of Yvonne Rodriguez, Appellant, v. Cesar A. Perales, as Social Services Commissioner of the State of New York, Respondent, et al., Respondent.

Prior History: [**1]** Appeal, by permission of the Court of Appeals, from an order of the Appellate Division of the Supreme Court in the First Judicial Department, entered June 23, 1994, which (1) reversed, on the law, a judgment of the Supreme Court (Herman Cahn, J.), entered in New York County in a proceeding pursuant to CPLR article 78, granting the petition, adjudging that multiple Federal Supplemental Security Income (SSI) checks issued at different time periods do not constitute an initial payment recoverable by the New York City Human Resources Administration as interim assistance, annulling respondents' determination to retain petitioner's SSI check as a recoupment of amounts paid as Interim Assistance Home Relief Benefits and directing reimbursement of $ 2,997 to petitioner, (2) reinstated respondents' determination, and (3) dismissed the petition.

Matter of Rodriguez v Perales, 205 AD2d 418, reversed.

Disposition: Order reversed, with costs, and judgment of Supreme Court, New York County, reinstated.

Core Terms

benefits, interim, recipient, recoupment, social services, initial payment, reimbursement, retroactive, corrective, regulations, first payment, eligible, disability, social service agency, attachment, awaiting, retroactive benefit, respondents', windfall

Case Summary

Procedural Posture

Petitioner applicant appealed the order of the Appellate Division of the Supreme Court in the First Judicial Department (New York) which reversed the trial court's ruling that pursuant to *42 U.S.C.S. § 1383(g)*, respondent local government could not recover multiple Federal Supplemental Security Income checks issued at different times based on interim benefits provided to the applicant. reversed.

Overview

The applicant submitted an application for Supplemental Income Security (SSI) benefits. The local government paid her interim home relief assistance while she awaited a decision from the Department of Health and Human Services (HHS). Ultimately, HHS determined that the applicant was eligible to receive SSI disability benefits, but the benefits did not begin until several months later. HHS later determined that the applicant was entitled to receive retroactive benefits, so it issued an additional retroactive check to cover benefits due to the applicant. The local government agency claimed this check as additional reimbursement for the interim home relief payments. The applicant argued that *42 U.S.C.S. § 1383(g)* only entitled recoupment of the first payment. The court held that *§ 1383(g)* only permitted local recoupment of the retroactive amount initially determined to be due to the applicant. Therefore, the local government agency had to direct to the applicant

any portion of the second retroactive SSI check that it was withholding. In reaching its decision, the court relied on a HHS administrative ruling.

Outcome

The court reversed the judgment of the lower court and reinstated the judgment of the trial court in favor of the applicant.

LexisNexis® Headnotes

Public Health & Welfare Law > ... > Disability Insurance & SSI Benefits > Eligibility > General Overview

Public Health & Welfare Law > Social Security > Disability Insurance & SSI Benefits > General Overview

Public Health & Welfare Law > Social Security > Disability Insurance & SSI Benefits > US Social Security Administration Appeals Council

HN1 **Disability Insurance & SSI Benefits, Eligibility**

To facilitate the recoupment of interim assistance, *42 U.S.C.S. § 1383 (g)* provides that, where the Supplemental Security Income (SSI) applicant has executed a written agreement, the Federal agency may send the applicant's initial SSI payment directly to the agency that granted interim assistance.

Public Health & Welfare Law > Social Security > Disability Insurance & SSI Benefits > General Overview

HN2 **Social Security, Disability Insurance & SSI Benefits**

As a general rule, Supplemental Security Income (SSI) benefits are not subject to execution, levy, attachment, garnishment, or other legal process. *42 U.S.C.S. §§ 407* and *1383(d)(1)*. The courts construe this anti-attachment strictly to prohibit local social services agencies from recouping any interim public assistance provided to SSI recipients by claiming a share of their SSI benefits.

Governments > Legislation > Effect & Operation > Retrospective Operation

Public Health & Welfare Law > ... > Disability Insurance & SSI Benefits > Eligibility > Application Filing & Processing

Workers' Compensation & SSDI > ... > Evidence > Burdens of Proof > Claimants

Public Health & Welfare Law > Social Security > Disability Insurance & SSI Benefits > General Overview

HN3 **Effect & Operation, Retrospective Operation**

However, *42 U.S.C.S. § 1383(g)* explicitly authorizes localities to recover interim assistance provided to Supplemental Security Income (SSI) applicants out of the retroactive benefits they are awarded. The purpose of this legislation is to provide an incentive to States to furnish financial assistance to needy individuals awaiting disposition of their applications for SSI benefits. The precise method Congress chose to effectuate this goal was to exempt from the general anti-attachment rule those benefits "that the Federal agency has determined to be due with respect to the individual at the time the Secretary [of Health and Human Services] makes the first payment." *42 U.S.C.S. § 1383(g)(2)*. This language is controlling in determining the amount of SSI benefits that are subject to local recoupment.

Governments > Legislation > Interpretation

HN4 **Legislation, Interpretation**

In the interpretation of a statute the court must assume that the Legislature did not deliberately place a phrase in the statute that was intended to serve no purpose and

each word must be read and given a distinct and consistent meaning.

Public Health & Welfare Law > ... > Disability Insurance & SSI Benefits > Administrative Hearings > General Overview

Workers' Compensation & SSDI > Social Security Disability Insurance > Overpayments

Public Health & Welfare Law > Social Security > Disability Insurance & SSI Benefits > General Overview

Public Health & Welfare Law > ... > Disability Insurance & SSI Benefits > Benefit Determinations & Payments > Overpayments & Underpayments

HN5[] **Disability Insurance & SSI Benefits, Administrative Hearings**

The Secretary of the United States Department of Health and Human Services (Secretary) resolved a dispute between the New York State Department of Social Services and the Social Security Administration over the latter's policy of sending "corrective" retroactive Supplemental Security Income (SSI) payments directly to the recipient rather than to the State. U.S. Dept. of Health & Human Servs. Decision No. 1429, Re: New York State Department of Social Services (Dec. 5, 1994). The Secretary upheld the policy, noting that direct payment to the State is unwarranted because the underpaid benefits, later sent directly to the recipient, are unavailable for the state to offset amounts which it paid as interim assistance.

Administrative Law > Judicial Review > Standards of Review > Deference to Agency Statutory Interpretation

Administrative Law > Judicial Review > Standards of Review > General Overview

Administrative Law > Separation of Powers > Legislative Controls > General Overview

HN6[] **Standards of Review, Deference to Agency Statutory Interpretation**

As the agency charged with administering and enforcing the Supplemental Security Income (SSI) program, the United States Department of Health and Human Services is entitled to considerable deference in its construction and application of the program's enabling legislation. Generally, the court should uphold the agency's interpretation of the statutes it administers if the interpretation is not unreasonable or irrational.

Public Health & Welfare Law > ... > Disability Insurance & SSI Benefits > Eligibility > Application Filing & Processing

Public Health & Welfare Law > Social Security > Disability Insurance & SSI Benefits > General Overview

HN7[] **Eligibility, Application Filing & Processing**

N.Y. Soc. Serv. Law § 158(a), which implements the Federal recoupment plan, contemplates only that the amount of interim assistance given by the State will be reimbursed from the initial payment. "Initial payment" is defined as the first payment of supplemental security income benefits after a person files an application for benefits. The Social Services Department's regulations simply parallel the language of the enabling Federal legislation. 18 N.Y. C.R.R. 353.2. Thus, like the Federal statute, the governing state provisions authorize recoupment only from the amount initially determined to be due to the recipient and not from any subsequent corrective payments that are made.

Headnotes/Summary

Headnotes

Social Services - Recoupment of Advance Allowances - SSI Interim Assistance - Recoupment Only from Retroactive Amount Initially Determined to be Due Where a local public assistance agency furnishes an eligible Federal Supplemental Security Income (SSI) applicant with interim assistance and there has been a recalculation of the retroactive SSI benefits due, which results in the recipient's retroactive benefits being paid in more than one installment, only the retroactive amount that is initially determined to be due the recipient is subject to local recoupment. Generally, SSI

benefits are not subject to attachment, but *42 USC § 1383 (g)* explicitly authorizes localities to recover interim assistance provided to SSI applicants out of the retroactive benefits they are awarded and exempts from the antiattachment rule those benefits "that the [Federal agency] has determined to be due with respect to the individual at the time the Secretary [of the United States Department of Health and Human Services] makes the first payment". The statute should be construed to limit the amount of SSI benefits that may be taken by a locality to that which the Federal agency initially determines is due the applicant, regardless of any corrective action that may later be taken, so that the first three words of the phrase "determined to be due" are not rendered superfluous. The Secretary, who is ultimately responsible for administering the SSI program, has noted in an administrative letter decision that underpaid benefits, later sent directly to the recipient, would be unavailable for the State to offset amounts which it paid as interim assistance. Further, the State statute which implements the Federal recoupment plan authorizes recoupment only from the amount initially determined to be due to the recipient and not from any subsequent corrective payments that may be made *(see,* Social Services Law § 158). The possibility of a windfall for individuals who succeed in obtaining an upward adjustment of their retroactive entitlements as a result of administrative appeals is not alone sufficient reason to adopt a contrary rule. Moreover, notwithstanding any undesirable consequences, the applicable Federal statute must be strictly construed in this context because there is a strong underlying Federal policy forbidding attachment of SSI benefits without express legislative authority.

Counsel: *Jill Ann Boskey,* New York City, and *Wayne G. Hawley* for appellant. I. Basic rules of statutory construction require a finding that "interim assistance" cannot be recovered from **[****2]** petitioner's thirteenth SSI payment. *(* *Watt v Alaska, 451 US 259*; *DiMarco v Hudson Val. Blood Servs., 147 AD2d 156*; *Chevron, U. S. A. v Natural Resources Defense Council, 467 US 837*; *Immigration & Nationalization Serv. v Cardoza-Fonseca, 480 US 421*; *Independent Ins. Agents v Board of Governors, 838 F2d 627*.) II. This Court should enforce the choice of the United States Congress to protect from interim assistance recovery any SSI benefits not due at the time the first payment of SSI benefits is made. *(* *Rodriguez v United States, 480 US 522*; *Ellender v Schweiker, 575 F Supp 590, 781 F2d 314*; *Philpott v Essex County Welfare Bd., 409 US 413*; *Bennett v Arkansas, 485 US 395*; *Moore v Colautti, 483 F Supp 357, 633 F2d 210*; *White v Bowen, 835 F2d 974*; *Matter of Baez v Bane, 159 Misc 2d 838*; *Matter of Delmar v Blum, 53 NY2d 105*; *Rivers v Schweiker, 523 F Supp 738, 692 F2d 871*, *cert denied sub nom. Rivers v Blum, 460 US 1088*.)

Dennis C. Vacco, Attorney-General, New York City *(Carol Schechter* and *Victoria A. Graffeo* of counsel), for Cesar A. Perales, respondent. Recovery of the full amount of interim **[****3]** assistance paid to petitioner was authorized under Federal and State law. *(* *Matter of Carnegie v Perales, 200 AD2d 502*; *Commissioner v Brown, 380 US 563*; *Rosado v Wyman, 397 US 397*; *Kelly v United States, 924 F2d 355*; *Matter of Howard v Wyman, 28 NY2d 434*; *Matter of Johnson v Joy, 48 NY2d 689*; *Matter of Bernstein v Toia, 43 NY2d 437*; *Philpott v Essex County Welfare Bd., 409 US 413*; *Moore v Colautti, 483 F Supp 357, 633 F2d 210*; *Matter of Lutz v Amrhein, 151 AD2d 672*.)

Judges: Chief Judge Kaye and Judges Simons, Levine and Ciparick concur with Judge Titone; Judge Smith dissents and votes to affirm in a separate opinion in which Judge Bellacosa concurs.

Opinion by: Titone

Opinion

[*363] [248] [***253]** Titone, J.

Applicants for Federal Supplemental Security Income (SSI) sometimes experience delays of several months or even years before their entitlement to benefits is determined. To ease the severe financial hardships that these delays may occasion, the local public assistance agencies are authorized to furnish eligible applicants with interim assistance and to recoup the outlay from the recipient's "first" or "initial" SSI payment. **[****4]** The issue in this appeal is whether the locality's right to

recoupment may be exercised against the entire amount of retroactive SSI benefits paid to a recipient, where, as here, there has been a recalculation of the retroactive benefits due and, as a consequence, the recipient's retroactive benefits have been paid in more than one installment. Adhering to the clear language of the applicable statutes, we conclude that, under the circumstances presented in this case, only the retroactive amount that is initially determined to be due the recipient is subject to local recoupment.

In December of 1987, petitioner applied for SSI, claiming that she was disabled. While she was waiting for her application to be decided, petitioner received interim Home Relief assistance from the New York City Department of Social Services. On March 6, 1990, the Federal agency determined that petitioner was eligible to receive SSI disability benefits. However, according to the agency, petitioner's disability had not begun until September of 1988, and, consequently, she was entitled to a retroactive payment of only $ 7,652, representing the amount determined to be due for the period from September 1988 **[****5]** through April 1990. Petitioner subsequently commenced an administrative appeal from the Federal agency's **[*364]** determination, arguing that her disability had begun as early as December of 1987.

In the meantime, the City Department of Social Services advised petitioner that it would retain the entire retroactive SSI payment she had been awarded as reimbursement for the interim assistance it had provided. [1] Petitioner's Home Relief case was closed effective May 16, 1990, and petitioner thereafter began receiving monthly SSI benefits.

Petitioner's appeal from the Federal agency's determination was ultimately resolved in her favor when the Secretary of Health and Human Services' Appeals Council concluded that she was actually entitled to disability **[****6]** benefits from December 11, 1987, as she originally had claimed. As a result of this decision, the Federal agency issued an additional retroactive check to cover benefits due petitioner between December 11, 1987 and September 1988. A portion of this check was then claimed by the City as additional reimbursement for the interim Home Relief assistance it had given petitioner before her SSI application was determined.

Petitioner requested a fair hearing before the State Department of Social Services to challenge the City's claim. Petitioner did not dispute that the additional amount claimed by the City was equal to the amount it had granted her in interim Home Relief benefits. Instead, she argued that the City was not entitled to a share of the second retroactive SSI benefit check because the applicable statutes and regulations permitted recoupment only from the "first" or "initial" SSI payment. The Social Services Department rejected petitioner's argument. Petitioner then brought the present CPLR article 78 proceeding to challenge that determination.

Although Supreme Court granted the petitioner the relief she sought, the Appellate Division reversed, holding that the reference **[****7]** **[**249]** **[***254]** to "first payment" in the controlling Federal statute (*42 USC § 1383 [g] [2]*) was meant "only to set the point in time governing the calculation" and that "the amount to be reimbursed to the local government" is the amount necessary to reimburse it for the interim assistance it provided (*205 AD2d 418, 419*). In so ruling, the Appellate Division relied, in part, on its policy-based concern that the contrary rule would **[*365]** afford individuals in petitioner's position a windfall solely because "the Social Security Administration made a mistake in calculation … and later corrected this error in a second retroactive check" *(id., at 419*). We now reverse.

HN2[↑] As a general rule, SSI benefits are not subject to execution, levy, attachment, garnishment or other legal process *(see, 42 USC §§ 407, 1383 [d] [1]*). This antiattachment was construed strictly in *Philpott v Essex County Welfare Bd. (409 US 413*) to prohibit local social services agencies from recouping any interim public assistance provided to SSI recipients by claiming a share of their SSI benefits. ***HN3***[↑] However, in 1974, Congress overrode *Philpott* by enacting *42 USC § 1383* **[****8]** *(g)*, which explicitly authorizes localities to recover interim assistance provided to SSI applicants out of the retroactive benefits they are awarded (Pub L 93-368 § 5). The purpose of this legislation was to provide an incentive to States to furnish financial assistance to needy individuals awaiting disposition of their applications for SSI benefits *(see,* HR Rep No. 1296, 94th Cong, 2d Sess 3-5, reprinted in 1976 US Code Cong & Admin News 1726, 1729-1730). The precise method Congress chose to effectuate this goal

[1] ***HN1***[↑] To facilitate the localities' recoupment, *42 USC § 1383 (g)* provides that, where an SSI applicant has executed a written agreement, the Federal agency may send the applicant's initial SSI payment directly to the agency that has granted interim assistance.

was to exempt from the general antiattachment rule those benefits "that the [Federal agency] has determined to be due with respect to the individual at the time the Secretary makes the first payment" (*42 USC § 1383 [g] [2]* [emphasis supplied]). It is this language which must be deemed controlling in determining the amount of SSI benefits that are subject to local recoupment.

Petitioner contends that the amount of SSI benefits that may be taken by a locality is limited to that which the Federal agency initially determines is due to the applicant, regardless of any corrective action that may later be taken. This contention is premised on petitioner's **[****9]** view that the underscored language in *section 1383 (g)* was intended to modify the whole phrase "determined to be due." Respondents, in contrast, argue that the underscored temporal language relates only to the word "due" in that phrase. This minor grammatical difference of opinion has major consequences. If respondents' view is correct, the entire retroactive amount that is owed "at the time … [of] the first payment" would be subject to local attachment, regardless of when the determination of the amount owed is made. On the other hand, if petitioner's position is correct, the local interim-assistance provider could attach only the amount fixed by the Federal agency's original decision.

[*366] Contrary to the holding of the Appellate Division, we reject respondents' position and conclude that petitioner's proffered construction of *42 USC § 1383 (g)* represents the better view. Respondents' construction is unsatisfactory because it would render the first three words of the phrase "determined to be due" superfluous--a result that the rules of statutory construction disfavor. "It is well settled that ***HN4***[↑] in the interpretation of a statute we must assume that the Legislature **[****10]** did not deliberately place a phrase in the statute which was intended to serve no purpose … and each word must be read and given a distinct and consistent meaning" *(Matter of Smathers, 309 NY 487, 495* [citations omitted]).

Moreover, respondents' position has recently been explicitly rejected by the Secretary of the United States Department of Health and Human Services (HHS), the officer who is ultimately responsible for administering the SSI program. In a transmittal that was denominated a "Final Decision" and was dated December 5, 1994, ***HN5***[↑] the Secretary resolved a dispute between the New York State Department of Social Services and the Social Security Administration over the latter's policy of sending "corrective" retroactive SSI payments directly to the recipient rather than to the State (US Dept of Health & Human Servs Decision No. 1429, **[**250]** **[***255]** Re: New York State Department of Social Services, Departmental Appeals Board Docket No. A-93-109). [2] The Secretary upheld the policy, noting that direct payment to the State would be unwarranted because "the underpaid benefits, later sent directly to the recipient, would be unavailable for the state to offset amounts **[****11]** which it paid as interim assistance" *(id.,* at 25). In reaching that conclusion, the Secretary reviewed virtually every argument made by respondents here and found them to be unpersuasive *(id.,* at 21-26). [3]

[**12]** ***HN6***[↑]

[*367] As the agency charged with administering and enforcing the SSI program, HHS is entitled to considerable deference in its construction and application of the program's enabling legislation *(e.g., Howard v Wyman, 28 NY2d 434, 438)*. An agency's interpretation of the statutes it administers generally should be upheld if not unreasonable or irrational *(e.g., Matter of Salvati v Eimicke, 72 NY2d 784, 791*; *Matter of Mounting & Finishing Co. v McGoldrick, 294 NY 104, 108*; *cf., Kurcsics v Merchants Mut. Ins. Co., 49 NY2d 451*). Indeed, respondents expressly recognize the application of this principle here, although their argument rests on the premise that *their* view of the applicable State provisions rather than the Secretary's view of the parallel Federal provisions should be controlling.

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[2] The Appellate Division did not have the benefit of this "Final Decision" at the time it made its decision on respondents' appeal.

[3] The dissent's assertion that the letter decision "has no application here" is puzzling. It is true that the Secretary's letter concerned the State's dispute with HHS regarding the latter's policy of sending "corrective" lump-sum SSI payments directly to the recipient *(see,* Internal SSA Program Operations Systems Manual § SI 02003.030A.2), while the lump-sum payment in this case was sent to the local social services agency. However, this fortuity, which apparently resulted from an administrative error on the part of HHS, has no analytical significance. Underlying the issue of whether the payment should be sent to the State or to the recipient is the dispositive question of which party is *entitled* to the fund. On that question, the Secretary clearly and unmistakably ruled that the corrective payment belongs to the recipient and not the State. That conclusion is directly on point in this dispute.

Deference to the Federal agency's construction is particularly appropriate in this dispute involving the Social Security Act, which represents a " 'scheme of cooperative federalism' " *(Matter of Jones v Berman, 37 NY2d 42, 52*, quoting *King v Smith, 392 US 309, 316)* and ordinarily requires participating localities to comply with the Federal administrative **[****13]** agency's regulations and rulings *(see, Hagans v Lavine, 415 US 528, 530, n 1*; *Matter of Dunbar v Toia, 45 NY2d 764, 766*; *Matter of Beaudoin v Toia [Jorczak], 45 NY2d 343, 348)*. While the principle of "cooperative federalism" does not require blind adherence to all Federal directives, sound judicial policy counsels in favor of deference where, as here, the Federal ruling is not irrational or inconsistent with the language of the applicable Federal statute *(cf., Matter of Bosh v Fahey, 53 NY2d 896*).

Notably, ***HN7***[⬆] Social Services Law § 158, which implements the Federal recoupment plan, contemplates only that the amount of interim assistance given by the State will be reimbursed "from [the] *initial* payment" (subd [a]) (emphasis supplied). "Initial payment" is defined as "the first payment of supplemental security income benefits after a person files an application for benefits" *(id.)*. The Social Services Department's regulations simply parallel the language of the enabling Federal legislation (*18 NYCRR 353.2*; *see,* 18 NYCRR former 370.7 [a] [2] [repealed eff Nov. 3, 1993]). Thus, like the Federal statute, the governing State provisions authorize **[****14]** recoupment only from the amount initially determined to be due to the recipient **[*368]** and not from any subsequent corrective payments that may be made. [4]

[**15] [**251] [***256]** We recognize, as both respondents and the dissenters stress, that limiting the State to reimbursement from the SSI recipient's first payment may produce a windfall for individuals such as petitioner who succeed in obtaining an upward adjustment of their retroactive entitlements as a result of administrative appeals. However, the possibility of a windfall in such cases [5] is not alone a sufficient reason to adopt the rule respondents urge, particularly in view of the language of *42 USC § 1383 (g)*, the HHS Secretary's contrary position and the fact that the statute does not evince a legislative intent to ensure a one-to-one correspondence between the amount of interim assistance paid and the amount of reimbursement recovered. Indeed, as the HHS Secretary noted in her Final Decision (at 25), the Social Security Administration does not customarily seek a refund from the State when there has been an *over*payment in the initial amount sent on behalf of the recipient. Furthermore, any perceived "windfall" effect from the rule limiting the State's recovery out of retroactive SSI payments is mitigated by the fact that the State may have other sources for recovering **[****16]** overpayment *(see, e.g.,* Social Services Law § 158 [d], [e] [i]).

Finally, notwithstanding any undesirable consequences such as the dissent perceives, the applicable Federal statute must be strictly construed in this context, because, as is evident from the associated case law and legislative history, there is a strong underlying Federal policy forbidding attachment of SSI benefits without express legislative authority. Just as remedial **[*369]** legislation in the form of *42 USC § 1383 (g)* was necessary to enable the States to recoup interim assistance from the retroactive amount initially determined to be due, so too is specific remedial legislation required to enable localities to recoup by attaching subsequently determined "corrective" payments. Such specific legislation **[****17]** does not presently exist.

For all of the foregoing reasons, we conclude that respondent City was not authorized to recoup its previously unreimbursed interim-assistance outlay from the proceeds of petitioner's Federal administrative appeal. Hence, respondent State Department of Social Services should have directed the City to return any portion of petitioner's second retroactive SSI check that

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[4] The dissent's reliance on ***18 NYCRR 353.2 (c) (3)*** is misplaced. Obviously, to the extent that the regulation permits a practice that is inconsistent with either *42 USC § 1383 (g)* or Social Services Law § 158, it is invalid and not to be followed. Further, there is no real inconsistency as the cited regulation merely permits the local social services agency to recoup interim assistance from "any check or checks *comprising an initial payment"* (***18 NYCRR 353.2 [c] [3]*** [emphasis supplied]). The regulation's use of the word "checks" in the plural can readily be interpreted as a means of accommodating SSA's requirement that payments exceeding $ 9,999.99 be made in multiple checks (Internal SSA Program Operators Systems Manual § SI 02003.030A.2). Construed in this manner, the regulation simply contemplates situations in which the amount initially determined to be due to the applicant exceeds the amount that can be paid through a single check and does not have the broader significance attributed to it by the dissent.

[5] According to the Social Security Administration's submissions to the HHS Secretary, its national rate for erroneous initial underpayments in 1991 (the last year for which statistics were then available) was only 1.1%.

it was withholding.

Accordingly, the order of the Appellate Division should be reversed, with costs, and the judgment of Supreme Court reinstated.

Dissent by: Smith

Dissent

Smith, J. (Dissenting). The issue here is whether the City was permitted to retain reimbursement for interim assistance provided petitioner although such reimbursement was made after the initial Federal SSI payment. Because I believe that the Appellate Division was correct when it determined that such corrective payment was properly made to the City, I dissent and vote to affirm the order of the Appellate Division.

On December 11, 1987, petitioner filed an application for Federal Supplemental Security Income disability benefits (SSI). While her application was being processed, she applied for and received Home Relief interim **[****18]** assistance benefits through the New York City Department of Social Services (City DSS). In April 1990, the Social Security Administration (SSA) determined petitioner eligible for benefits, but only as of September 14, 1988 and made an initial payment of benefits for the period September 14, 1988 through April 1990 directly to City DSS for interim assistance provided petitioner. City DSS inaccurately thought that the payment **[**252]** **[***257]** represented reimbursement for the entire period for which interim assistance was provided (December 11, 1987 though April 1990) and kept the entire payment.

Petitioner appealed SSA's initial determination that eligibility dated from September 1988 as opposed to December 1987, the date of her initial application. In November 1990, the SSA Appeals Council found that petitioner was actually disabled for the period December 11, 1987 through September 13, 1988 and awarded her benefits from that time period. This award of **[*370]** "retroactive benefits" was included in petitioner's thirteenth SSI check and sent directly to City DSS. City DSS again kept the complete thirteenth payment as reimbursement for interim assistance for the entire **[****19]** period December 11, 1987 through April 1990, instead of December 1987 through September 1988. Petitioner requested that City DSS correct its error. After realizing its error, City DSS recalculated the amount of interim assistance provided and remitted the excess to petitioner.

Petitioner, simultaneously, requested a fair hearing to review City DSS's determination to retain any portion of the "non-initial" payment. State DSS upheld City DSS's retention of part of the corrective payment. Petitioner commenced this CPLR article 78 proceeding seeking reversal of State DSS's decision after the fair hearing. The motion court held that the multiple checks issued at different times did not constitute an initial payment within the meaning of Federal and State law. The Appellate Division reversed, holding essentially that SSA's mistake in calculation should not result in a windfall to petitioner allowing her to receive SSI benefits for a period during which she also received Home Relief benefits.

Under the Federal SSI program, monthly Federal benefits are provided to eligible individuals who are aged, blind, or disabled and poor to maintain basic subsistence (*42 USC § 1381*). These **[****20]** benefits are not subject to attachment without express statutory authority (*42 USC §§ 407*, *1383 [d] [1]*). Determination of an applicant's eligibility for SSI benefits takes time and could in some instances leave applicants without assistance for the period during which their application is being processed. During this "interim" period, applicants may seek assistance from State agencies under the Interim Assistance Program (IAP) (*42 USC § 1383 [g]*; *20 CFR 416.1901*). The Interim Assistance Provisions of the Social Security Act is a program enacted by Congress in 1974 specifically to aid individuals awaiting determination of applications for Federal SSI benefits *(id.).* Under this program, State and local social service agencies are permitted to recoup interim assistance.

To receive reimbursement for interim payments, a State must agree to pay any excess reimbursement to the recipient (*42 USC § 1383 [g] [4] [A]*). The Federal regulations provide that when a recipient so authorizes, SSA may withhold a recipient's benefits and when SSA makes the "initial payment" **[*371]** of benefits, send payment directly to the State, provided the State has entered into an **[****21]** appropriate agreement with SSA (*20 CFR 416.1904*).

Social Services Law § 158 (a) provides the statutory authority for New York State to receive and deduct interim assistance from an SSI recipient's "initial payment." The regulations define "initial payment" as

the amount of SSI benefits SSA determines to be payable at the time the first payments of SSI benefits are made (*18 NYCRR 370.7 [a] [2]*). Although a State or local social service district is permitted to recover for interim assistance provided an individual awaiting determination on an SSI application, the regulation prohibits further recovery where the initial payment is insufficient to fully reimburse such agency for interim assistance. Specifically the regulations provide:

"Upon receipt of an initial payment, the local social services district shall deduct therefrom the amount of interim assistance provided. If the initial payment is less than the interim assistance provided, recoupment cannot be made from subsequent SSI payments" (*18 NYCRR 370.7 [c] [3]*).

Petitioner argues that the plain language of the Federal and State statues requires a finding that any payments, corrective or otherwise, made after the **[****22]** initial payment are to be paid directly to the recipient. Petitioner's **[**253]** **[***258]** strict reading of the statutes is contrary to the purpose and spirit of the Interim Assistance Program's enactment. States and local social service districts participating in the interim assistance program provide essential financial relief to applicants awaiting eligibility determination for Federal SSI benefits. As participation in the IAP program is voluntary, the possibility of continually losing valuable public resources to applicants receiving double benefits serves little or no incentive for continued State participation.

Essentially, petitioner contends that not only is she entitled to the interim assistance she received from City DSS while awaiting determination of her SSI application, but regardless of an error in calculation resulting in a double outlay of benefits from both City DSS and Federal SSI covering the identical period, she is nevertheless entitled to retain any excess not provided in the "initial payment" or the "first payment" of Federal benefits. This interpretation, however, is counter to the rationale for IAP's enactment. The purpose for **[*372]** which **[****23]** the Federal and State IAP statutes were enacted is that when an applicant is awaiting determination for SSI benefits and receives interim assistance from a State or local social service district, such agency is entitled to recoup whatever assistance has been provided.

The State apparently loses some reimbursement for interim assistance when SSA determines a person is not eligible for such assistance. Further, if a determination is made that an individual is entitled to benefits covering a period less than that for which the State has provided interim assistance, and the initial payment reflects only that period, the State is not permitted to recoup the balance of assistance provided from the recipient. While the statute specifically prohibits recoupment of interim assistance for periods an applicant is found ineligible for Federal SSI, this prohibition does not refer to a double recovery situation provided this petitioner.

Here, SSA made an initial determination of entitlement to benefits for only part of the period for which City DSS provided interim assistance, with payment made accordingly. Subsequently, SSA determined that petitioner was actually entitled to benefits for **[****24]** the entire period that City DSS provided interim assistance and, thereafter, SSA provided benefits on a retroactive basis to cover the period not provided for in the initial payment. In this instance, reimbursement to the State or local social service agency, even if after the first payment, is permissible to avoid the double receipt of benefits to the SSI recipient.

In a recent decision involving a dispute between State DSS and SSA regarding their interagency agreement under the SSI interim assistance program, the Secretary of the United States Department of Health and Human Services determined that SSA's policy of sending "corrective payments" directly to recipients rather than to the State was fully supported by statute. The Secretary concluded that recovery of interim assistance by State and local agencies to retroactive benefits is limited to that initially determined to be due. This conclusion not only frustrates the purpose of the IAP, but implies that the statute intends to provide recipients with, in this case, duplicate benefits. Faced with the unreimbursed costs of administering benefits under IAP, loss of benefits provided during periods when applicants are ineligible **[****25]** for SSI and the absorption of nonreimbursable benefits due to an error in **[*373]** eligibility determination on SSA's part, this conclusion further serves as a disincentive for State and local social service agencies to provide assistance under IAP.

It should be emphasized that the letter decision by the Secretary of the United States Department of Health and Human Services has no application here. The letter states, *inter alia,* that any corrective payments of SSI benefits, other than the initial or first payment, should be sent not to the City or State but directly to the recipient even though the City or State has made interim payments covered by the corrective payments. Here,

unlike the situation in the letter decision, the corrective payments were sent to the City. It is unreasonable to now say that the City must give those payments to a recipient who has received the interim benefits and then find another means of recouping those benefits from that same recipient. **[**254] [***259]** Moreover, the New York State regulations contemplate that an initial payment may be made in more than one check. Thus, *18 NYCRR 370.7 (a) (2)* states:

" [T]he amount of SSI benefits **[****26]** determined by the Social Security Administration (SSA) to be payable to an eligible individual (including retroactive amounts, if any) at the time the first *payments* of SSI benefits are made" (emphasis supplied).

Finally, the suggestion by the majority that recoupment can be made by applying Social Services Law § 158 (d) and (e) is not a reasonable alternative to the City's retention of the funds it has received. Those sections provide that a recipient of Home Relief can be required (1) to assign to the State and the social services district any rights of support from any other person or (2) to assist public authorities in establishing the paternity of a child and in efforts to secure assistance from the father.

Accordingly, I would affirm the order of the Appellate Division.

Chief Judge Kaye and Judges Simons, Levine and Ciparick concur with Judge Titone; Judge Smith dissents and votes to affirm in a separate opinion in which Judge Bellacosa concurs.

Order reversed, etc.

Ruocco v. Bateman, Eichler, Hill, Richards, Inc.

United States Court of Appeals for the Ninth Circuit

March 6, 1990, Pasadena, California, Argued and Submitted ; May 18, 1990, Filed

No. 88-6655

Reporter
903 F.2d 1232 *; 1990 U.S. App. LEXIS 7998 **; 12 Employee Benefits Cas. (BNA) 1557

John D. Ruocco, on behalf of himself and as the representative of a class of persons similarly situated, Plaintiff-Appellee, v. Bateman, Eichler, Hill, Richards, Incorporated, John R. Bolin, Theodore Prush, Defendants-Appellants

Prior History: [1]** Appeal from the United States District Court for the Central District of California; Dickran M. Tevrizian, District Judge, Presiding; D.C. No. CV-87-04173-DT.

Counsel: Craig B. Jorgensen, Jon L. Rewinski, Louis W. Karlin, Kindel & Anderson, Los Angeles, California, for the Defendants-Appellants.

J. Michael Hennigan, Richard M. Callahan, Jr., Hennigan & Mercer, Los Angeles, California, for the Plaintiff-Appellee.

Judges: David R. Thompson and Stephen S. Trott, Circuit Judges, and Malcolm F. Marsh, District Judge. * Opinion by Judge Malcolm F. Marsh.

Opinion by: MARSH

Opinion

[*1234] Marsh, District Judge

This action involves claims by John Ruocco, on behalf of himself and current and former Bateman, Eichler, Hill, Richards, Inc., et al., ("BEHR") employees who participated in BEHR's long-term disability plan between January 1, 1982 and December 30, 1984. The plaintiff class claims that BEHR violated its fiduciary duties, the Employee Retirement Income and Security Act ("ERISA"), *29 U.S.C. §§ 1001-1461 (1982 & Supp. V 1987)*, section 8315 **[**2]** of the California Commercial Code, and the Racketeer Influenced and Corrupt Organizations Act ("RICO"), *18 U.S.C. §§ 1961-1968 (1982 & Supp. V 1987)*, when it failed to distribute to the plan participants a surplus dividend received from BEHR's disability insurance carrier. BEHR appeals the district court's grant of partial summary judgment to Ruocco on the non-RICO causes of action awarding to Ruocco $ 629,423.31 minus administrative costs, and attorney's fees. We affirm the district court's decision with respect to defendant BEHR but reverse the decision holding defendants Bolin and Prush personally liable.

I.

BEHR is a stock brokerage and financial consulting firm with its principal place of business in Los Angeles, California. At all relevant times, John R. Bolin was BEHR's president, chief executive officer and chairman of the board of directors. Theodore W. Prush was BEHR's executive vice president, chief financial officer and a member of the board of directors.

From 1968 to 1986, BEHR offered its employees group long term disability insurance through Union Mutual Insurance Company ("Union Mutual"). The Union Mutual policy was paid for by the employees **[**3]** participating in the plan. BEHR deducted premiums from the pay of participating employees and transmitted these premiums to Union Mutual. While BEHR paid premiums itself from time to time in order to prevent a lapse in coverage, the amount of premiums paid by BEHR was minimal. BEHR paid all administrative costs for the plan. Ruocco, an employee BEHR until August 1986, elected the long term disability coverage provided by Union Mutual.

The Union Mutual policy provided:

> When proof is received that an insured employee is totally disabled as a result of sickness or injury and requires the regular attendance of a legally qualified physician, the Insurance Company will pay a monthly benefit to the insured employee after completion of the elimination period.

The policy defined "employee" as "a full-time employee,

* Honorable Malcolm F. Marsh, United States District Judge for the District of Oregon, sitting by designation.

individual, proprietor, or partner who is regularly working at least 30 hours per week during the regular work week of the employer." The policy also provided that

> all insurance provided under this Policy for an insured employee will cease at 12:00 midnight on the earliest of the following occurrences: . . . (2) On the date **[*1235]** that the insured **[**4]** employee ceases to be in a class of employees eligible for insurance.

On September 24, 1986, Union Mutual notified BEHR that it intended to convert from a mutual insurance company to a wholly-owned subsidiary of a publicly-owned stock corporation called UNUM. Under Maine law, where Union Mutual was incorporated, such conversion could take place only upon distribution to each policyholder of a pro rata share of the retained surplus which the converting company had acquired while it was operating as a mutual company. Union Mutual determined the BEHR surplus by considering the premiums paid between January 1, 1982 and December 31, 1984. Union Mutual notified BEHR that the returned surplus would take the form of shares of UNUM stock and warrants to purchase additional shares of UNUM stock. The warrants had to be exercised between September 26 and October 28, 1986.

In October 1986, the Executive Committee of BEHR decided to exercise the warrants and paid $ 609,336 to buy 25,755 shares of UNUM stock. These shares were sold by BEHR in November 1986 for $ 712,249.30 thereby generating a profit of $ 104,913.30. In November 1986, BEHR also received the straight distribution of UNUM **[**5]** shares which BEHR sold on November 6, 1988 for $ 524,510.01. In total, BEHR received $ 629,423.31 from the profit on the sale of shares purchased on the warrants and the sale of the distributed shares.

On June 29, 1987, Ruocco filed this action, claiming that BEHR's decision to retain the UNUM distribution violated ERISA, California Commercial Code section 8315, and various provisions of RICO. The district court dismissed the RICO claims, but granted summary judgment to Ruocco on both the ERISA and California Commercial Code section 8315 claims. The court found that the BEHR long term disability plan was an "employee welfare benefit plan" as defined by ERISA, 29 U.S.C. § 1002(1), that defendants were "fiduciaries" of the Plan, that Ruocco was a "participant" in the plan, and that the surplus dividend constituted an "asset of the plan" pursuant to 29 U.S.C. section 1101. While the court found that defendants did not breach their fiduciary duty to the plaintiff class, the court held that defendants' decision to keep the UNUM distribution was "arbitrary and capricious." The court found that the balance of equities weighed in favor of **[**6]** the plan participants because "the premiums for the plan were paid for by the participants" and because "the funds would not inure to the benefit of the participants of the plan" if distributed to the defendants. The district court also found that the sale of the UNUM stock constituted a wrongful transfer of securities, in violation of California Commercial Code section 8315. Finally, the court ruled that plaintiffs were entitled to attorney's fees under ERISA pursuant to 29 U.S.C. section 1132(g)(1).

On September 6, 1988, BEHR petitioned this court for permission to pursue an immediate interlocutory appeal. The court granted this petition on December 2, 1988.

II.

A grant of summary judgement is reviewed de novo. Kruso v. International Tel. & Tel. Corp., 872 F.2d 1416, 1421 (9th Cir. 1989); State Farm Fire & Casualty Co. v. Martin, 872 F.2d 319, 320 (9th Cir. 1989). The appellate court's review is governed by the same standard used by the trial court under Fed.R.Civ.P. 56(c). Darring v. Kincheloe, 783 F.2d 874, 876 (9th Cir. 1986). The appellate court must determine, viewing the evidence in the light **[**7]** most favorable to the nonmoving party, whether there are any genuine issues of material facts and whether the district court correctly applied the relevant substantive law. Tzung v. State Farm Fire & Casualty Co., 873 F.2d 1338, 1339-40 (9th Cir. 1989); Judie v. Hamilton, 872 F.2d 919, 920 (9th Cir. 1989).

Issues dealing with the interpretation and application of ERISA provisions as well as preemption under ERISA are also subject to de novo review. Admiral Packing Co. v. Robert F. Kennedy Farm Workers ***[*1236]*** Medical Plan, 874 F.2d 683, 684 (9th Cir. 1989); Chase v. Trustees of W. Conf. of Teamsters Pension Trust Fund, 753 F.2d 744, 746 (9th Cir. 1985); Trustees of Amalg. Ins. Fund v. Geltman Indus., Inc., 784 F.2d 926, 929 (9th Cir.), *cert. denied*, *479 U.S. 822, 107 S. Ct. 90, 93 L. Ed. 2d 42, 55 U.S.L.W. 3232 (1986)*.

III.

BEHR asserts error on nine grounds.

1. *Lack of Jurisdiction*

BEHR argues that the district court erred because it lacked jurisdiction over plaintiff's ERISA claim. BEHR

argues that Ruocco was not a "participant" of a welfare benefit **[**8]** plan as defined by ERISA because Ruocco received all the benefits he was entitled to under the disability benefit plan and was no longer employed by BEHR at the time the Union Mutual surplus was distributed.

ERISA defines participant as "any employee or former employee of an employer . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan." *29 U.S.C. § 1002(7)*. The Supreme Court has interpreted ERISA's definition of participant as including both "employees in or reasonably expected to be in, currently covered employment," *Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 S. Ct. 948, 957-58, 103 L. Ed. 2d 80 (1989)* (quoting *Saladino v. ILGWU Nat'l Retirement Fund, 754 F.2d 473, 476 (2d Cir. 1985)*), or "former employees who 'have a reasonable expectation of returning to covered employment' or who have 'a colorable claim' to vested benefits." *Firestone, 109 S. Ct. at 957-58* (quoting *Kuntz v. Reese, 785 F.2d 1410, 1411* (9th Cir.), *cert. denied*, *479 U.S. 916, 93 L. Ed. 2d 291, 107 S. Ct. 318 (1986)*).

Applying the *Firestone* **[**9]** test to this case, we find that Ruocco presents "a colorable claim" of entitlement to the Union Mutual surplus based on his status as a former plan participant who contributed financially to the plan. This claim to entitlement is not altered by Ruocco's termination of employment with BEHR.

2. *California Insurance Code Section 10270.65*

BEHR argues that the district court erred because under *California Insurance Code section 10270.65*, BEHR was entitled to retain the Union Mutual surplus.

Section 10270.65 provides:

> If hereafter any dividend is paid or any premium refunded under any policy of group disability insurance heretofore or hereafter issued, the excess, if any, of the aggregate dividends or premium refunds under such policy over the aggregate expenditures for insurance under such policy made from funds contributed by the policyholder, or by an employer of such insured persons or by union or association to which insured persons belong, including expenditures made in connection with the administration of such policy, shall be applied by the policyholder for the benefit of such insured employees generally or their dependents or insured members generally or their **[**10]** dependents. For the purpose of this section and at the option of the policyholder, "policy" may include all group life and disability insurance policies of the policy holder.

Cal.Ins.Code § 10270.65 (West 1972).

The district court made three findings on this issue: first, that the code is not applicable to the facts of this case "since the UNUM distribution was neither a 'premium refund' nor 'dividend' as contemplated by the statute;" second, that because *section 10270.65* "does not contemplate the offsetting of employer costs from all benefit plans before providing the surplus to the participants of the plan," BEHR could only recoup administrative costs incurred in connection with the BEHR long term disability plan; and third, that *section 10270.65* is "preempted by ERISA, as it clearly 'relates to' an employee welfare benefit plan, as codified in *29 U.S.C. § 1144(a)* [1]."

[11]** **[*1237]** BEHR argues that the district court erred in its first holding because the Union Mutual distribution does constitute a "dividend" within the meaning of *section 10270.65*. BEHR argues that the court erred in its second holding because *section 10270.65* allows a policyholder to aggregate the costs incurred in connection with its group life policy. With respect to the third holding, BEHR argues that there is no ERISA preemption because *section 10270.65* deals with the regulation of insurance and therefore is covered by the insurance "saving clause" contained in *section 1144(b)(2)(A)*.

While defendants are correct that the distribution of the surplus constitutes a dividend under *section 10270.65* on which costs can be aggregated, *see* *Luksich v. Kaiser Steel Corp., 245 Cal.App.2d 373, 374-75, 53 Cal.Rptr. 875 (1966)*, we find that *section 10270.65* is preempted under ERISA because it relates to an employee benefit plan within the meaning of *29 U.S.C. section 1144(a)*.

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[1] *29 U.S.C. § 1144(a)* provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

The "saving clause" of § 1144(b)(2)(A) provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any state which regulates **[**12]** insurance, banking, or securities." In determining whether a state's law regulates insurance and therefore is not preempted under section 1144(a), the Supreme Court set forth the following two-part test in Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987):

> In *Metropolitan Life*, we were guided by several considerations in determining whether a state law falls under the saving clause. First, we took what guidance was available from a common sense view' of the language of the saving clause itself. 471 U.S. 724, 740, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985). Second, we made use of the case law interpreting the phrase 'business of insurance' under the McCarran-Ferguson Act, 15 U.S.C. § 1011 et seq., in interpreting the saving clause.

481 U.S. at 48. *See also* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 85 L. Ed. 2d 728, 105 S. Ct. 2380 (1985). With respect to the second-part of this test, the Court set forth the following three criteria for determining whether a practice falls under the 'business of insurance' for purposes **[**13]** of the McCarran-Ferguson Act: [2]

> '*First*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.'

Pilot Life, 481 U.S. at 48-49 (quoting Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129, 73 L. Ed. 2d 647, 102 S. Ct. 3002 (1982)) (emphasis in original).

California Insurance Code section 10270.65 does not regulate insurance within the meaning of either the McCarran-Ferguson Act or ERISA, 29 U.S.C. § 1144(b)(2)(A). This **[**14]** statute fails the first part of the *Metropolitan* test because it does not transfer or spread the policyholder's risk but rather deals merely with the administration of certain policy surplus. The statute fails the second part of the test because it is not an "integral part of the policy relationship" between the insurer and the insured but rather deals with the relationship between the policyholder and the insured. While section 10270.65 is limited to entities within the insurance industry, this alone does not support a finding of insurance regulation within the meaning of section 1144(b)(2)(A). The "saving clause" to ERISA exempts from preemption state regulation of insurance companies and terms of insurance contracts not state regulation of employee benefit plans funded by the insurance industry. [3] **[*1238]** The same conclusion is reached under a "common sense view" of section 10270.65.

[15]** 3. *Asset of the Insurer*

BEHR claims the retained surplus of a group disability carrier is not an asset of a covered plan pursuant to 29 U.S.C. section 1101 and therefore ERISA does not require BEHR to distribute the Union Mutual surplus to participating employees. Section 1101(b)(2) provides that "in the case of a plan to which a guaranteed benefit policy is issued by an insurer, the assets of such plan shall be deemed to include such policy, but shall not, solely by issuance of such policy, be deemed to include any assets of the insurer."

While the premium surplus may have been held as an asset by Union Mutual, this asset was not owned by the insurance company but was part of the interest of the mutually insured in the company. *See* 18 J. Appleman, Insurance Law and Practice § 10059 (1945). As stated, Union Mutual was required to distribute this retained surplus to policyholders prior to its conversion from a mutual insurance company to a wholly-owned subsidiary of a publicly-owned stock corporation. The surplus, therefore, did not constitute an asset of the

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[2] The McCarran-Ferguson Act of 1945 provides that "no act of Congress shall be construed to invalidate, impart, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . ." 15 U.S.C. § 1012(b) (1982).

[3] In reaching this conclusion, we also draw support from the fact that "the express pre-emption provisions of ERISA are deliberately expansive, and designed to 'establish pension plan regulation as exclusively a federal concern.'" Pilot Life, 481 U.S. at 45-46 (quoting Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523, 68 L. Ed. 2d 402, 101 S. Ct. 1895 (1981)); *see also* Board of Trustees v. H.F. Johnson, Inc., 830 F.2d 1009, 1016 (9th Cir. 1987)("ERISA preemption is to be construed broadly").

insurer within the meaning of 29 U.S.C. section 1101(b)(2).

[16]** 4. *Unexpected and Undeserved Windfall*

BEHR contends that the district court erred in awarding the Union Mutual surplus to former employees because the award constitutes an unexpected and undeserved windfall for the employees. In determining who was entitled to the surplus, the district court relied heavily on the Third Circuit's decision in Chait v. Bernstein, 835 F.2d 1017 (3d Cir. 1987). In *Chait*, the court held that an employer could amend an ERISA plan to allow surplus assets to revert to the employer despite the plan's prohibition on amendments to the plan to allow the funds to be used for purposes other than for the exclusive benefit of the employees. The court held that the plan could be so amended because the plan contained no additional language limiting the reversion beyond the "exclusive benefit" provision and because the equities of the case favored the employer's creditors rather than the vested employees. *Id. at 1027*. In reaching this conclusion, the court emphasized the fact that the plan was a "defined benefit plan to which the employees never contributed." On this matter, the court held:

> In the context of **[**17]** a defined-benefit plan to which the employer was the sole contributor that does not contain explicit prohibitory language, we see no congressional policy that would prevent allowing the employer to amend the plan to receive excess assets after paying out all the benefits.

Id. See also Wright v. Nimmons, 641 F. Supp. 1391, 1406-07 (S.D.Tex. 1986) (noting that where a trust plan is silent as to the distribution of assets, if the employer has "exclusively funded a plan," the "unbargained for distribution of excess assets to participants represents an unintended windfall for employees").

In this case, the district court found that the balancing of equities weighed in favor of the plan participants because the premiums for the plan were paid for by the participants and because "outside of minor administrative costs, BEHR paid nothing." The court also found that if the surplus were distributed to the defendants, the fund would not inure to the benefit of the plan participants, but rather "as a result of BEHR's incentive bonus plan, would fall in large part into the hands of BEHR's Executive Committee which had voted to keep the distribution." We agree with **[**18]** the district court that the balance of equities weighs in favor of the plaintiff class.

[*1239] 5. *Resulting Trust*

Next BEHR argues that it is entitled to retain the Union Mutual surplus under the law of trust because BEHR was the creator or settlor of the plan trust. BEHR argues that, as a result of its status as settlor of the trust, when surplus assets remained in the long term disability fund after the trust's purpose had been fulfilled, a resulting trust arose for its benefit. We reject BEHR's argument. BEHR did not pay the premium costs to fund the plan and therefore was neither a 'creator' nor 'settlor' of the trust. *See, e.g.,* Lehman v. Commissioner of Internal Revenue, 109 F.2d 99, 100 (2d Cir.), *cert. denied*, *310 U.S. 637, 60 S. Ct. 1080, 84 L. Ed. 1406 (1940)* (defining settlor as one who furnishes the consideration for a trust).

6. *Financial Risk*

BEHR argues that the district court erred in ordering BEHR to pay its former employees the profits which it earned by exercising the UNUM warrants because BEHR risked its own money in exercising the warrants and could not have provided its former employees with sufficient **[**19]** notice to exercise these warrants given the large number of employees involved. BEHR's argument as to what would have happened had it given the plan participants notice is speculative and does not support a finding that BEHR is entitled to retain the surplus. Nor does the fact that BEHR used its own money to exercise the warrants justify BEHR's retention of the acquired profit.

7. California Commercial Code Section 8315

BEHR argues that the district court erred in finding that the sale of the UNUM stock by defendants constituted a wrongful transfer of securities in violation of California Commercial Code section 8315 which prohibits the wrongful transfer of securities. [4] We disagree. The

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[4] Section 8315(1) of the California Commercial Code states in pertinent part:

> Any person against whom the transfer of a security is wrongful for any reason, . . . as against any purchaser except a bona fide purchaser, may do any of the following:

district court correctly found that section 8315 is a state statute regulating securities and therefore is saved from ERISA preemption under *29 U.S.C. section 1144(b)(2)(A)*. Contrary to BEHR's contention, we find no inconsistency between the district court's finding that *California Insurance Code section 10270.65* is preempted by ERISA because it does *not* regulate insurance and the court's finding that *California Commercial Code section 8315* is not preempted **[**20]** because it *does* regulate securities.

8. *Attorney's Fees*

BEHR argues that the district court erred in awarding attorney fees *sua sponte* because it did not discuss the factors set forth in *Hummell v. S.E. Rykoff & Co., 634 F.2d 446, 452 (9th Cir. 1980)* and did not give the parties an adequate opportunity to address this matter. We disagree. The district court provided BEHR with an opportunity to address the matter when it received BEHR's opposition to the proposed statement of undisputed facts. The district **[**21]** court also considered the *Hummell* factors in determining that an award of attorney's fees was reasonable and appropriate. In *Hummell*, the court held that the following five factors must be considered in determining whether to award attorney's fees under *29 U.S.C. section 1132(g)*:

> (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of fees; (3) whether an award of fees against the opposing parties would deter others from acting in similar circumstances; (4) whether the parties requesting fees sought to benefit all participants and solve a significant legal question regarding ERISA; and (5) the relative merits of the parties' positions.

Hummell, 634 F.2d at 453. The district court in this case applied the *Hummell* test **[*1240]** and found that defendants had the ability to satisfy an award of attorney's fees, that the awarding of fees will deter others from acting in an arbitrary and capricious manner, that Ruocco was seeking to benefit all participants of the BEHR Plan and to resolve significant legal questions concerning ERISA, and that **[**22]** Ruocco's position in this litigation was substantiated on both legal and equitable grounds.

9. *Personal Liability of Bolin and Prush*

While the district court did not err in awarding the Union Mutual surplus and attorney's fees to the plaintiff class, the district court did err in its finding that defendants Bolin and Prush were personally liable in light of its additional finding that neither defendant breached his fiduciary duty or otherwise acted in bad faith. While Bolin and Prush may have benefited by their decision to retain the UNUM surplus under BEHR's bonus incentive program for top executives, there is no evidence that Bolin or Prush did anything personally or that the decision to retain the UNUM surplus was not a corporate act. Likewise, while Bolin and Prush were members of the Executive Committee, the decisionmaking body of BEHR, there is no evidence that they controlled this Committee.

CONCLUSION

We affirm the judgment of the district court awarding the plaintiff class $ 629,423.31 minus administrative costs, and attorney's fees against defendant BEHR. We reverse the court's decision holding defendants Bolin and Prush personally liable. Plaintiff shall recover **[**23]** from defendant BEHR 80 percent of his costs on appeal.

AFFIRMED IN PART, REVERSED IN PART.

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> (a) Reclaim possession of any new certificated security wrongfully transferred.
>
> (b) Obtain possession of any new certificated security representing all or part of the same rights . . .
>
> (d) Have damages.

Schoch v Lake Champlain OB-GYN, P.C.

Supreme Court of New York, Saratoga County

June 7, 2019, Decided

2018-4228

Reporter
2019 N.Y. Misc. LEXIS 3911 *; 2019 NY Slip Op 51176(U) **; 64 Misc. 3d 1215(A); 116 N.Y.S.3d 861

[1]** Kim E. Schoch, CNM, OB/GYN NP, Plaintiff, against Lake Champlain OB-GYN, P.C., Defendant.

Notice: PUBLISHED IN TABLE FORMAT IN THE NEW YORK SUPPLEMENT.

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

Core Terms

premiums, policies, proceeds, unjust enrichment, cash proceeds, named insured, demutualization, escrow, costs, professional liability insurance, doctrine of stare decisis, mutual insurance company, summary judgment motion, grant summary judgment, cash consideration, significant fact, summary judgment, certified nurse, collaborative, practitioners, declaring, Awarding, coverage, requests, bargain, insured, refund, terse

Headnotes/Summary

Headnotes

Insurance—Liability Insurance—Medical corporation, as policy administrator, rather than insured nurse midwife, was entitled to cash proceeds from demutualization of insurance company. *Insurance Law § 7307(e)* (Conversion of domestic mutual property/casualty insurance companies or advance premium corporations into domestic stock property/casualty insurance companies; insurers not in rehabilitation).

Counsel: **[*1]** For Plaintiff: Nolan, Heller Kaufman, LLP, Albany, New York.

For Defendant: Dreyer Boyajian LaMarche Safarnko, Albany, New York.

Judges: ANN C. CROWELL, J.S.C.

Opinion by: ANN C. CROWELL

Opinion

Ann C. Crowell, J.

The plaintiff, Kim E. Schoch, CNM, OB/GYN NP ("Schoch") requests an Order pursuant to *CPLR § 3212* granting summary judgment declaring that Schoch is entitled to $74,747.03 in cash proceeds being held in escrow. The defendant, Lake Champlain OB-GYN, P.C. ("Lake Champlain") requests an Order pursuant to *CPLR § 3212* granting summary judgment declaring that Lake Champlain is entitled to $74,747.03 in cash proceeds being held in escrow.

From June 18, 2007 to February 27, 2015, Schoch was employed by Lake Champlain as a Certified Nurse Midwife (CNM) pursuant to a written employment agreement. Lake Champlain purchased professional

liability insurance for all of its physicians, certified nurse midwives and nurse practitioners, including Schoch, from Medical Liability Mutual Insurance Company ("MLMIC"). New York law does not permit Schoch to practice as a CNM unless she is in a collaborative relationship with enumerated medical practitioners or entities. *See*, Insurance Law §6950 (1). Lake Champlain was able to purchase coverage for Schoch because of her collaborative **[*2]** relationship with Lake Champlain. Lake Champlain selected, bargained for, purchased, controlled and maintained the MLMIC policies for Schoch. Lake Champlain paid all of the premiums for the policies and received any policy dividends or premium reductions. Lake Champlain requested Schoch be listed as the "insured" on the applicable insurance policies that **[**2]** provided her individual coverage while practicing at Lake Champlain in the amount of 1 million/ 3 million dollars. The endorsements to the policy were issued to "Lake Champlain OB-GYN, P.C." Lake Champlain was named as the "Policy Administrator" on the policy. Upon Schoch's departure from the practice in February of 2015, Lake Champlain received the policy cancellation premium refund of $8,664.00. Schoch does not make any claim to the policy refund.

In 2018, MLMIC announced that it was converting from a mutual insurance company into a stock insurance company. As part of the conversion, MLMIC was required to distribute a "cash consideration" to policy holders/members to extinguish their membership interests in an amount calculated upon the premiums paid on the policies. The amount of cash consideration for the policies with Schoch listed **[*3]** as the named insured is $74,747.03.

Schoch's motion for summary judgment relies upon Justice Sedita's March 22, 2019 decision in *Maple-Gate Anesthsiologists, P.C. v Nasrin, 63 Misc 3d 703, 96 N.Y.S.3d 837, 2019 NY Slip Op 29075 [Sup. Ct., Erie Cty. 2019]*. Justice Sedita determined that *Insurance Law § 7307(e)* and the New York State Department of Financial Service's decision on the demutualization of MLMIC required that the cash consideration be paid to the "policyholder," named insured. Justice Sedita found that the practices' allegations of unjust enrichment to be nothing more than bare legal conclusions.

Lake Champlain's cross-motion for summary judgment relies upon the Appellate Division, First Department's decision, issued two and half weeks later on April 4, 2019, in *Schaffer, Schonholz & Drossman, LLP v Title, 171 AD3d 465, 96 N.Y.S.3d 526 [1st Dept. 2019]*. Upon facts submitted to the Appellate Division, First Department pursuant to *CPLR § 3222(b)(3)*, the Court determined:

> "Although respondent was named as the insured on the relevant MLMIC professional liability insurance policy, petitioner purchased the policy and paid all the premiums on it. Respondent does not deny that she did not pay any of the annual premiums or any of the other costs related to the policy. Nor did she bargain for the benefit of the demutualization proceeds. Awarding respondent the cash proceeds of MLMIC's demutualization would result in her unjust enrichment." **[*4]** (citations omitted)

The doctrine of *stare decisis* provides that once a court has resolved a legal issue, it should not be re-examined each and every time it is presented. *Battle v State, 257 AD2d 745, 682 N.Y.S.2d 726 [3d Dept. 1999]* (internal citations omitted). Schoch discounts the Appellate Division, First Department's decision in *Schaffer, Schonholz & Drossman, LLP v Title, supra* based upon its terseness and lack of detail. However terse, the First Department found as a matter of law that an award of the MLMIC proceeds to the named insured doctor would result in her unjust enrichment. The significant facts relied upon by the First Department are not distinguishable from the significant facts in this case. This Court is bound to follow the Appellate Division, First Department until such time as the Appellate Division, Third Department or the Court of Appeal issues a contrary decision. Based upon the doctrine of *stare decisis* Schoch's motion for summary judgment is denied. Lake Champlain's cross - motion for summary judgment is granted.

It is declared that judgment be entered awarding defendant Lake Champlain OB-GYN, P.C. the MLMIC proceeds in the amount of is $74,747.03, plus the interest accrued while the proceeds were in escrow, plus costs and disbursements. Any relief not specifically granted **[*5]** is denied. No costs are awarded to any party. This decision shall constitute the Judgment of the **[**3]** Court. The original Decision and Judgment shall be forwarded to the attorney for defendant Lake Champlain for filing and entry. The underlying papers will be filed by the Court.

Dated: June 7, 2019

Ballston Spa, New York

ANN C. CROWELL, J.S.C.

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At a Motion Term of the Supreme Court of the State of New York, held in and for the Sixth Judicial District, at the Broome County Courthouse, Binghamton, New York on the 28th day of June, 2019.

PRESENT: HON. MOLLY REYNOLDS FITZGERALD
JUSTICE PRESIDING

STATE OF NEW YORK
SUPREME COURT : COUNTY OF BROOME

JENNIFER M. SHOBACK, CNM, f/k/a JENNIFER M. DAVIDSON, CNM,

Plaintiff,

DECISION AND ORDER

-against-

Index No.: EFCA2018003334

BROOME OBSTETRICS AND GYNECOLOGY, P.C,

Defendant.

This declaratory action asks the court to answer the question: When a mutual liability insurance company demutualizes, who is entitled to the distribution payment - the employer, who has paid the premiums, or the employee who is the policyholder?

FACTS

Plaintiff, Jennifer Shoback, was employed by defendant, Broome Obstetrics, as a certified nurse midwife from July, 2015 - August, 2017. Her employment was pursuant to an Employment Agreement which provided the employer would maintain, at its expense, a policy of liability insurance on plaintiff's behalf.

Defendant provided a policy through Medical Liability Mutual Insurance Company,

then a mutual insurance company. Plaintiff was the policyholder and, so as to enable it to make the premium payments, named defendant as her policy administrator. There is no dispute that defendant made all premium payments.

In 2016 MLMIC applied to the New York State Department of Financial Services to file a Plan to convert from a mutual insurance company, a company owned by the policy holders, to a stock insurance company. Such a conversion must comply with the mandates of Insurance Law § 7307, which provides at the time of demutualization, the eligible policyholders of said company shall receive either a cash consideration and/or stock in exchange for the extinguishment of their equitable share of the company.

In this case, the mandates of § 7307 were assimilated into MLMIC's "Conversion Plan". Under New York Insurance Law, such a conversion is allowable only if the policy holders receive consideration for their equitable share. Here, MLMIC chose cash as the consideration. The total amount paid to MLMIC policy holders for the extinguishment of their membership interests would total $2.502 billion. In the case at bar, the disputed cash consideration is $49,273.59.

Plaintiff contends that the policy was provided to plaintiff as compensation for her services and that the cash consideration in question is a result of the extinguishment of a membership interest in the company. As the owner of the policy, and thus the membership interest, the cash consideration should come to her. Defendant argues that since it paid all the premiums on the policy, equity demands it receive the money and that plaintiff will be unjustly enriched if the funds go to her.

Plaintiff has moved for summary judgment, seeking an order from the court declaring that she is entitled to the demutualization distribution funds. In support of her

motion, plaintiff has submitted an attorney's affidavit with attachments, plaintiff's affidavit with attachments, including, inter alia, her employment agreement with defendant, and a memorandum of law in support of her motion. Defendant opposes the motion arguing that it is premature, and that plaintiff has failed to make a prima facie showing of entitlement to summary judgment. In support of its opposition, defendant has filed an attorney's affidavit with attachments including the affidavit of Marybeth Vanderpoole, Practice Manager of Broome Obstetrics and Gynecology, P.C., and a memorandum of law.

LEGAL ANALYSIS

The rights to the proceeds of a demutualization of a mutual insurance company are defined by the company's "Conversion Plan", *Bank of New York v Janowick*, 470 F3d 264, 274 (2012). The Plan in this case was approved by the New York State Department of Financial Services on September 6, 2018 and approved by the policyholders on September 14, 2018. It provided that the policyholders "or their designees" would receive cash for the extinguishment of their membership interests. The plan defines Policyholder as "the Person(s) identified on the declarations page of such Policy as the insured", and Eligible Policyholders as those *policyholders* that had a policy in effect between July 15, 2013 through July 14, 2016. It defines Policy Administrator as the person designated on the declarations page to administer the policy on behalf of the policyholder, and Designees as those 'Policy Administrators...*to the extent designated by the Eligible Policyholders* to receive the portion of the Cash Consideration allocated to such Eligible Policyholder'(emphasis added).

It is undisputed that plaintiff was the insured named on the declarations page, and as such the policyholder; and defendant was the policy administrator. To date, despite

repeated requests from defendant, plaintiff has not named defendant her designee.

The language of the Plan is clear and unambiguous, and as such must be accorded the plain meaning of its terms, *Goldman v Emerald Green Prop. Owner's Assn., Inc.*, 116 AD3d 1279 , 1280 (2014). According to those terms, plaintiff is entitled to the money.

Defendant's argument - that it paid the premiums and as such is entitled to the funds, is unpersuasive. Policyholders in a mutual insurance company acquire two separate types of rights - contractual rights and membership rights. The contractual rights are paid for by the premiums, and pay for the cost of the insurance itself. "The premiums paid covered the rights under the insurance contract, not any membership rights...premium payments go toward the actual cost of the insurance benefits provided", *Dorrance v U. S.*, 809 F3d 479, 485[1].

Here, the defendant paid the premiums as part of its obligation under the Employment Agreement with plaintiff. She provided services and in return defendant was confident that she was covered (and hence it was covered) in terms of malpractice insurance. This arrangement benefitted both parties.

The membership rights are acquired at "no cost", and are in fact, a benefit of being the policyholder, *Dorrance v United States*, at 485. They do not arise as a result of paying the premiums, but are intrinsic to the owner of the policy, the policyholder.

The bottom line is that the cash consideration that is generated as a result of demutualization is a "windfall", or "a pot of money no one expected or even envisioned", *Dorrance* at 486. Here, it was a result of a restructuring of a mutual insurance company

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[1] Defendant argues that Dorrance is not relevant as it is a tax case. While the facts may differ from the case at bar, the legal import of the case lies in its analysis of the demutualization process.

into a stock company. However, negative connotations aside, the fact that this is a "windfall" does not, per se, render it illicit or unjust. The court is certainly inclined to agree with the plain language of the Plan and the Insurance Law that in this case, plaintiff, the policyholder should be entitled to receive it.

However, all of the foregoing is academic in light of *Matter of Schaffer, Schonholz & Drossman, LLP v Title,* 171 AD3d 465, an April, 2019 decision out of the 1st Department. The case involved the very issue before this court (in fact involving the same demutualization of MLMIC), who is entitled to the cash consideration. The Appellate Division found that the medical practice - the entity that had paid the premiums - was entitled to receive the funds and that any other result would unjustly enrich the individual practitioner. Despite a thorough search, the court has not discovered any third department cases that have ruled on this issue. "Where the issue has not been addressed within the Department, Supreme Court is bound by the doctrine of stare decisis to apply precedent established in another Department, either until a contrary rule is established by the Appellate Division in its own Department or by the Court of Appeals", *D'Alessandro v. Carro,* 123 AD3d 1, 6 (2014); *Tzolis v. Wolff*, 39 AD3d 138, 142 (2007); *Mountain View Coach Lines v Storms,* 102 AD2d 663, 664 (1984).

State trial courts must follow a higher court's existing precedent "even though they may disagree", *People v Rivera,* 5 NY3d 61 (2005).

Thus plaintiff's motion for summary judgment is denied. This constitutes the Decision and Order of the Court

Dated: September 10, 2019

HON. MOLLY REYNOLDS FITZGERALD
SUPREME COURT JUSTICE

cc: Justin A. Heller, Esq.
Jared R. Mack, Esq.
Judith E. Osburn, Broome County Chief Court Clerk

Smith v. Chase Manhattan Bank, USA, N.A.

Supreme Court of New York, Appellate Division, Second Department

November 1, 2001, Argued ; April 15, 2002, Decided

2000-08199

Reporter
293 A.D.2d 598 *; 741 N.Y.S.2d 100 **; 2002 N.Y. App. Div. LEXIS 3790 ***

Timothy P. Smith et al., Appellants, v. Chase Manhattan Bank, USA, N.A., et al., Respondents.

Prior History: [*1]** In a purported class action to recover damages for a violation of General Business Law § 349, breach of contract, unjust enrichment, and a violation of Civil Rights Law §§ 50 and 51, the plaintiffs appeal from an order of the Supreme Court, Kings County (Clemente, J.), dated July 27, 2000, which granted the defendants' motion pursuant to CPLR 3211 (a) (1) and (7) to dismiss the complaint.

Counsel: Wolf Popper, LLP, New York, N.Y. (Lester L. Levy and Peter G. A. Safirstein of counsel), and Schoengold & Sporn, P.C., New York, N.Y. (Samuel P. Sporn and Jay P. Saltzman of counsel), for appellants (one brief filed).

Skadden, Arps, Slate, Meagher & Flom, LLP, New York, N.Y. (Andrew L. Sandler of counsel), for respondents.

Judges: NANCY E. SMITH, J.P., SONDRA MILLER, DANIEL F. LUCIANO, ROBERT W. SCHMIDT, JJ. SMITH, J.P., S. MILLER, LUCIANO and SCHMIDT, JJ., concur.

Opinion

[*598] [101]** Ordered that the order is affirmed, with costs.

The plaintiffs, who purport to represent a class of similarly-situated persons, are holders of credit cards and mortgages issued by Chase Manhattan Bank USA, **[***2]** N.A. The plaintiffs commenced this class action against the defendants, Chase Manhattan Bank USA, N.A., and its parent, Chase Manhattan Corporation (hereinafter collectively Chase), alleging five separate causes of action: (1) a violation of General Business Law § 349 (a) for engaging in a deceptive practice, (2) breach of contract, (3) unjust enrichment, (4) a violation of Civil Rights Law § 50, and (5) a violation of Civil Rights Law § 51.

The complaint alleges that Chase violated its commitment to protect customer privacy and confidentiality and not to share customer information with any unrelated third party, except, inter alia, to conduct its business or make available special offers of products and services which might be of interest to customers. This confidentiality commitment was contained in a printed document entitled "Customer Information Principles," which was distributed to the plaintiffs. Allegedly unbeknownst to the plaintiffs, without their consent and without giving the plaintiffs an opportunity to opt out, Chase sold information to nonaffiliated third-party vendors, including the plaintiffs' **[***3]** names, addresses, telephone numbers, account or loan numbers, credit card usage, and other financial data. The third-party vendors used this information and created lists of Chase customers, including the plaintiffs, who might be interested in their products or services. These lists were then provided to telemarketing and direct mail representatives to conduct solicitations. In return for the information, the third-party vendors agreed to pay Chase a commission (of up to 24% of the sale) in the event that a product or service offered were purchased.

The defendants moved to dismiss all five causes of action for **[*599]** failure to state a cause of action. The Supreme Court granted the **[**102]** defendants' motion in its entirety. We affirm.

To establish a cause of action under General Business Law § 349, a plaintiff must prove that the challenged act or practice was consumer oriented, that it was misleading in a material way, and that the plaintiff suffered injury as a result of the deceptive act. Whether a representation or omission, the deceptive practice **[***4]** must be likely to mislead a reasonable consumer acting reasonably under the circumstances. In addition, to recover under the statute, a plaintiff must prove actual injury, though not necessarily pecuniary harm (*see* Stutman v Chemical Bank, 95 NY2d 24, 29; *see also* Small v Lorillard Tobacco Co., 94 NY2d 43;

Oswego Laborers' Local 214 Pension Fund v Marine Midland Bank, 85 NY2d 20).

Presuming the allegations in the complaint to be true, and giving them the benefit of every favorable inference (*see Cron v Hargro Fabrics, 91 NY2d 362, 366)*, to the extent that the plaintiffs alleged that Chase sold confidential customer information to third-party vendors in violation of its document entitled "Customer Information Principles," the complaint alleges actionable deception. However, the plaintiffs have not alleged, and cannot prove, any "actual injury" as is necessary under *General Business Law § 349* (*Stutman v Chemical Bank, supra at 29*; *Small v Lorillard Tobacco Co., supra*; *Oswego Laborers' Local 214 Pension Fund v Marine Midland Bank, supra*). The **[***5]** complaint alleged that Chase's "deceptive acts and practices deceived the plaintiffs and other members of the class, and have directly, forseeably and proximately caused actual damages and injury to the plaintiffs and other members of the class in amounts yet to be determined." These allegations failed to allege any actual harm. Elsewhere in the complaint, the plaintiffs alleged: "the products and services offered to class members as a result of [Chase's] practices of selling class members' confidential financial information included memberships in discount shoppers' clubs, emergency road service plans, dental and legal service plans, travel clubs, home and garden supply clubs, and credit card registration and magazine subscription services."

Thus, the "harm" at the heart of this purported class action, is that class members were merely offered products and services which they were free to decline. This does not qualify as actual harm.

The complaint does not allege a single instance where a named plaintiff or any class member suffered any actual harm due to the receipt of an unwanted telephone solicitation or a **[*600]** piece of junk mail. Accordingly, the court properly **[***6]** dismissed the plaintiffs' General Business Law causes of action.

The plaintiffs seek to recover damages for unjust enrichment based on the profits Chase earned as commissions on the purchases made by members of the plaintiffs' class. "To state a cause of action for unjust enrichment, a plaintiff must allege that it conferred a benefit upon the defendant, and that the defendant will obtain such benefit without adequately compensating plaintiff therefor" (*Nakamura v Fujii, 253 AD2d 387, 390*; *see Wolf v National Council of Young Israel, 264 AD2d 416, 417)*. The plaintiffs failed to state a cause of action to recover damages for unjust enrichment since the members of the plaintiffs' class who made purchases **[**103]** of products and/or services received a benefit. There being no allegation that the benefits received were less than what these purchasers bargained for, it cannot be said that the commissions paid by the third-party vendors to Chase belong to the plaintiffs as a matter of equity (*see Wiener v Lazard Freres & Co., 241 AD2d 114, 121*; **[***7]** *Fandy Corp. v Chang, 272 AD2d 369*; *Bugarsky v Marcantonio, 254 AD2d 384*).

Similarly, the plaintiffs failed to state a cause of action to recover damages for breach of contract. The plaintiffs' allegation of contract damages consisted solely of the phrase "all to the damage of the class." Such a vague and conclusory allegation is insufficient to support a cause of action for breach of contract (*see Gordon v Dino De Laurentiis Corp., 141 AD2d 435, 436)*. Even if the complaint were construed to allege damages for the invasive and unsolicited telephone calls, no cause of action is stated, since damages for emotional distress are insufficient to state a cause of action for breach of contract (*see Wehringer v Standard Sec. Life Ins. Co., 57 NY2d 757, 759)*. In addition, the plaintiffs may not rely on Chase's profits to satisfy the damage element of their cause of action, since the plaintiffs never had any expectation of monetary compensation.

The plaintiffs have failed to state a cause of action under *Civil Rights Law §§ 50* **[***8]** and *51*. *Civil Rights Law §§ 50* and *51*, which must be narrowly construed, were never intended to address the wrongs complained of by the plaintiffs (*see Messenger v Gruner & Jahr Print. & Publ., 94 NY2d 436, 441*, *cert denied 531 US 818*; *Arrington v New York Times Co., 55 NY2d 433, 439*, *cert denied 459 US 1146*).

Smith, J.P., S. Miller, Luciano and Schmidt, JJ., concur.

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Towne Bus Corp. v. Insurance Co. of Greater N.Y.

Supreme Court of New York, New York County

January 18, 2008, Decided

120333/99

Reporter
18 Misc. 3d 1121(A) *; 856 N.Y.S.2d 503 **; 2008 N.Y. Misc. LEXIS 207 ***; 2008 NY Slip Op 50149(U) ****

[**1]** Towne Bus Corp., Plaintiff, against Insurance Company of Greater New York, Defendant.

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

Judges: **[***1]** Emily Jane Goodman, J.

Opinion by: Emily Jane Goodman

Opinion

Emily Jane Goodman, J.

In this action, plaintiff Towne Bus Corp., an insured under a workers' compensation liability insurance policy, seeks the recovery of a policyholder dividend on a renewal policy. Defendant Insurance Company of Greater New York, the insurer, now moves, pursuant to *CPLR 3212*, for summary judgment dismissing the complaint. For the following reasons, the motion is granted.

BACKGROUND The underlying facts are not in dispute. Plaintiff purchased a workers' compensation and employers' liability policy (policy No. 6631003142) from defendant, with a policy period from February 1, 1996 through February 1, 1997 (the original policy) (Hess Affirm., Exh. A, Information Page). Plaintiff was the named insured. The insurance applied to claims brought under the Workers' Compensation Law of the State of New York (*id.*). At the end of that policy period, defendant renewed plaintiff's policy for another year, for a period from February 1, 1997 through February 1, 1998 (the renewal policy) (Hess Affirm., Exh. B, Information Page). [1]

Part Six of the renewal policy permitted plaintiff to cancel the policy (*id.,* Part Six-Conditions [D] [1]). The renewal policy states that the "policy period will end on the day and hour stated in the cancelation notice" (*id.,* Part Six-Conditions [D] [3]).

The policies were "audit premium" policies, where the insured pays estimated premiums, known as deposit premiums, based on estimated payroll for the coming year. After termination of the policy, the insurer audits the policy to determine the earned premium (the actual amount of premium owed to the insurer based on actual payroll information), and generally either refunds the difference to the insured or requires the insured to pay an additional amount. Specifically, Part Five of the renewal policy provides, in relevant part, that:

[**2]** The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium will be determined after this policy ends by using the actual, not the estimated, premium basis and the proper classifications and rates that lawfully apply to the business and work covered by this policy. If **[***3]** the final premium is more than the premium you paid to us, you must pay us the balance. If it is less, we will refund the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.

(*id.,* Part Five-Premium [E]). It further states that, if the insured cancelled the policy, final premium would be determined in the following way unless defendant's manuals provided otherwise: "final premium will be more than pro rata; it will be based on the time this policy was in force, and increased by our short-rate cancelation table and procedure. Final premium will not be less than the minimum premium" (*id.,* Part Five-Premium [E] [2]).

With regard to dividends, the renewal policy states, as in the original policy, that:

[1] The policies state that "[t]his policy includes . . . the Information Page and all endorsements and schedules listed **[***2]** there" (Hess Affirm., Exh. A, General Section [A]; Hess Affirm., Exh. B, General Section [A]).

Dividend: You shall participate in the earnings of the Company to such extent and upon such conditions as shall be determined by the Board of Directors of the Company in accordance with Law and as made applicable to this policy provided that you shall have complied with all of the terms of this policy with respect to the payment of premium.

(*id.,* policy jacket [emphasis in original]).

By letter dated September 15, **[***4]** 1997, plaintiff cancelled its renewal policy effective October 15, 1997, several months before the expiration of the policy. An endorsement reflects that the renewal policy was cancelled at plaintiff's request. Plaintiff replaced its coverage with another insurance carrier.

On October 1, 1997, defendant held a meeting of its Board of Directors, at which it passed a resolution concerning payment of dividends on workers' compensation policies. The minutes state that:

> [T]he Company shall pay a dividend upon Workers Compensation policies written or renewed by the Company and canceled or expiring during the period October 1, 1997, through December 31, 1997, both dates inclusive, as follows:

. . .

(B) On policies upon risks in the State of New York, a dividend plan that is identified as a Workers' Compensation Flat Percentage Dividend Plan, a dividend of 8% of the earned premium on all coverages, upon risks which develop a final annual audited earned premium of $ 50,000.00 or more;

. . .

Provided, however, that:

[**3]** . . .

(3) No dividend shall be payable on policies or renewals thereof which have been canceled prior to their full term of one year, unless such policy or renewal has been canceled after **[***5]** being in effect for six months by the Company upon its initiative for reasons other than non-payment of premium, or unless such policy or renewal has been immediately replaced by another policy written by the Company or its parent.

(Hess Affirm., Exh. C, 10/1/97 Minutes of Board of Directors of Insurance Company of Greater New York, at 2, 3, 4).

Plaintiff thereafter brought the present action. The complaint contains one cause of action for breach of contract for failure to pay dividends on the renewal policy, and seeks damages in an amount of $ 90,000. Defendant counterclaimed against plaintiff for $ 7,104 in unpaid premiums. However, defendant thereafter refunded $ 18,375.95 to plaintiff for unused premium for the renewal policy, and plaintiff does not dispute that it was paid the correct amount for the unused premium (Marksohn Aff., P 4). Thus, the only issue to be resolved is plaintiff's entitlement to a dividend on the renewal policy.

Defendant moves for summary judgment, contending that the issuance of a dividend was within its discretion under case law and under the language of the dividend provision. Thus, plaintiff did not qualify pursuant to the dividend resolution, since plaintiff **[***6]** cancelled the policy prior to the expiration of its full term. [2]

Plaintiff contends first that it expected to share in dividends on a pro rata basis. According to plaintiff, defendant's construction of the dividend provision of the policy impermissibly places plaintiff at defendant's mercy, because every contract contains an implied obligation of good faith and fair dealing. And, the dividend provision only requires that it complied with all of the terms of the policy with respect to the payment of premiums, which it undisputedly did. Second, plaintiff was never provided with a copy of the renewal policy, and thus it would be unjust to bind it to terms of **[***7]** which it was not aware. Third, the language of the policy is ambiguous in that it did not provide plaintiff with notice of the severe financial consequences of early cancellation. In addition, plaintiff requests, through its attorney's affirmation and without serving a separate notice of cross motion, that summary judgment be granted in its favor.

In reply, defendant does not dispute plaintiff's assertion that it was never provided with a copy of the renewal policy, but argues that it knew the terms because the original policy was automatically renewed by operation

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[2] Defendant also submits affidavits stating that an audit of the original policy determined that the total earned premium was $ 1,117,245, less a deposit premium of $ 1,155,251, which left a credit of $ 38,006 to plaintiff. Plaintiff's dividend in the sum of $ 167,587 for the original policy was then added to that credit, for a total credit of $ 205,593 for the original policy (Salik Aff., P 3; D'Onofrio Aff., PP 5-6). However, plaintiff's only claim is with respect to the renewal policy, not the original policy (Complaint, PP 6-8).

of *Workers' Compensation Law § 54* for a one-year period on the same terms.

[**4] DISCUSSION**

An insurance "dividend" is an adjustment of the premium between the original estimate and the actual amount found to have been necessary in retrospect (*Kern v John Hancock Mut. Life Ins. Co., 8 AD2d 256, 259, 186 N.Y.S.2d 992 [1st Dept 1959]*, *affd 8 NY2d 833, 168 N.E.2d 532, 203 N.Y.S.2d 92 [1960]*). In other words, an insurance dividend is a partial return to the policyholder of the amount it was charged for the insurance (*Spencer, White & Prentis, Inc. v City of New York, 262 App Div 285, 286, 28 N.Y.S.2d 401 [1st Dept]*, *lv denied 262 App Div 992, 30 N.Y.S.2d 809 [1941]*; *Scholem v Prudential Ins. Co., 172 Misc 664, 665, 15 N.Y.S.2d 947 [Sup Ct, NY County 1939]*). **[***8]** Therefore, the distribution of an insurance dividend is not akin to a division of surplus among stockholders of record (*Kern, 8 AD2d at 259*). "The declaration of a dividend upon a policy reduces pro tanto the cost of insurance to the holder of the policy. That is its purpose and effect" (*Rhine v New York Life Ins. Co., 273 NY 1, 13, 6 N.E.2d 74 [1936]*).

Defendant contends that the courts have upheld the power of an insurer's Board of Directors to declare policyholder dividends. It is true that an insurer's directors have broad discretion as to the determination of surplus, how much of the surplus should be retained by the company, and how much of the surplus should be distributed to policyholders [3] (*Rhine, 273 NY at 8*; *Greeff v Equitable Life Assur. Socy., 160 NY 19, 32, 54 N.E. 712 [1899]*; *Kern, 8 AD2d at 262*; *see generally* 5 Couch on Ins. § 80:51 [3d ed 2007]). The distribution to policyholders of surplus is known as "equitable apportionment" (*Rhine, 273 NY at 8* [internal quotation marks omitted]). Courts will not interfere unless there has been bad faith, willful neglect, or abuse of discretion (*Greeff, 160 NY at 32*). However, plaintiff is not challenging the manner in which defendant computed the dividend, **[***9]** nor is it seeking to compel defendant to declare the dividend in some other manner. Rather, plaintiff is suing defendant for breach of contract for its share of the dividends on the renewal policy (*see Kern, 8 AD2d at 263*).

Insurance Co. of Greater NY v Glen Haven Residential Health Care Facility (253 AD2d 378, 676 N.Y.S.2d 176 [1st Dept 1998]), relied upon by defendant, is not dispositive of the issues in this case. There, the Appellate Division, First Department, stated that "[w]e also agree with the IAS Court that the payment of dividends was within plaintiff's discretion, and that plaintiff was justified in refusing to pay a dividend to defendant based on defendant's failure to meet its obligation to pay the premium" (*id. at 379*). A review **[***10]** of the record on appeal reveals that the dividend provision in that case was identical to the one in this case. Here, in contrast, defendant does not dispute that plaintiff paid its premium until the date of cancellation, when the policy period ended. In fact, defendant remitted $ 18,375.95 in unused premium to plaintiff after the renewal policy was cancelled.

Thus, the court turns to the terms of the renewal policy. "Workers' compensation insurance policies are no more than contracts, and as such are governed by the ordinary rules of contractual construction" (*Commissioners of State Ins. Fund v Photocircuits Corp., 20 AD3d **[****5]** 173, 180-181, 798 N.Y.S.2d 367 [1st Dept 2005]*). Where the terms of an insurance contract are clear and unambiguous, they must be given their plain and ordinary meaning, and the interpretation of such terms is an issue of law for the court (*see City of New York v Continental Cas. Co., 27 AD3d 28, 31, 805 N.Y.S.2d 391 [1st Dept 2005]*).

An unambiguous provision is one that is not "reasonably susceptible of more than one interpretation" (*McCabe v Witteveen, 34 AD3d 652, 654, 825 N.Y.S.2d 499 [2d Dept 2006]* [internal quotation marks and citation omitted]; *see also Broad St., LLC v Gulf Ins. Co., 37 AD3d 126, 131, 832 N.Y.S.2d 1 [1st Dept 2006]*, **[***11]** quoting *Breed v Ins. Co. of N. Am., 46 NY2d 351, 355, 385 N.E.2d 1280, 413 N.Y.S.2d 352 [1978]*, *rearg denied 46 NY2d 940, 415 N.Y.S.2d 1027 [1979]* ["contract is unambiguous if the language has a definite and precise meaning, unattended by danger of misconception in the purport of the [agreement] itself, and concerning which there is no reasonable basis for a difference of opinion'"]). "[T]he test to determine whether an insurance contract is ambiguous focuses on the reasonable expectations of the average insured upon

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[3] The purpose of this retention of surplus' funds . . . is to cover all the insurer's risks and obligations, as well as to insure the security of its policyholders in the future as well as the present, and to cover any contingencies that may arise, or that may be fairly anticipated" (5 Couch on Ins. § 80:51 [3d ed 2007]). In determining the amount of surplus to be credited as dividends, the insurer typically considers the amount of premiums paid (*id.*, § 80:54).

reading the policy'" (*Penna v Federal Ins. Co., 28 AD3d 731, 732, 814 N.Y.S.2d 226 [2d Dept 2006]*, quoting *Matter of Mostow v State Farm Ins. Cos., 88 NY2d 321, 326-327, 668 N.E.2d 392, 645 N.Y.S.2d 421 [1996]*). But a literal construction which places one party at the mercy of the other should be avoided, if possible (*McGrail v Equitable Life Assur. Socy. of U.S., 292 NY 419, 424, 55 N.E.2d 483, rearg denied 293 NY 663, 56 N.E.2d 258 [1944]*; *Lowy & Donnath v City of New York, 98 AD2d 42, 45, 469 N.Y.S.2d 760 [1st Dept 1983], affd 62 NY2d 746, 465 N.E.2d 369, 476 N.Y.S.2d 830 [1984]*; *Jacobowitz v Mutual Benefit Health & Acc. Assn., 10 AD2d 159, 162, 198 N.Y.S.2d 7 [1st Dept 1960]*).

If the terms of an insurance contract are ambiguous, the terms must be construed in favor of the insured and against the insurer, the drafter of the policy language (*Marshall v Tower Ins. Co. of NY, 44 AD3d 1014, 1015, 845 N.Y.S.2d 90 [2d Dept 2007]*; **[***12]** *Tower Ins. Co. of NY v Breyter, 37 AD3d 309, 830 N.Y.S.2d 122 [1st Dept 2007]*; *242-44 E. 77th St., LLC v Greater NY Mut. Ins. Co., 31 AD3d 100, 105, 815 N.Y.S.2d 507 [1st Dept 2006]*). However, the terms of an insurance contract are not ambiguous simply because the parties interpret the language differently (*Commercial Union Ins. Co. v Liberty Mut. Ins. Co., 36 AD3d 645, 645-646, 828 N.Y.S.2d 479 [2d Dept 2007]*).

In the instant case, the renewal policy states that plaintiff "shall participate in the earnings of the Company to such extent and upon such conditions as shall be determined by the Board of Directors of the Company in accordance with Law and as made applicable to this policy provided that [plaintiff] shall have complied with all of the terms of this policy with respect to the payment of premium" (Hess Affirm., Exh. B, policy jacket). The plain language of this provision is clear and unambiguous. Although the provision states that plaintiff "shall" participate in the earnings of the Company, this phrase is clearly modified by "*upon such conditions as shall be determined by the Board of Directors of the Company.*" Any reasonable insured would read this provision to mean that defendant's Board of Directors had the discretion to make **[***13]** payments of any dividends, and that dividends were not guaranteed. The court is not free to rewrite the insurance contract based upon plaintiff's subjective interpretation of the policy language or notions of fairness (*see Broad St., LLC, 37 AD3d at 131*, quoting *Bretton v Mutual of Omaha Ins. Co., 110 AD2d 46, 49, 492 N.Y.S.2d 760 [1st Dept], affd 66 NY2d 1020, 489 N.E.2d 1299, 499 N.Y.S.2d 397 [1985]* [" [a] court, no matter how well intentional, cannot create policy terms by implication or rewrite an insurance contract. Nor should a court disregard the provisions of an insurance contract which are clear and unequivocal'"]). While the covenant of good faith and fair dealing is implicit in every contract, it cannot be used to add terms to a contract between two sophisticated parties, as here (*see D & L Holdings v Goldman Co., 287 [****6] AD2d 65, 73, 734 N.Y.S.2d 25 [1st Dept 2001], lv denied 97 NY2d 611, 769 N.E.2d 351, 742 N.Y.S.2d 604 [2002]*). Moreover, plaintiff was aware of the terms of the renewal policy since the relevant terms were identical to those in the original policy, and the original policy was automatically renewed in the absence of notice of defendant's intention not to renew that policy (*see Workers' Compensation Law § 54 [5]*).

On October 1, 1997, the Board of Directors made **[***14]** a resolution to pay dividends on policies covering risks in New York, but not for "policies or renewals thereof which have been canceled [by the insured] prior to their full term of one year, . . . [] unless such policy or renewal has been immediately replaced by another policy written by the Company or its parent" (Hess Affirm., Exh. B, at 4). Plaintiff cancelled its policy approximately eight months into the renewal policy, and did not replace its policy with defendant, and thus, did not pay premiums for the entire one-year period of the renewal policy. Notably, plaintiff does not allege or claim here that defendant abused its discretion or made this determination in bad faith (*see Rhine, 273 NY at 8*). [4] Therefore, plaintiff was not entitled to a dividend.

Accordingly, it is

ORDERED that the motion by defendant Insurance Company of Greater New York for summary judgment is granted and the complaint is dismissed with costs and disbursements to defendant as taxed by the Clerk of the Court upon the submission of an appropriate bill of costs; and it is further

ORDERED that the Clerk is directed to enter judgment accordingly.

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[4] Plaintiff appears to argue that defendant unfairly discriminated against it by failing to pay a dividend, relying upon *Fidelity & Cas. Co. of NY v Metropolitan Life Ins. Co. (42 Misc 2d 616, 248 N.Y.S.2d 559 [Sup Ct, NY County 1963])*. However, that case dealt with equitable apportionment of dividends (*id. at 627*). In this case, plaintiff did not receive any dividends at all, and does not claim that any insured that cancelled early did in fact receive **[***15]** any dividends.

This Constitutes the Decision and Order of the Court.

Dated: January 18, 2008

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Urgent Med. Care, PLLC v Amedure

Supreme Court of New York, Greene County

July 12, 2019, Decided

19-0121

Reporter
2019 N.Y. Misc. LEXIS 4039 *; 2019 NY Slip Op 51188(U) **; 64 Misc. 3d 1216(A); 117 N.Y.S.3d 459

[1]** Urgent Medical Care, PLLC, Plaintiff, against Amy J. Brueckner Amedure, Defendant.

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

Counsel: [*1] For Plaintiff: JOHN D. ASPLAND, JR., ESQ., FITZEGERALD MORRIS BAKER FIRTH P.C., Glens Falls, NY.

For Defendant: MICHAEL R. FRASCARELLI, ESQ., CATANIA, MAHON, MILLIGRAM & RIDER, PLLC, Newburgh, New York.

Judges: RAYMOND J. ELLIOTT, III, Supreme Court Justice.

Core Terms

policyholders, MLMIC, demutualization, premiums, unjust enrichment, designation, Eligible, proceeds, mutual insurance company, motion to dismiss, conversion, casualty, equitable, ownership, parties, ownership interest, insurance company, premium payment, malpractice, membership, insurer, rights, https, stock

Headnotes/Summary

Headnotes

Insurance—Liability Insurance—Cash Proceeds from Demutualization of Insurance Company—Unjust Enrichment. Equity—Unjust Enrichment—Cash Proceeds from Demutualization of Insurance Company.

Opinion by: RAYMOND J. ELLIOTT

Opinion

Raymond J. Elliott, III, J.

When a person lawfully receives a payment for an ownership interest that was created through payments made by another person, can a claim be stated, based in equity, for unjust enrichment? In short, that is the issue this motion requires the Court to resolve.

Defendant worked as a doctor in a practice owned by Plaintiff. Plaintiff paid Defendant's malpractice premiums. Due to the demutualization of a malpractice insurance provider, **[**2]** Defendant received a payment of nearly double the amount of three years' worth of premium payments for her ownership interest in that company. Plaintiff is suing Defendant alleging that Defendant has become unjustly enriched through receipt of these proceeds since Plaintiff paid the premiums throughout the relevant period and believes it

has an equitable claim to the distribution. Before the Court is Defendant's Motion to Dismiss. Plaintiff has submitted an Amended Summons **[*2]** and Complaint correcting the previously erroneously named Plaintiff. Defendant does not contest the amendment; however, she elects to have her Motion applied to the new pleadings.

Motion to Dismiss

/i>

*In determining a motion to dismiss a complaint, the court's role is ordinarily limited to determining whether the complaint states a cause of action (see Frank v Daimler Chrysler Corp., 292 AD2d 118, 121, 741 N.Y.S.2d 9 [1st Dept 2002]). The court must "accept the facts as alleged in the complaint as true, accord plaintiff the benefit of every possible favorable inference, and determine only whether the facts as alleged fit within any cognizable legal theory" (Nonnon v City of New York, 9 NY3d 825, 826, 874 N.E.2d 720, 842 N.Y.S.2d 756 [2007]). "The sole criterion on a motion to dismiss is whether the pleading states a cause of action, and if from its four corners factual allegations are discerned which taken together manifest any cognizable action at law, a motion for dismissal will fail" (Harris v IG Greenpoint Corp., 72 AD3d 608, 609, 900 N.Y.S.2d 44 [1st Dept 2010]). "A motion [to dismiss] must be decided without regard to evidence submitted by defendants, unless that evidence 'conclusively establishes the falsity of an alleged fact'" (ARB Upstate Communications LLC v R.J. Reuter, L.L.C.., 93 AD3d 929, 930, 940 N.Y.S.2d 679 [3d Dept 2012], citing Gray v Schenectady City School Dist., 86 AD3d 771, 772, 927 N.Y.S.2d 442 [3d Dept 2011]). "Whether the complaint will later survive a motion for summary judgment, or whether the plaintiff will ultimately be able to prove its claims, of course, plays no part in the determination **[*3]** of the motion to dismiss" (Shaya B. Pacific, LLC v Wilson, Elser, Moskowitz, Edelman & Dicker, LLP, 38 AD3d 34, 38, 827 N.Y.S.2d 231 [2nd Dept 2006], citing EBC I, Inc. v Goldman, Sachs & Co., 5 NY3d 11, 19, 832 N.E.2d 26, 799 N.Y.S.2d 170 [2005]). Even were this Court to have doubts about the viability of the claim, the existence of potentially meritorious claims within the record, even if inartfully pleaded, requires denial of a motion to dismiss (see Rovello v Orofino Realty Co., 40 NY2d 633, 635, 357 N.E.2d 970, 389 N.Y.S.2d 314 [1976]).*

Unjust Enrichment

Although "unjust enrichment is not a catchall cause of action to be used when others fail" (Corsello v Verizon New York, Inc., 18 NY3d 777, 790, 967 N.E.2d 1177, 944 N.Y.S.2d 732 [2012]), the Court of Appeals has noted the broad equity jurisdiction of the Courts and our power to correct unjust enrichment, going so far as to cite Aristotle in this context, stating "[l]aw without principle is not law; law without justice is of limited value. Since adherence to principles of 'law' does not invariably produce justice, equity is necessary" (Simonds v Simonds, 45 NY2d 233, 239, 380 N.E.2d 189, 408 N.Y.S.2d 359 [1978]). To recover under a theory of unjust enrichment, "[a] plaintiff 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" (New York State Workers' Compensation Bd. v Program Risk Mgt., Inc., 150 AD3d 1589, 1594, 55 N.Y.S.3d 790 [3d Dept 2017] [internal quotation marks, brackets and citations omitted]; see Georgia Malone & Co., Inc. v Rieder, 19 NY3d 511, 516, 973 N.E.2d 743, 950 N.Y.S.2d 333 [2012]).

*"The essence of such a cause of action is that one party is in possession of money or property that rightly belongs to another" (Clifford R. Gray, Inc. v LeChase Const. Servs., LLC, 31 AD3d 983, 988, 819 N.Y.S.2d 182 [3d Dept 2006]). This requirement of ownership **[*4]** is in the context of an **[**3]** equitable claim, not legal ownership rights; therefore, a party may be legally entitled to a benefit through a contract but still equitably owe those funds to another (see Simonds v Simonds, 45 NY2d at 239; see also Restatement [Third] Restitution and Unjust Enrichment § 26, Illustration 11). "'The essential inquiry in any action for unjust enrichment or restitution is whether it is against equity and good conscience to permit the defendant to retain what is sought to be recovered'" (Goel v Ramachandran, 111 AD3d 783, 791, 975 N.Y.S.2d 428 [2013], quoting Paramount Film Distrib. Corp. v State of New York, 30 NY2d 415, 421, 285 N.E.2d 695, 334 N.Y.S.2d 388 [1972], cert denied 414 U.S. 829, 94 S. Ct. 57, 38 L. Ed. 2d 64 [1973]).*

"[I]t is not prerequisite of unjust enrichment claim that one enriched commit wrongful or unlawful act" (Mayer v Bishop, 158 AD2d 878, 878, 551 N.Y.S.2d 673 [3d Dept 1990], lv denied 76 NY2d 704, 559 N.E.2d 677, 559 N.Y.S.2d 983 [1990]). A claim for unjust enrichment "is undoubtedly equitable and depends upon broad considerations of equity and justice" (Paramount Film Distrib. Corp. v State of New York, 30 NY2d at 421. "In determining whether this equitable remedy is warranted,

*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" (Betz v Blatt, 160 AD3d 696, 701, 74 N.Y.S.3d 75 [2d Dept 2018] [internal quotation marks and citations omitted]). Ultimately, "to determine whether there has indeed been unjust enrichment the inquiry must focus on the 'human setting involved', not **[*5]** merely upon the transaction in isolation" (Mayer v Bishop, 158 AD2d at 880, quoting McGrath v Hilding, 41 NY2d 625, 629, 363 N.E.2d 328, 394 N.Y.S.2d 603 [1977])*.

Statement of Facts

In 2018, Medical Liability Mutual Insurance Company (hereinafter MLMIC) approved a demutualization, resulting in a payment based on the ownership interest in the insurance policy at issue in this suit, which Plaintiff believes to be approximately $57,000 [Amended Complaint ¶ 19]. Defendant worked as a doctor for Plaintiff from 2009 until December 2018. Defendant swears she obtained a policy with MLMIC to provide malpractice coverage prior to her employment with Plaintiff [Defendant's Affidavit: ¶ 7]. Defendant states that not until 2011, when she ended her private practice, did Plaintiff assume responsibility for the MLMIC premiums [Defendant's Affidavit: ¶ 7-8]. Defendant asserts that she agreed to diminished compensation and the premium payments were "in lieu of" an increase in salary [Defendant's Affidavit: ¶ 8].

*Plaintiff alleges that "[a]s a provider of health care services, Plaintiff's liability protection needs required all employees, providing health care services, to be covered by insurance" [Amended Complaint ¶ 4]. Therefore, "during the course of her employment and specifically for the period of July **[*6]** 15, 2013 through July 14, 2016, [Defendant] was covered with malpractice insurance by [Plaintiff]" [Plaintiff's Affidavit: ¶ 4]. Plaintiff alleges that "[d]espite the fact that [it] was maintaining the policy and making the premium payment directly to the insurer, through a clerical error, [Plaintiff] was mistakenly listed as the policy administrator" [Plaintiff's Affidavit: ¶ 6]. Further, Plaintiff asserts that "the premiums were simply an operating/overhead expense of [Plaintiff]" and not an employee benefit [Plaintiff's Affidavit: ¶ 7].*

Demutualization

The New York Superintendent of Financial Services' September 6, 2018, decision (hereinafter DFS Decision) explains the nature of the demutualization and the ownership stake as follows:

> *A mutual insurance company is owned by and operated for the benefit of its policyholders. A policyholder's ownership interest in a mutual company is known as a **[**4]** "membership interest." These membership interests provide policy holders with certain benefits, including the right to vote on matters submitted to a vote of members such as the election of directors, and the right to receive a distribution of profits earned by the mutual insurance company in the **[*7]** form of a dividend. Membership interests are not freely transferrable; they exist only in connection with a policyholder's ownership of a policy.*
>
> *When a demutualization occurs, membership interests in the mutual insurance company are converted to equity interests in the converted stock insurance company and eligible policyholders of the mutual insurance company thereby become shareholders of the converted stock insurance company. Under the Insurance Law, a plan of conversion is the operative document governing a demutualization, with such document subject to various procedural requirements and the Superintendent's approval. In the case of a property/casualty insurer such as MLMIC, such approval is subject to the standards set forth in Insurance Law § 7307 (h) (1) [DFS Decision p. 3-4].*

*Demutualization has been referred to as a "windfall" in some cases because it is often unclear if parties knew the ownership stake even existed prior to the demutualization plan (see e.g. Bank of New York v Janowick, 470 F3d 264, 272 [6th Cir 2006] ["Here, it is clear that none of the parties expected to receive the demutualization proceeds, which will constitute a windfall to whoever receives them"]; see also Ruocco v Bateman, Eichler, Hill, Richards, Inc., 903 F2d 1232, 1238 [9th Cir 1990]; Chicago Truck Drivers, Helpers & Warehouse Workers Union (Indep.) Health & Welfare Fund v. Local 710, Int'l Bhd. of Teamsters, Chicago Truck Drivers, Helper & Warehouse Workers Union (Indep.) Pension Fund, No. 02 C 3115, 2005 U.S. Dist. LEXIS 42877, 2005 WL 525427, at *4 [ND Ill March 4, 2005]). Following the trend of demutualization in the life insurance industry one expert **[*8]** wrote, regarding*

property/casualty insurance as at issue here, that "[m]ost policyholders in such companies—including not only individuals but businesses, non-profit institutions, and municipalities—are undoubtedly unaware that they have substantial rights as owners which could be realized in the form of stock ownership, or in cash or otherwise, upon demutualization" (Peter M. Lencsis, Demutualization of New York Domestic Property/casualty Insurers, NY St BJ 42 [October 1998]).

MLMIC Demutualization

A recent Supreme Court case (Sedita III, J.) lays out the relevant history of this transaction:

> *The MLMIC Board of Directors approved a proposed transaction by which MLMIC would demutualize, convert to a stock insurance company, and be acquired by the National Indemnity Company (NICO) for $2.502 billion. The MLMIC Board later adopted a plan of conversion, whereby cash consideration would be paid to policyholders/members in exchange for the extinguishment of the policyholder membership interests. Pursuant to § 8.2 (a) of the Plan of Conversion (the Plan), "Each Eligible Policyholder (or it's designee) shall receive a cash payment in an amount equal to the applicable conversion." Pursuant to § 2.1 of the **[*9]** Plan, an "eligible policyholder" was the person designated as the insured, while a "designee" meant employers or policy administrators, "designated by Eligible Policyholders to receive the portion of the Cash Consideration allocated to such Eligible Policyholders." The Plan did not provide for the policy administrator to receive cash consideration absent such a designation from the policyholder/member*.
>
> *The New York Superintendent of Financial Services held a public hearing and approved the Plan. In her September 6, 2018 decision (DFS Decision), the Superintendent wrote: "MLMIC's eligible policyholders will receive cash consideration. 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 explicitly provides that each Eligible Policyholder's equitable share of the purchase price shall be determined based on the amount of the net premiums paid on eligible policies" (DFS Decision, p.4)*.
>
> *The DFS Decision also acknowledged testimony and written comments from medical groups. Nearly identical **[*10]** to the plaintiff's contentions in this case, the medical groups had argued that the cash consideration belonged to them because they had paid the premiums on behalf of the policyholders and/or had acted as the policy administrators. Addressing these arguments, the Superintendent of Financial Services wrote: "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." Such a claim would be, "decided either by agreement of the parties or by an arbitrator or court" (DFS Decision, p.25)*.

(Maple-Gate Anesthesiologists, P.C. v Nasrin, 63 Misc 3d 703, 704, 96 N.Y.S.3d 837 [Sup Ct, Erie County 2019, Sedita III, J.]).

Ownership Interest: Policyholder vs. Policy Administrator

*Both Insurance Law § 3435 and Regulation 135 (11 NYCRR 153) permit the issuance of group property/casualty insurance only with respect to public and not-for-profit insureds. Thus, under New York law with the limited exception of a risk retention group authorized under Federal law, group property/casualty **[*11]** insurance for physician groups may not be written in New York (see Office of General Counsel, Department of Financial Services, New York Medical Professional Liability Insurance [June 4, 2008] OGC Op No 08-06-02, available at https://www.dfs.ny.gov/insurance/ogco2008/rg080602.htm). Therefore, as a matter of course, medical malpractice insurance must generally be acquired for each provider rather than for a group. Thus, regardless for who paid the premium, the providers were the policyholders*.

"A court may take judicial notice of matters of public

record, such as an incontrovertible official document or other reliable documents, the existence and accuracy of which are not disputed, and information culled from public records" (10A Carmody-Wait 2d § 56:33; see Matter of 60 Mkt. St. Assoc. v Hartnett, 153 AD2d 205, 208, 551 N.Y.S.2d 346 n [3d Dept 1990], affd 76 NY2d 993, 565 N.E.2d 1264, 564 N.Y.S.2d 713 [1990]; Matter of Sunhill Water Corp. v Water Resources Commn., 32 AD2d 1006, 1008, 301 N.Y.S.2d 935 [3d Dept 1969]). As both parties rely significantly on the demutualization process approved by the New York Superintendent of Financial Services, this Court finds it appropriate to take judicial notice of the entire record of the process as provided through the New York Superintendent of Financial Services (see Department of Financial Services, Public Hearings and Decisions: Medical Liability Mutual Insurance Company [MLMIC] ***[*12]*** *Demutualization Plan of Conversion from Property and Casualty Mutual Insurance Company to Property and Casualty Stock Insurance Company, available at* ***[**5]*** *https://www.dfs.ny.gov/reports_and_publications/public_hearings [Last Accessed July 12, 2019]).*

Although the provider was the policyholder, MLMIC's counsel explained in written testimony that "a Policy Administrator is a Person designated by a Policyholder to act as administrator of the Policy for certain specified purposes. Designations are made on a form provided by MLMIC as part of the application process or at any point in time selected by the Policyholder. The form has been available on-line continuously throughout the Eligibility Period. Designations received as part of the application process are reflected on the declaration page of the applicable Policy. Policy Administrators can also be 'otherwise designated' by the submission of the prescribed form by the Policyholder following the issuance of the Policy. In such a case, the Policy Administrator would not be named on the declarations page of the Policy until the Policy is renewed, but an endorsement to the Policy would be issued in the interim" (Willkie Farr & Gallagher LLP, ***[*13]*** *Written Testimony at Public Hearing In the Matter of Medical Liability Mutual Insurance Company, [August 28, 2018], available at https://www.dfs.ny.gov/docs/about/hearings/mlmic_08232018/willkie.pdf).*

As part of the hearing process, several representatives for hospitals and other practices expressed concerns regarding the distribution of proceeds of the demutualization. MLMIC's Plan of Conversion (MLMIC, Plan of Conversation of Medical Liability Mutual Insurance Company, available at https://www.mlmic.com/wp-content/uploads/2018/09/mlmic_plan_of_conversion.pdf [June 15, 2018]), included "Schedule I: Objection Procedures." This procedure created a process for Policy Administrators to object to the distribution to the policyholder, causing the payment to be escrowed. The fact that the plan itself contemplated objections between policy administrators and policyholders creates, at least some, inference of acknowledge that these proceeds would be in dispute.

A significant point of contention exists regarding the nature of the policy administrator designation. Dr. Richard Frimer of Maple Medical LLP testified that his practice made all the premium payments "actually suffering sometimes to ***[*14]*** *pay the premiums" (Department of Financial Services, Hearing Transcript, 124-134, [August 23, 2018], available at https://www.dfs.ny.gov/system/files/documents/2019/01/mlmic_transcript_20180823.pdf [hereinafter Hearing Transcript]). Frimer testified that despite MLMIC's estimate of 40 percent of policyholders having a different policy administrator, the common practice for many practices, including his own was for premiums to be paid on behalf of employees without designation [Hearing Transcript p.127-128]. Frimer also asserted that although the designation may have existed within the period at issue for calculating the proceeds, the designation has not always existed, thereby longtime employees could have a policy beginning before designation was even possible [Hearing Transcript p.131].*

Frimer's testimony was further corroborated by one hospital system that went so far as book approximately $24 million in proceeds as part of their cash flow projection due to their belief that as the payor of the premiums, they were entitled to the payment [Hearing Transcript p.156-176]. That testimony also noted the obstacle to group policies forcing the current conflict [Hearing Transcript p.170]. ***[*15]*** *In response to this testimony, the Superintendent specifically noted that that "nothing in this procedure prevent anyone from exercising whatever legal rights they have" [Hearing Transcript p. 175].*

These examples are emblematic of multiple oral and written testimonies that were provided to the Department of Financial Services regarding the claims of employers having paid ***[**6]*** *the premiums to MLMIC and having acted as the owners of the policy, despite not being the policyholders or, in some cases, even declared as the policy administrator. Notably, MLMIC's*

counsel submitted written testimony that stated, "In all events [regarding declaration of a Policy Administrator] there must be an affirmative designation in writing on MLMIC's prescribed form. The mere acceptance of a policy application and premium on a Policy from a Person not designated by the Policyholder as a Policy Administrator does not confer the status of Policy Administrator on such Person" [Willkie Farr & Gallagher LLP, Written Testimony].

The DFS Decision stated that "[t]he Objection Procedure provides a reasonable framework for the resolution of disputes between certain policyholders and entities that claim to be Policy Administrators. ***[*16]*** *Importantly, the Objection Procedure does not, in any way, impact any person's rights to resolve their dispute in any forum of their choosing or as required by contract or law. Rather, the sole purpose of the Objection Procedure is to create a category of disputed claims for which the cash consideration attributable to such claims will be placed in an escrow and released by MLMIC upon one of two events: MLMIC either receives (a) 'joint written instructions from the Eligible Policyholder and the Policy Administrator . . . as to how the allocation is to be distributed,' or (b) 'a non-appealable order of an arbitration panel or court with proper jurisdiction ordering payment of the allocation to the Policy Administrator . . . or the Eligible Policyholder'" (DFS Decision p.23).*

First, the Court need not now resolve the dispute regarding what creates a policy administrator. Second, the Court does not, at this time, credit or give weight to the testimony provided at the hearing except to merely put context to the DFS Decision. Both the Superintendent's statement at the hearing and the decision's clear language stating that "the Objection Procedure does not, in any way, impact any person's ***[*17]*** *rights to resolve their dispute in any forum of their choosing or as required by contract or law" clearly establish that the Department of Financial Services did not resolve the issues around equitable claims nor did they seek to in any way limit the ability of parties to bring these claims.*

Precedent

There is a dearth of case law regarding demutualization of a property/casualty insurance company. Significantly, much of the case law that does exist is in the context of mutual life insurance and is driven by state law as well as the Federal Employee Retirement Income Security Act (hereinafter ERISA).

In Maple-Gate Anesthesiologists, P.C. v Nasrin, (supra), Supreme Court considered similar claims to those at issue here. The Court dismissed the complaint finding there was no claim of ownership and, therefore, no claim of unjust enrichment. Notably, in that case there were written employment agreements defining the relationship between the parties, which stated that "professional liability insurance premiums as an 'employment benefit for and on behalf of' the employee" (Maple-Gate Anesthesiologists, P.C. v Nasrin, 63 Misc 3d at 704). Neither party claims such an agreement exists here.

The only Appellate Court decision regarding this issue is from the First Department in Schaffer, Schonholz & Drossman, LLP v Title (171 AD3d 465, 465, 96 N.Y.S.3d 526 [1st Dept 2019]). There, the Court ruled on stipulated facts that were ***[*18]*** *submitted and relied on ERISA demutualization (Id.). The Court found that despite respondent being named as the policyholder, plaintiff had paid the premiums and all costs related to the policy and there was no record of bargaining for the benefit of demutualization proceeds, so [a]warding respondent the cash proceeds of MLMIC's demutualization would result in her unjust enrichment" (Id.) Here, the parties contest the nature* ***[**7]*** *of the understanding by which Plaintiff assumed payment of the premiums.*

The Motion to Dismiss Must be Denied

In essence, an unjust enrichment claim accrues when one person has obtained money from the efforts of another person under such circumstances that, in fairness and good conscience, the money should not be retained (see Miller v Schloss, 218 NY 400, 407, 113 N.E. 337 [1916]). In such circumstances, the law requires the enriched person to compensate the other person (see Bradkin v Leverton, 26 NY2d 192, 196-197, 257 N.E.2d 643, 309 N.Y.S.2d 192 [1970]). Such a claim is based not in legal title, but in equity (see Simonds v Simonds, 45 NY2d at 239).

Here, viewing the Complaint in the light most favorable to Plaintiff and giving it all reasonable inferences, Plaintiff has stated a claim for unjust enrichment. Plaintiff paid the premiums. Plaintiff claims that, but for a mistake of fact, it would be the policy administrator, and ***[*19]*** *it was its payments and efforts that created the proceeds from demutualization. Defendant*

vigorously disagrees and properly notes she has legal title to the proceeds. Legal title does not end the inquiry (see Simonds v Simonds, 45 NY2d at 239; Castellotti v Free, 138 AD3d 198, 207, 27 N.Y.S.3d 507 [1st Dept 2016]). "In determining a motion to dismiss . . ., the evidence must be accepted as true and given the benefit of every reasonable inference which may be drawn therefrom. The question of credibility is irrelevant, and should not be considered" (Gonzalez v Gonzalez, 262 AD2d 281, 282, 691 N.Y.S.2d 122, [2d Dept 1999]). Therefore, it is not currently before the Court to resolve whether Plaintiff's claims are true or even plausible, but only if they state a claim. Here, Plaintiff has clearly stated such a claim.

According, it is

ORDERED, Defendant's Motion to Dismiss the Amended Complaint is **denied**.

This shall constitute the Decision, Order and Judgment of the court. This Decision, Order and Judgment is being returned to the attorney for Plaintiff. All original supporting documentation is being filed with the Greene County Clerk's Office. The signing of this Decision, Order and Judgment shall not constitute entry or filing under CPLR 2220. Counsel is not relieved from the applicable provision of that rule relating to filing, entry and notice of entry.

SO ORDERED AND ADJUDGED [*20]

ENTER.

Dated: July 12, 2019

Catskill, New York

RAYMOND J. ELLIOTT, III

Supreme Court Justice

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Utica Fire Ins. Co. v. Gozdziak

Supreme Court of New York, Appellate Division, Fourth Department

November 19, 1993, Filed

0910

Reporter
198 A.D.2d 775 *; 604 N.Y.S.2d 371 **; 1993 N.Y. App. Div. LEXIS 11364 ***

UTICA FIRE INSURANCE COMPANY OF ONEIDA COUNTY, APPELLANT-RESPONDENT, v. JOANNE A. GOZDZIAK, INDIVIDUALLY AND AS PARENT AND NATURAL GUARDIAN OF RICHARD M. GOZDZIAK, RESPONDENT, RONALD J. GOZDZIAK, DAVID GOZDZIAK AND KEVIN GOZDZIAK, INDIVIDUALLY AND AS EXECUTOR OF THE ESTATE OF ALICE GOZDZIAK, DECEASED, APPELLANTS-RESPONDENTS.

Prior History: [*1]** (Appeals from Judgment of Supreme Court, Erie County, Wolf, Jr., J. - Declaratory Judgment.)

Core Terms

resident, insureds, policyholder, underlying action, ambiguity, modified, exclusion clause, household, indemnify, coverage, comma, exclude coverage, summary judgment, bodily injury, no duty, declaration, grandmother, infant, costs, uncle

Case Summary

Procedural Posture
Appellant insurer sought review of a judgment of the Supreme Court of Erie County (New York), which denied its motion for a declaration that it did not have a duty to defend or indemnify appellee insureds, who were defendants in an underlying action.

Overview
The court concluded that the policy unambiguously excluded coverage in the circumstances presented. The policy exclusion set forth three distinct classes of individuals, whose injury was not covered: the policyholder; the policyholder's resident relatives; and minors in the care of the policyholder or his resident relatives, regardless of the minors' residence. The court found that such an interpretation was supported by the language and structure of the parallel policy provision that defined an insured. The policy eschewed any residency requirement in defining an insured to include persons under the age of 21 in the care of the insured or the insured's resident relatives; therefore, the infant who sustained injuries at the insured's home while he visited his father who resided therein, was encompassed by the exclusion. The court modified the judgment appealed from by granting the insurer's declaration that it had no duty to defend and indemnify its insureds in the underlying action.

Outcome
The court modified the lower court's judgment by declaring that the insurer had no duty to defend and indemnify the insureds in an action that was filed to recover for injuries that an infant sustained in a fireworks accident while he was a guest at the insured's home.

LexisNexis® Headnotes

Insurance Law > Claim, Contract & Practice Issues > Policy Interpretation > Exclusions

Insurance Law > Claim, Contract & Practice Issues > Policy Interpretation > General Overview

Insurance Law > ... > Policy Interpretation > Ambiguous Terms > General Overview

HN1 **Policy Interpretation, Exclusions**

Where the meaning of a policy of insurance is in doubt or is subject to more than one reasonable interpretation, all ambiguity must be resolved in favor of the policyholder and against the company which issued the policy. When an insurer wishes to exclude certain coverage from its policy obligations, it must do so in clear and unmistakable language.

Insurance Law > ... > Policy Interpretation > Ambiguous Terms > Construction Against Insurers

Insurance Law > ... > Policy Interpretation > Ambiguous Terms > General Overview

Insurance Law > Claim, Contract & Practice Issues > Policy Interpretation > Exclusions

HN2 **Ambiguous Terms, Construction Against Insurers**

Ambiguity should be resolved in favor of the policyholder and against the insurer.

Judges: PRESENT: DENMAN, P.J., CALLAHAN, BALIO, BOOMER, BOEHM, JJ.

Opinion

[371]** **[*775]** Judgment modified on the law and as modified affirmed without costs and judgment granted in accordance with the following Memorandum: Plaintiff insurer brought this action seeking a declaration that it has no duty to defend or indemnify its insureds, who are defendants in an underlying action. The underlying action was brought on behalf of an infant, Richard Gozdziak, to recover for injuries sustained in a fireworks accident. The accident occurred while Richard, whose parents are divorced and whose mother has physical custody of him, was making an overnight visit to the home of his late grandmother, where his father and uncle lived. The underlying action was commenced against Richard's father, his uncle and his grandmother's estate, all of whom are insureds under the policy issued by plaintiff.

Plaintiff's duty to defend and indemnify hinges on the interpretation of Coverage L of the policy, which excludes coverage for "bodily injury to you (meaning the policyholder), and if residents of your household, **[***2]** your relatives, and persons under the age of 21 in your care or in the care of your resident relatives". The issue is whether the residency condition of the exclusion applies not only to the insured's "relatives", but also to those "persons under the age of 21" in the care of the policyholder or his resident relatives.

We conclude that the policy unambiguously excludes coverage in the circumstances presented. The exclusion sets forth three distinct classes of individuals, injury to whom is not covered: the policyholder; the policyholder's resident relatives; and minors in the **[**372]** care of the policyholder or his resident relatives, irrespective of the minors' residence. That construction is supported by the placement of the final comma in the exclusion; that comma would be unnecessary if the interpretation **[*776]** advanced by defendants had been intended. That interpretation is further supported by the language and structure of the parallel policy provision defining an "insured". The policy eschews any residency requirement in defining an insured to include "persons under the age of 21 in your care or in the care of your resident relatives". The policy exclusion should be read **[***3]** the same way, given the apparent intent to define covered injured persons and covered defendants (insureds) in mutually exclusive fashion.

We modify the judgment appealed from to deny

defendants summary judgment and to grant plaintiff summary judgment declaring that it has no duty to defend and indemnify its insureds in the underlying action. We affirm so much of the judgment as denied defendants costs and attorney's fees.

All concur except Callahan, J., who dissents in part in the following Memorandum: I agree with Supreme Court that the language of the exclusionary clause is ambiguous. ***HN1***[⬆] "Where the meaning of a policy of insurance is in doubt or is subject to more than one reasonable interpretation, all ambiguity must be resolved in favor of the policyholder and against the company which issued the policy" (*Little v Blue Cross of Western N.Y., 72 AD2d 200, 203)*. When an insurer wishes to exclude certain coverage from its policy obligations, it must do so in clear and unmistakable language (*Seaboard Sur. Co. v Gillette Co., 64 NY2d 304, 311*; *McCarthy v New York Prop. Ins. Underwriting Assn., 158 AD2d 961, 962*; *Suba v State Farm Fire & Cas. Co., 114 AD2d 280, **[***4]** 282*, *lv denied 67 NY2d 610*).

The exclusionary clause herein provides that coverage "does not apply to: 1. bodily injury to you, and *if residents of your household*, your relatives, and persons under the age of 21 in your care or in the care of your resident relatives" (emphasis added). It is unclear, however, whether the phrase, "and if residents of your household", which is set off by commas, is intended to modify the phrases, "persons under the age of 21 in your care", or just "relatives". Thus, the terms of the exclusionary clause are at least ambiguous, and that ***HN2***[⬆] ambiguity should be resolved in favor of the policyholder and against the insurer (*see, Paychex Inc. v Covenant Ins. Co., 156 AD2d 936*). Because the injured infant was not a resident of the covered premises, he was not within the exclusion.

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Wellbilt Equip. Corp. v. Fireman

Supreme Court of New York, Appellate Division, First Department

October 12, 2000, Decided

No Number in Original

Reporter
275 A.D.2d 162 *; 719 N.Y.S.2d 213 **; 2000 N.Y. App. Div. LEXIS 14135 ***

Wellbilt Equipment Corporation, Respondent, v.
Sheldon Fireman et al., Appellants, et al., Defendants.

Prior History: [*1]** Appeal from an order of the Supreme Court (Carol Huff, J.), entered July 16, 1998 in New York County, which, to the extent appealed from, granted summary judgment to plaintiff and dismissed defendants' second, third and fourth counterclaims.

Disposition: Appeal from order, Supreme Court, New York County, entered on or about July 16, 1998, dismissed as academic, without costs.

Counsel: *Barry J. Glickman* of counsel (*Michael L. Slonim* on the brief; *Zeichner Ellman & Krause, L. L. P.,* attorneys), for respondent.

Jeffrey Turkel of counsel (*Gary M. Rosenberg, Warren A. Estis* and *Norman Flitt* on the brief; *Rosenberg & Estis, P. C.,* attorneys), for appellants.

Judges: Nardelli, J. P., Tom, Mazzarelli and Ellerin, JJ., concur.

Opinion by: Friedman

Opinion

[*163] [214]** Friedman, J.

On this appeal we are required to determine whether a *Lien Law § 39-a* claim, which seeks damages for the alleged wilful exaggeration of a lien, survives the consensual discharge of the lien. We conclude that where, as here, the lien is discharged on consent of the parties and the lienor's action to foreclose the lien is discontinued, a wilful exaggeration **[***2]** claim does not survive.

In or about September 1994, defendants hired plaintiff Wellbilt to construct the Red Eye Grill restaurant in Manhattan. * Plaintiff asserts that after construction commenced defendants repeatedly changed architects, building plans, and interior requirements. As a result, plaintiff advised defendants that construction costs would likely rise.

After construction was largely completed, the Red Eye Grill restaurant opened for business in November of 1996. About the same time, plaintiff demanded that defendants make additional payments towards the construction cost, which plaintiff asserted had risen to $ 5,000,000. In a letter dated December 2, 1996, defendants admitted to plaintiff **[***3]** that it was entitled to more than $ 2,362,000 in fees, disputing only the amount that **[*164]** plaintiff was due beyond that sum. Despite the acknowledgment that $ 2,362,000 was due, defendants paid plaintiff only $ 2,054,000, leaving a balance that, according to defendants' own calculations, exceeded $ 300,000. In view of defendants' failure to make payment beyond the $ 2,054,000, plaintiff filed a lien against the property.

The first lien, which was filed on July 22, 1997, alleged that the total cost of construction was $ 5,000,000, of which a balance of $ 2,946,000 remained unpaid. The dispute not being resolved, this action was commenced one month later.

Plaintiff's complaint asserted causes of action, *inter alia,* for breach of contract and foreclosure of the lien. Shortly after commencement of the action, however, plaintiff discovered that its lien was fatally defective because it had failed to file proof of service of the notice of lien with the County Clerk within 35 days as required by *Lien Law § 11*. In view of this, plaintiff refiled the lien on September 10, 1997, this time properly filing proof of service.

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* There is an ongoing dispute as to which of the defendants actually hired plaintiff and is liable for the payment of plaintiff's fees. Although we refer to defendants collectively for purposes of this decision, we make no finding as to this issue as it is irrelevant to the legal issue presented.

As plaintiff's foreclosure **[***4]** action was premised on the defective lien it had previously filed, plaintiff also served a supplemental summons and complaint identical in all respects to its original summons and complaint, except that the complaint sought to foreclose the second lien, instead of the first.

In response, defendants served an amended answer, which interposed various counterclaims. As is relevant to this appeal, the second counterclaim alleged that both of the liens filed by plaintiff were wilfully exaggerated, thereby requiring the liens to be discharged. The third counterclaim attacked the allegedly duplicative nature of the liens, i.e., since both liens were for the identical work, the liens viewed together were necessarily exaggerated. The fourth counterclaim sought damages pursuant to *Lien Law § 39-a*, asserting that the liens were wilfully exaggerated whether viewed individually or jointly.

Thereafter, plaintiff moved for partial summary judgment against defendants in the amount of $ 406,000 and for an immediate trial as to the extent of plaintiff's damages beyond that amount. The motion was premised upon a concession in defendants' answer, which stated that plaintiff **[***5]** had been paid all but $ 406,000. Defendants **[**215]** cross-moved for summary judgment on their second, third, and fourth counterclaims, arguing that the two liens, when viewed together, were exaggerated since they were duplicative of each other.

Supreme Court granted plaintiff partial summary judgment, awarding it damages in the sum of $ 406,000 (a matter which is **[*165]** not the subject of this appeal), leaving for trial a determination of whether plaintiff was entitled to any sums beyond $ 406,000. The court also denied defendants' cross motion for summary judgment and granted plaintiff reverse summary judgment dismissing defendants' second, third, and fourth counterclaims.

In dismissing defendants' counterclaims, Supreme Court apparently viewed such claims as being rooted only in the alleged duplication of the liens. Since the court found that the first lien was void by operation of law, and that the second lien was filed merely because of plaintiff's failure to properly perfect the first lien, the court concluded that there was no basis for a wilful exaggeration claim. This appeal by defendants followed.

Before this appeal was perfected, however, defendants entered **[***6]** into a stipulation with plaintiff regarding the lien. Pursuant to that stipulation, plaintiff discharged the lien and discontinued its seventh cause of action, which sought to foreclose the lien. The stipulation did not resolve the issue of how much additional money plaintiff was owed. That issue was left for trial.

The principal issue presented by this appeal concerns the effect of this stipulation on defendants' counterclaims. A subsidiary issue concerns the effect of plaintiff's filing of duplicate liens. Analysis of the matter must begin with the statutory backdrop.

Section 39 of the Lien Law provides that: "In any action … to enforce a mechanic's lien … if the court shall find that a lienor has wilfully exaggerated the amount for which he claims a lien as stated in his notice of lien, his lien shall be declared to be void."

Where a lien has been discharged under this section, *Lien Law § 39-a* permits the recovery of damages. Thus, *section 39-a* provides: " **[***7]** Where in any action … to enforce a mechanic's lien … the court shall have declared said lien to be void on account of wilful exaggeration the person filing such notice of lien shall be liable in damages to the owner or contractor."

Regarding the issue of plaintiff's filing of duplicate liens, we agree with Supreme Court's conclusion that a wilful exaggeration claim premised upon this ground cannot stand. The first lien filed by plaintiff was, as a matter of law, void because of plaintiff's failure to file proof of service of the notice of lien with the County Clerk within 35 days as required by *Lien Law § 11* (*Outrigger Constr. Co. v Nostrand Ave. Dev. Corp., 217 AD2d 689*). **[*166]** In view of this, plaintiff's filing of a second lien, which it plainly did in recognition that its first lien was defective, could not support a claim of wilful exaggeration. Hence, Supreme Court was correct in finding that the second filing did not entitle defendants to summary judgment.

Defendants contend, however, that, even if Supreme Court was correct with **[***8]** regard to the duplication of the liens, the court nevertheless erred in dismissing their wilful exaggeration claims and granting plaintiff reverse summary judgment. In this regard, they point out that, setting aside the purported duplication of the lien, there remained a claim that the second lien, viewed individually, was itself wilfully exaggerated. Defendants further contend that the subsequent discharge of the lien pursuant to stipulation has no effect on the viability of their exaggeration claim. This latter contention by defendants does not bear scrutiny.

In interpreting the Lien Law, our courts have held that damages under section 39-a **[**216]** may not be awarded unless the lien has been declared void for wilful exaggeration after a trial in an action to foreclose the lien (*see,* Joe Smith, Inc. v Otis-Charles Corp., 279 App Div 1, 4, *affd* 304 NY 684; *see also,* Pyramid Champlain Co. v Brosseau & Co., 267 AD2d 539, 542; *Stamatopoulos v Karasik, 238 AD2d 688, 691, lv dismissed and denied 92 NY2d 844*; **[***9]** *Pamco Indus. v Medical Plaza Assocs., 231 AD2d 504, 505*; Guzman v Estate of Fluker, 226 AD2d 676, 678; Bowmar, Mechanics' Liens in New York § 3.12 [1992]). The conclusion reached by these courts is well founded as it flows from the explicit words of the statute.

In this connection, section 39-a, by its terms, only permits a wilful exaggeration claim to be asserted in an action "to enforce a mechanic's lien," namely, a foreclosure action. Where the lien has been discharged prior to trial, the action is no longer one seeking to enforce a mechanic's lien. The action is, at that juncture, merely one in contract (*see,* Joe Smith, Inc. v Otis-Charles Corp., *supra*; Guzman v Estate of Fluker, *supra*; *see also,* Bowmar, Mechanics' Liens in New York § 3.12, at 131-132).

Additionally, section 39-a provides for damages only where "the court shall have declared [the] lien to be void on account of wilful exaggeration" pursuant to section 39 **[***10]** (*see,* Pyramid Champlain Co. v Brosseau & Co., *supra* [sections 39 and 39-a must be read in tandem]; Bowmar, Mechanics' Liens in New York, *op. cit.,* at 130). Where the lien has been discharged for reasons unrelated to its supposed exaggeration, there remains **[*167]** no lien to be declared void by the court (*see,* Joe Smith, Inc. v Otis-Charles Corp., *supra*; Guzman v Estate of Fluker, *supra*).

In this case, plaintiff's lien was discharged on consent of the parties and its foreclosure action discontinued. Hence, a wilful exaggeration claim is precluded.

Notwithstanding the foregoing, defendants assert that the discharge of a lien only eviscerates a wilful exaggeration claim if it has been discharged on procedural grounds. Based upon this conclusion, defendants assert that where, as here, the lien does not suffer from any procedural defects, its consensual discharge has no effect on a wilful exaggeration claim.

We initially observe that there is nothing in the statutory framework to support the distinction advocated by defendants. As previously noted, the statute, by its terms, requires that the wilful exaggeration claim **[***11]** be asserted in the context of a foreclosure action and that the lien be declared void by the court on account of wilful exaggeration. It is evident that, whether a lien is discharged because of some procedural ground or on consent via stipulation, the end result is the same. In either case, there is no longer a foreclosure action or a lien to be declared void.

Contrary to defendants' claim, there is also nothing in the cases interpreting the Lien Law to support the distinction for which it advocates. It is true that in many of the reported cases dismissing wilful exaggeration claims the subject liens had been discharged on procedural grounds or because the liens were otherwise defective (*see, e.g.,* Joe Smith, Inc. v Otis-Charles Corp., 279 App Div 1, 4, *affd* 304 NY 684, *supra; see also,* Pyramid Champlain Co. v Brosseau & Co., 267 AD2d 539, 542-543, *supra; Stamatopoulos v Karasik, 238 AD2d 688, 691, supra; Pamco Indus. v Medical Plaza Assocs., 231 AD2d 504, 505, supra*). However, this factual circumstance **[***12]** had no bearing on the ratio decidendi that compelled dismissal of the claims. This analysis of the case law is borne out in the oft-cited decision of *Joe Smith, Inc. v Otis-Charles Corp.* (*supra*).

In *Smith,* the defendant (apparently the owner of the property against which the **[**217]** lien was asserted) moved to dismiss the lien at the outset of trial, asserting that the notice of lien suffered from certain deficiencies in its content. The court reserved decision and, at the conclusion of the plaintiff's case, granted the defendant's motion and discharged the lien. The action was thereafter tried and finally submitted, not as one seeking foreclosure of the lien, but as one seeking recovery on the contract between the parties.

[*168] The Court, relying on the specific language of Lien Law § 39-a, found that the defendant's wilful exaggeration claim was not cognizable because "the lien having been discharged, there remained no lien to be foreclosed or to be declared void" (*id., at 4*). The Court then stated: "The [defendant] having succeeded in obtaining a discharge of the lien at the beginning of the **[***13]** trial, the foreclosure action was thereby terminated, and thereafter the court was without authority to declare the lien void on account of wilful exaggeration" (*id., at 5*).

What emerges from *Smith* is that it was irrelevant that the lien was discharged for procedural reasons. What was relevant was only that there was neither a lien to be declared void nor a foreclosure action extant. These dual requirements, as previously noted, flow directly

from the statutory language of Lien Law § 39 and 39-a.

One further observation regarding *Smith* is necessary. The *Smith* Court noted that the defendant could have preserved its wilful exaggeration claim by abandoning its procedural defense to the lien (id., at 4). Stated otherwise, notwithstanding that the lien may have suffered from technical deficiencies, defendant's wilful exaggeration claim would have been cognizable if it had not obtained a discharge of the lien on procedural grounds. This shows that the determinative factor in assessing the viability of a wilful exaggeration **[***14]** claim is the continued existence of the lien and the continued existence of the action to foreclose the lien.

To the extent defendants rely upon this Court's decision in Bran Elec. v MHA, Inc. (269 AD2d 231) in support of a contrary conclusion, such reliance is misplaced. In *Bran* we did not hold, as defendants contend, that a wilful exaggeration claim survives the discharge of a mechanic's lien. That issue was neither briefed nor presented to the Court for adjudication. Thus, as a case "is precedent only as to those questions presented, considered and squarely decided" (People v Bourne, 139 AD2d 210, 216, *lv denied 72 NY2d 955*), *Bran* cannot be viewed as expressing any opinion on the issue presented here.

This brings us to defendants' claim that Lien Law § 12-a authorizes the assertion of a wilful exaggeration claim even if the lien is discharged for reasons other than exaggeration. Section 12-a (1) provides as follows: " **[***15]** Within sixty days after the original filing, a lienor may amend his lien … provided that no action … to enforce … the mechanics' lien has been brought in the interim, where the purpose of the amendment is to reduce the amount of the lien, except the question of wilful exaggeration shall survive such amendment."

[*169] According to defendants, since a lienor cannot escape a wilful exaggeration claim when it unilaterally reduces its lien via a pre-action amendment, it follows that it cannot escape such a claim when it discharges its lien on consent of the parties via stipulation. The answer to defendants' Lien Law § 12-a argument lies in a critical observation regarding the nature of Lien Law liability.

Lien Law § 39-a, which is penal in nature, is a purely statutory offense, providing for drastic consequences in the event the statute is violated (Joe Smith, Inc. v Otis-Charles Corp., supra, at 4). **[**218]** As a result, there can be no liability under this provision by implication of fact or law (*id.* **[***16]**). Furthermore, the statute must be strictly construed in favor of the person upon who the penalty is sought to be imposed (*id.*).

Bearing these principles in mind, it is apparent that defendants seek to impose liability in this case not because section 12-a specifically provides for continued liability after the consensual discharge of a lien, but because of what defendants believe flows by implication from the statute. To accept defendants' argument would, therefore, impose liability by implication, which, as indicated, is not permitted.

In any event, even if section 12-a were interpreted as prohibiting a lienor from extricating itself from a wilful exaggeration claim by unilaterally discharging its lien (an issue we need not decide), plaintiff in this case did not act unilaterally. Rather, the lien was discharged on consent via stipulation. This is of critical significance. As previously indicated, where an owner succeeds in obtaining a discharge of a lien on procedural grounds by court order, the owner's wilful exaggeration claim is extinguished. It follows that, where an owner succeeds in obtaining a discharge of the lien via stipulation, a wilful exaggeration claim **[***17]** should be similarly precluded.

In the end, we acknowledge that Supreme Court seems to have misperceived defendants' wilful exaggeration claim as being rooted solely in the purported duplication of the lien. We also acknowledge that, at the time the court rendered its decision, defendants still had a viable claim premised upon the alleged exaggeration of the second lien irrespective of any duplication. While this would mean that Supreme Court prematurely dismissed defendants' counterclaims, the fact remains that, at this juncture, where a stipulation has been executed, a wilful exaggeration claim is no longer viable, as a matter of law. Thus, defendants' appeal has been rendered academic.

[*170] Accordingly, defendants' appeal from an order of the Supreme Court, New York County (Carol Huff, J.), entered on or about July 16, 1998, which, to the extent appealed from, granted plaintiff summary judgment dismissing defendants' second, third, and fourth counterclaims, should be dismissed as academic, without costs.

Nardelli, J. P., Tom, Mazzarelli and Ellerin, JJ., concur.

Appeal from order, Supreme Court, New York County, entered on or about July 16, 1998, dismissed as **[***18]** academic, without costs.

End of Document

Wright v. Nimmons

United States District Court for the Southern District of Texas, Houston Division

August 18, 1986, Decided ; August 18, 1986, Filed

No. H-83-6906

Reporter
641 F. Supp. 1391 *; 1986 U.S. Dist. LEXIS 21449 **; 7 Employee Benefits Cas. (BNA) 2184

LEWIS A. WRIGHT, ET AL. v. DONALD S. NIMMONS, TRUSTEE

Core Terms

plans, benefits, pension plan, termination, recapture, fiduciary, acquisition, employees, documents, provisions, advice, pension, rights, exclusive benefit, profit sharing plan, plan participant, actuarial, appointed, circumstances, prepare, sponsor, vested, fiduciary duty, amend, annual report, contributions, obligations, over-funded, calculated, deposit

Counsel: **[**1]** Roger P. Greenberg and Jane Cooper-Hill, Richie & Greenberg, for Plaintiffs.

William T. Green, III and Mark Alexander, Green, Downey, Patterson & Schultz, for Defendant.

Judges: Carl O. Bue, Jr.

Opinion by: BUE, JR.

Opinion

[*1393] Honorable Carl O. Bue, Jr.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. *Introduction*

This is an action for equitable relief and statutory damages arising under the Employee Retirement Income Security Act of 1974 ("ERISA"). *29 U.S.C. § 1001 et seq.* Following the acquisition of four related closely-held corporations by Defendant, Donald S. Nimmons ("Nimmons"), the Plaintiffs, who are former shareholders, officers, and directors of the corporations, and participants and beneficiaries of the corporations' defined benefit pension plan, commenced suit against Defendant alleging breaches of fiduciary duty and seeking to protect their rights under ERISA. In his capacity as Trustee of the plan, Defendant has filed counterclaims seeking damages for violation of ERISA's prohibited transactions provisions which occurred prior to the change in corporate ownership. The controversy between the parties concerns the validity of two competing pension plans. Specifically, **[**2]** the proponents of the competing plans claim entitlement to the residual assets which are to be distributed as a consequence of the corporations' cessation of business.

This case came on for trial before the Court sitting without a jury. Having heard all of the testimony and reviewed the documentary evidence, this Court concludes that Plaintiffs are entitled to recover statutory damages, and to obtain equitable relief as a consequence of Defendant's breach of his fiduciary duty, and hereby enters its Findings of Fact and Conclusions of Law consistent therewith.

II. *Findings of Fact*

A. *The Formation of the Pension and Profit Sharing Plans*

1. In 1971, Lewis Alvin Wright ("L.A. Wright") and Shelley V. Pate ("S.V. Pate") formed W.P. Constructors, Inc. ("W.P."), a construction company that specialized in the construction of underground water and sewage systems. For many years prior to the formation of the

corporation, the business was operated as a partnership. The corporation was formed upon the advice of Nimmons who served as an accountant and financial consultant to the partnership.

2. The principals also incorporated three related companies: Pate Construction Company, **[**3]** Inc. ("Pate Co."), Aldine Construction Company, Inc. ("Aldine") and W.P. Leasing Corporation, Inc. ("Leasing"). Both Pate Co. and Aldine provided contract labor to W.P., while Leasing provided heavy equipment.

3. At about the same time that the businesses were incorporated, Nimmons advised L.A. Wright and S.V. Pate to establish pension and profit sharing plans for the employees of the corporations. Nimmons acted as agent in dealing with the attorney who prepared the initial pension plan for W.P., and the profit sharing plans for Pate Co. and Aldine. On Nimmons' recommendation, the corporations adopted the respective plans in 1971.

4. The original trustees were S.V. Pate and L.A. Wright. The original plan administrative committee consisted of Wright, Pate, and Clarice Cantrell ("C. Cantrell"). None of these individuals had experience, expertise, or knowledge concerning the administration of pension or profit sharing plans. Thus, they relied in all respects on Nimmons, who held himself out as a knowledgeable pension plan advisor.

5. W.P. was a closely-held corporation and essentially a family business. Consequently, the pension plan beneficiaries are primarily family members. However, **[**4]** the instant cause of action was also brought on behalf of the beneficiaries of the profit sharing plan, former employees of Pate Co. and Aldine, who comprised the labor force for the work performed by W.P.

B. *Administration of the Original Pension and Profit Sharing Plans*

6. Although the employer, W.P., assumed certain administrative duties for the plan, Nimmons was consulted regularly regarding plan administration. Nimmons' duties on behalf of the plans included the following: (1) keeping the books; (2) compiling employee data; (3) calculating employer **[*1394]** contributions; (4) preparing required governmental reports and financial statements, and (5) preparing annual reports.

7. In addition to these specific tasks, Nimmons had an informal relationship of long-standing with the principals of the corporations. Due to this informal relationship of trust, Nimmons was provided with keys to the corporate offices so that he would have immediate access to the corporate books and records, including the books of the plans.

8. Nimmons rendered investment advice to the corporations, and served as a paid consultant from 1971 until 1981. The corporate principals, who were also **[**5]** trustees of the pension and profit sharing plans, relied extensively upon Nimmons' expertise and advice regarding the administration of the plans.

C. *The Original Pension and Profit Sharing Plans' Loss of Qualified Tax Status*

9. Nimmons served as the enrolled agent for the pension and profit sharing plans. In this capacity, he was empowered to appear before the Internal Revenue Service ("IRS") on behalf of the plans.

10. The passage of ERISA in 1974 imposed new requirements on employee benefits plans. Plans which did not meet the new requirements were threatened with severe consequences. Contributions made to a plan which loses its qualified status are not tax deductible by the corporation, and are taxable as ordinary income to the beneficiaries.

11. As the enrolled agent for the plans, Nimmons was charged with the duty of cooperating with the IRS on matters of plan qualification. By 1978, the IRS had still not received indication that the plans had been restated to comply with ERISA. Pursuant to an inquiry in December of 1970, Nimmons informed the IRS that the plans had been amended to comply with ERISA, and that an application for a determination letter would be forthcoming. **[**6]** However, the application for determination and amended plans were not sent. In August of 1979, the IRS conducted an investigation of the 1977 and 1978 annual returns. During that investigation, Nimmons provided the IRS with a prototype plan, but the plan had not been executed by the corporate officers or trustees.

12. Despite requests by the IRS for executed copies of a plan conforming to ERISA, and for a copy of the application for determination that had allegedly been filed, these were never received. Finding that the original plan documents were the operative plans, the IRS proceeded to review those plans for compliance with ERISA, but many deficiencies were noted.

13. A request by the IRS for corrective amendments and data sufficient to entitle the plans to ENCEP relief was

made on August 20, 1981, but no response was received. The ENCEP program was designed to permit the IRS to qualify a plan retroactively if the plan had been administered in accordance with ERISA, even if plan documents in existence during the period did not conform with ERISA requirements.

14. In an attempt to comply with the requirements of ERISA so that the plans could retain their qualified status, Nimmons **[**7]** hired Hand and Associates in the Spring of 1980 to prepare "Schedule B's" for the plan years ending on May 31, 1977, 1978, and 1979.

15. A "Schedule B" is a computation of actuarial liabilities which must be signed by an enrolled actuary and filed each year with the plan's annual reports. For several years, Nimmons filed annual reports (Form 5500-C) without attaching the required "Schedule B's."

16. Margaret Young, an enrolled actuary employed by Hand and Associates, prepared "Schedule B's" for the years 1977-79. She also requested current information so that she could prepare the "Schedule B" for the plan year ending May 31, 1980. Although Nimmons promised to provide the information, he never sent it to Young. Instead, he once again prepared Form 5500-C without a "Schedule B," erroneously indicating on the form that a "Schedule B" was not required.

[*1395] 17. Throughout the years of investigation, the IRS dealt exclusively with Nimmons on behalf of the plans. Having determined that the original plan documents failed to comply with ERISA, and based upon the lack of response to repeated requests for conforming documents, the IRS assumed that the taxpayer did not desire to comply **[**8]** with ERISA requirements. Consequently, a final revocation letter was sent by the IRS on December 3, 1981, which resulted in the loss of the plans' qualified status.

18. Nimmons did not advise the trustees and plan administrators concerning the repeated requests by the IRS for amendments, even though they were not aware of ERISA or its requirements, and depended exclusively upon him for compliance with governmental regulations.

19. As a consequence of Nimmons' misfeasance, the qualified status of the plans was revoked, and the corporation and participants have incurred tax liability for the years that the plans were unqualified.

D. *The Stark and Frahm Plan*

20. Upon receipt of the final revocation letter from the IRS, dated December 3, 1981, L. Anthony Wright ("A. Wright") called Nimmons to question him about its significance. Nimmons assured him that there was no cause for alarm.

21. Upon the advice of their bonding agent, Roy Simmons, in February of 1982, however, the corporate directors retained the law firm of Stark and Frahm to counsel them with respect to Nimmons' failure to maintain the qualified status of the plan.

22. In February of 1982, A. Wright, then vice-president **[**9]** of the corporations, and Steve Pate ("S. Pate"), secretary/treasurer of the corporations, met with a representative of Stark and Frahm at Simmons' office. They explained the corporate structure and history of the plans, as they understood them, and requested Stark and Frahm to resolve their problems with the IRS.

23. In February of 1982, A. Wright, on behalf of the corporations, executed a power of attorney which authorized Stark and Frahm to draft and execute plan amendments that could be approved by the IRS. Stark and Frahm prepared a plan as directed, and diligently attempted to correct the problems resulting from the revocation letters.

24. On May 27, 1982, the Board of Directors of W.P. adopted by resolution the *Third Amendment* to The W.P. Pension Plan, renamed The W.P. Constructors, Inc. Defined Benefit Investment Fund Pension Plan (the Stark and Frahm Plan). Also on May 27, 1982, the pension plan amendment with trust agreement was executed on behalf of W.P. by A. Wright. The execution of the plan was attested to by S. Pate, corporate secretary. The executed instrument was acknowledged and delivered to A. Wright and S. Pate, who signed the instrument as the newly appointed **[**10]** trustees of the plan. A copy of the instrument was also delivered to Nimmons. Due to the continued negotiations for acquisition of the corporations, the principals of W.P. kept Nimmons informed regarding activities pertaining to the plans.

25. The Stark and Frahm pension plan follows a form typically used for closely-held corporations. With respect to excess assets, the plan specifically directs a pro-rata distribution among plan participants upon termination of the plan. [1]

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[1] The termination provision of the Stark and Frahm plan, Section 13.3, provides as follows:

> In the event the plan is terminated for any reason, the

[11]** **[*1396]** 26. The Stark and Frahm plan provides for payment of benefits following a participant's termination of employment (Section 6.1(a)(3)), and for the lump sum payment of benefits (Section 6.2(b)(1)).

27. The Stark and Frahm plan also provides for the members and beneficiaries to receive a summary annual report, other information as required by ERISA, and an annual statement of benefits (Section 3.3).

28. In the Fall of 1982, Nimmons finally reviewed the Stark and Frahm plan. Since the amendment executed in May of 1982 had never been returned to Stark and Frahm for filing with the IRS, the law firm once again prepared and sent new corporate resolutions and blank signature pages for execution. After Nimmons received these blank documents for review, he noted that they did not accurately reflect his choice of trustees, and he requested that new documents be prepared in accordance with his wishes. Nimmons did not note any problems, however, with the previously executed documents. Nimmons did request Stark and Frahm to destroy the incorrect documents. However, rather than waiting for new documents to be prepared which accurately reflected his choice of trustees, Nimmons, on **[**12]** December 8, 1982, instructed Stark and Frahm to submit the plan, as executed by A. Wright on May 27, 1982, to the IRS for requalification. Pursuant to Nimmons' instructions, Stark and Frahm submitted their plan with an application for determination to the IRS, and notified Nimmons of the submission. (Testimony of Nimmons; S. Pate; Donald Stark; Robert Frahm; Plaintiffs' Exhibit Nos. 12, 15, 16, 17, 18, 38, 39; Defendant's Exhibit Nos. 16, 19, 20, 21, 22, 29, 30, 31).

29. On April 14, 1983, Nimmons attempted to remove S. Pate and A. Wright as plan administrators, and S. Pate as trustee, to appoint himself as sole administrator, and to appoint S. Pate, A. Wright, Neil Cantrell, and himself as trustees. However, a trust instrument was not signed by these "trustees" at that time. Nimmons' actions were not properly taken under the Stark and Frahm plan, and on the advice of counsel, he repeated this procedure in January of 1984. On April 14, 1983, Nimmons also attempted to amend the excess asset distribution provisions of the Stark and Frahm plan, and a provision relating to the effect of the company's dissolution or insolvency.

30. On May 31, 1983, Nimmons again attempted to amend the **[**13]** Stark and Frahm plan, but failed to replace it with a properly executed trust instrument.

E. *The Hutcheson and Grundy Plan*

31. In April of 1983, Nimmons executed a power of attorney in favor of the law firm of Hutcheson and Grundy, and instructed them to withdraw the Stark and Frahm plan from IRS consideration. As a result, the IRS notified W.P. that it would give no further consideration to the Stark and Frahm plan. Consequently, the plan retained its unqualified status, and continued to incur the attendant tax liabilities.

32. In May of 1983, Hutcheson and Grundy prepared a plan which permitted the corporation to recapture excess assets. In the interest of getting a plan qualified with the IRS, S. Pate, N. Cantrell, and A. Wright agreed to sign the plan as trustees as long as Nimmons would sign a reservation **[*1397]** of rights agreement acknowledging their claim to the excess assets. Nimmons agreed to this arrangement upon the advice of counsel, but subsequently refused to sign the agreement. As a result, the plan was not submitted to the IRS and remained unqualified.

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vesting provisions contained herein shall be inapplicable and each member's accrued benefit shall become 100% vested. As of the date of termination, the present value of the accrued benefits of all members shall be adjusted to equal the net worth of the investment fund. . . . In the event the plan is terminated and the provisions of paragraph 13.4, which limit the benefit available to a member, cause the plan investment fund to exceed the sum of such member's unrestricted benefit plus the present value of the accrued benefits of all other members, the amount of such excess shall be used to increase each member's benefit, including the benefit of a restricted member, by allocating a portion of such excess to each member in the ratio that the present value of each such member's accrued benefit bears to the total present value of all member's accrued benefits. In allocating such excess, the present value of a restricted Member's Accrued Benefit shall be the full present value of his Accrued Benefit without regard to the limitation set forth in Paragraph 13.4. The Plan Administrator shall notify the Internal Revenue Service of such termination for a determination of the effect such termination shall have on the qualification of the Plan and the tax exempt status of the Trust, and shall make no distributions until such determination has been received. Unless the Company is a professional service company having 25 or fewer Members of the Plan, the Plan Administrator shall also notify the Pension Benefit Guaranty Corporation and shall make no distributions until receipt of Notice of Sufficiency from the Pension Benefit Guaranty Corporation, the Plan Administrator shall make settlement of the Members' Accrued Benefits in the accordance with Article VI.

33. Nimmons took no further action with respect to requalification until after Plaintiffs filed the **[**14]** instant lawsuit. Following Nimmons' refusal to sign the reservation of rights agreement in July of 1983, an amended plan (Hutcheson and Grundy II) was not executed until May of 1984.

34. The Hutcheson and Grundy II plan was submitted to the IRS with an application for determination which erroneously informed the IRS that the proposed plan was not the subject of litigation. The IRS noted that the plan was deficient in some respects. After corrective amendments, however, the Hutcheson and Grundy II plan was qualified in May of 1985, but only as far back as 1983.

35. Defendant's counsel reached the conclusion that the Stark and Frahm plan had been executed without authority and "back-dated" premised upon explanations and documentation provided by Defendant. However, Nimmons' assertion that concern for governmental regulation and potential liability motivated the withdrawal of the Stark and Frahm plan is inconsistent with his well documented prior conduct with respect to the plans. Accordingly, this Court finds that the "back-dating" theory advanced by Nimmons was fashioned in a last-ditch effort to seize control of excess assets upon termination of the plan.

F. *Funding the Pension* **[**15]** *and Profit Sharing Plans*

36. In the early 1970's, S.V. Pate inquired into the purchase of a tract of land in Leon and Robertson Counties. Acting upon the advice of Nimmons, the principals of W.P. caused the pension plan, rather than the individuals or the corporation, to purchase the land. Subsequently, the land was platted and recorded as Lake Limestone Coves, a development adjacent to and bordering Lake Limestone. In 1978 and 1979, W.P. gratuitously improved the property by clearing, grading, and constructing roads and culverts. As a result of these improvements and the property's proximity to Lake Limestone, the value of the property appreciated considerably.

37. As a consequence of appreciation in value of the plan's primary asset, the W.P. pension plan became "over-funded." An over-funded plan is one in which plan assets exceed the plan's obligation to pay vested benefits. Since employer contributions were unnecessary as a result of overfunding, there have been no contributions to the pension plan subsequent to Nimmons' acquisition of the corporations.

38. Nimmons, who is intimately familiar with the corporate books and records, was aware of the appreciation of the property. **[**16]** He estimated the increasing value of the property on the Form 5500-C's prepared for filing with the IRS each year.

39. Nimmons understood and appreciated the difference between plan assets and actuarial liabilities. In other words, he knew the significance of an over-funded plan. The principals of the corporation and plan participants, on the other hand, did not understand this significance. Although they knew that there were sufficient assets to make additional employer contributions unnecessary, they believed that all of the assets in the plan belonged to the participants and beneficiaries.

40. The excess plan assets accumulated as a result of the efforts of the former principals of the corporation. Since the corporations were family operated, everyone assumed that assets would accumulate solely for the benefit of the plan participants, and that no conflicting claims would ever be asserted by the corporation.

G. *The Change of Corporate Ownership*

41. In August or September of 1981, Nimmons expressed an interest in acquiring W.P. and the related corporations. At that time, the corporations were owned by S. V. Pate and A. Wright, who negotiated the sale of the companies. **[**17]** The negotiations continued into 1982. An agreement **[*1398]** was reached, and closing was set for April 15, 1982. The closing was postponed several times and was finally accomplished on July 22, 1982. The purchase terms provided that Nimmons, through his holding company, was to pay Five Hundred Thousand Dollars ($ 500,000.00) in cash to both S.V. Pate and A. Wright, was to give a $ 500,000.00 promissory note to A. Wright, and to place $ 500,000.00 into a certificate of deposit for S.V. Pate, payable in one year. The only money that has been paid is the initial $ 500,000.00 in cash to each owner. Wright's note and Pate's certificate of deposit have not been paid.

42. The purchase price of the corporations was negotiated after determining the book value of corporate assets, including equipment, real property, receivables, and pending contracts. There was no discussion concerning the plans prior to the sale. The parties did not treat the pension plan as a corporate asset, and the value of excess assets in the plans was not a factor in determining the purchase price of the corporations.

43. No consideration was paid to the principals for the excess assets in the pension plans. S.V. **[**18]** Pate

and A. Wright would not have sold the corporations to Nimmons had they known that he would attempt to recapture any of the plan's assets.

44. The corporations had a long-standing attorney-client relationship with a relative of Defendant. Thus, W.P.'s counsel withdrew from legal representation prior to the closing date to avoid a conflict of interests. With full knowledge that the principals were unrepresented by counsel at the time of the closing, Nimmons failed to disclose the information that he had gleaned from many years as a paid plan consultant -- that the pension plan was over-funded, and that the sponsoring employer might recapture excess plan assets in certain circumstances.

45. Since all aspects of plan administration had been essentially delegated to Nimmons, the principals did not understand ERISA requirements. As a consequence of this lack of understanding, S.V. Pate executed an agreement at the closing which allowed him to continue acting in a trustee capacity, upon the misunderstanding that he would thereby be able to exert control over plan assets. Moreover, Nimmons was fully aware of the principal's lack of knowledge and dependence upon him regarding matters **[**19]** pertinent to the pension plan, and he was equally aware of S.V. Pate's mistaken impression when signing the trustee agreement at the time of closing.

46. By March of 1983, Nimmons was experiencing severe cash flow problems, and looked to the pension plan as a ready source of cash. He intended to terminate the plans and recapture excess assets to pay the debts of his corporations.

H. *Administration of the Plans Subsequent to the Change In Corporate Ownership*

47. Following Nimmons' acquisition of the corporations, the trustees of the W.P. plan were supposed to be: Nimmons, A. Wright, S.V. Pate, and N. Cantrell. However, Nimmons, as sole shareholder after his acquisition, failed to adopt a resolution effectuating an agreement with S.V. Pate and Neil Cantrell that they could serve as trustees. Accordingly, on July 22, 1982, the trustees were still S. Pate and A. Wright, who had been appointed on May 27, 1982.

48. Although he had not been officially appointed as trustee or administrator, Nimmons assumed exclusive control of the W.P. plan after his acquisition of the corporation. He opened trust bank accounts on his own signature, made unilateral investment decisions, and prevented **[**20]** the trustees or plan administrators from asserting any control over trust matters.

49. On January 20, 1984, Nimmons removed S. V. Pate, N. Cantrell, and A. Wright as trustees of the plans, and purported to appoint his wife and other family members to trustee positions. However, on March 2, 1984, Nimmons removed all trustees except himself, and at the time of trial purported to be the sole administrator and sole trustee of the plans.

[*1399] 50. During negotiations with InterFirst Bank Houston, N.A. ("InterFirst"), to obtain financing for his acquisition of the subject corporations, Nimmons indicated that the plan's cash assets would be moved to InterFirst if InterFirst financed the acquisition. After the acquisition, Nimmons, in fact, did move the cash deposits to InterFirst.

51. Although service upon Defendant in the instant case was accomplished by mail pursuant to *Fed. R. Civ. P. 4*, Nimmons did not answer within twenty (20) days. Instead, on December 19, 1983, Nimmons met with officers of InterFirst, and executed a deed of trust in favor of the bank covering the plans' Lake Limestone Coves property. Thereafter, Nimmons was served by personal service on December 22, 1983.

[21]** 52. On June 28, 1983, Nimmons executed a security agreement in favor of InterFirst, which granted a security interest in all of the pension plan assets that might ultimately be recaptured by the corporate sponsor. The security agreement was given to secure the payment of corporate debt personally guaranteed by Nimmons.

53. During the years that the plans were administered by W.P., the corporate sponsor paid all plan expenses and provided requisite services gratuitously. However, Nimmons has charged the plan a "trustee's fee" of Eighty Dollars ($ 80.00) per hour during the pendency of the instant lawsuit. This charge has been for menial and clerical tasks, such as driving to the bank to make deposits, driving to the post office to pick up mail, and posting in ledger books. Moreover, Nimmons has charged the plan an Eighty Dollar ($ 80.00) per hour fee for time spent in efforts to resolve the problems created by his own negligence. For example, Nimmons has charged the same "trustee's fee" for time spent meeting with his attorneys to defend the instant lawsuit, and for time spent with the representatives of InterFirst in an attempt to resolve the problems caused by his execution of **[**22]** the deed of trust on plan property in December of 1983. The total "trustee's fees" charged to the plans

between April of 1983. and February of 1985, when this Court's order prevented further payments, were approximately Ninety-Nine Thousand Dollars ($ 99,000.00).

54. The plan assets consist primarily of cash deposits totalling in excess of Eight Hundred Thousand Dollars ($ 800,000.00). In addition, the plan owns residential lots at Lake Limestone Coves. In connection with approximately fifty (50) monthly payments on contracts for deeds, it is necessary to compile deposit slips, post receipts of payments, and deposit payments in a trust account. The remaining unsold lots require little attention other than marketing efforts.

55. In 1981, Nimmons signed a contract for deed for two (2) lots at Lake Limestone Coves. Although obligated to make annual payments to the pension plan for these lots, Nimmons has failed to make any payments since he acquired the companies.

56. The record reveals that the pension and profit sharing plans could be administered efficiently for less than Ten Thousand Dollars ($ 10,000.00) per year. Even if an institutional trustee had been appointed, a reasonably **[**23]** anticipated charge would be less than Fifteen Thousand Dollars ($ 15,000.00) per year.

57. Since Nimmons' acquisition of the corporations, "administrative expenses" have exceeded Forty Thousand Dollars ($ 40,000.00) per year. Nevertheless, Nimmons has failed to prepare or file with appropriate government agencies the forms, reports, and returns required to be filed. Specifically, he has failed to prepare and file annual reports (Form 5500-C) and Schedule B's. He did not request, nor did he obtain, an extension of time in which to file such returns. Moreover, the failure to file timely returns and reports subjects the plan to potential penalties, and prevents both the government and plan participants from obtaining an accounting of trust assets. Notice to the Pension Benefit Guaranty Corporation ("PBGC") and to the IRS was not given when all of W.P.'s employees were terminated. Notwithstanding the generous fees charged, annual statements of benefits were not prepared and provided **[*1400]** to participants until after an injunction was obtained from this Court.

I. *The Payment of Benefits to Plan Beneficiaries*

58. The original plan permitted participants to elect optional **[**24]** forms of payment of benefits at retirement, including lump sum payments, provided the option was acceptable to the administrative committee. Since the company was closely held by family members, it was generally understood that each participant's election would be respected.

59. In 1979, for example, the committee approved the election of C. Cantrell to take the lump sum actuarial equivalent of her vested benefit upon departure from the company. Nimmons requested Hand and Associates to calculate the benefits due to C. Cantrell. Although Young advised Nimmons that C. Cantrell's lump sum present value benefit was approximately Ten Thousand Dollars ($ 10,000.00), and that the reserve necessary for the benefit was nearly Fifty Thousand Dollars ($ 50,000.00), Nimmons erroneously advised the plan trustees to pay C. Cantrell a lump sum benefit of Forty-Seven Thousand Dollars ($ 47,000.00).

60. At the time of his retirement from the company in 1975, L.A. Wright sold his stock in equal shares to N. Cantrell, his son-in-law, and to A. Wright, his son. However, L.A. Wright elected to defer receipt of his benefits until his normal retirement age of sixty-five, which occurred in February of **[**25]** 1983.

61. In April of 1983, L.A. Wright requested payment of his lump sum benefits. Nimmons made no response in writing to Wright's request until June 29, 1984. Despite the fact that Hand and Associates had calculated Wright's benefits in 1980, and Nimmons therefore knew that Wright was entitled to the payment of benefits in February of 1983, he requested another actuary to recalculate the benefits. The actuary, William H. Mercer-Meidinger, was not contacted to perform an actuarial valuation until May of 1984, and Nimmons did not provide sufficient employee census information to permit the calculation of vested benefits until July of 1984.

62. Although ordered to pay Wright's benefits on August 22, 1984, Nimmons did not pay the benefits until this Court once again ordered the payment on September 24, 1984, pursuant to a hearing on Plaintiff's show cause motion. When the benefits were finally paid to Wright, the calculations prepared by Hand and Associates in 1980 were used, since Nimmons had discovered that the Meidinger analysis would result in a larger settlement.

63. The employees of Pate Co. and Aldine were terminated in April of 1983. However, they were not offered an election **[**26]** to receive benefits until an agreed injunction was entered on August 22, 1984. Moreover, when benefit checks were finally sent to participants, they contained a "conditional release" of

the participants' claims against Nimmons.

64. In addition to refusing to pay benefits that were clearly due, Nimmons has also paid benefits to employees who were not entitled to receive benefits in August of 1984 because they had not been employed by the corporations long enough to have a vested interest. In fact, some of the employees paid by Nimmons had been employed for less than two weeks.

65. On March 12, 1984, the plan participants made written requests for copies of the latest summary plan description, the annual report, and a statement of vested benefits. The participants did not receive a statement of their benefits until August of 1984, after they had filed an application for a preliminary injunction and an agreed injunction had been entered requiring Nimmons to provide the requested information. The requested summary plan description was not provided until July of 1984. The requested annual report has never been provided.

66. Finally, employee benefits have been calculated under the Hutcheson **[**27]** and Grundy plan, which was not in existence at the time that the employees were terminated. The amended plan, Hutcheson and Grundy II, purports to make changes **[*1401]** which adversely affect the rights of the participants. For example, the amended plan does not specify various optional forms of payment, such as lump sum payments, which had been specifically available under prior plans. Thus, the amended plan purports to make forms of payment discretionary which had been expressly available under the plans in effect at the time the employees were terminated. Although Nimmons made a trial offer to pay lump sum benefits, his refusal to pay benefits until the time of trial was apparently motivated by malice rather than a good faith exercise of discretion.

67. By early April of 1983, all jobs had been abandoned, all field workers terminated, and no work was being performed by W.P. Although employees were paid wages through April 15, 1983, all employees of W.P. had been terminated prior to that date. Moreover, W.P. has not conducted business or hired employees since April of 1983. There are no beneficiaries of the pension plan, other than Plaintiffs, whose rights should be determined **[**28]** with reference to the Stark and Frahm plan. There is no indication that W.P. will ever resume business operations, employ personnel or make contributions to the pension plan since the corporations are insolvent.

68. As a direct consequence of Defendant's conduct, Plaintiffs have incurred substantial legal expenses. A reasonable award of attorney's fees to Plaintiffs for having to file this lawsuit to pursue their rights as ERISA participants is Two Hundred Forty Thousand Dollars ($ 240,000.00).

J. *The Counterclaims Asserted by Nimmons*

69. Until counterclaims were asserted by Nimmons in the case at bar, no claim has ever been asserted or intended to be asserted against the plan on behalf of the corporations for the gratuitous improvements of the plan's real property at Lake Limestone Coves.

70. To prevent contamination of water wells by septic tanks, regulations promulgated by the Brazos River Authority require water wells on the plan's property to be located at a distance of at least three hundred (300) feet from the nearest residential lot. Thus, to ensure that construction did not occur near the water well serving the plan's development, the lots on which the water well **[**29]** was situated were conveyed to Lakemont Construction Company in December of 1982. These lots, which were conveyed by A. Wright and S. Pate, acting in their capacity as trustees, were not capable of being sold by the plan because no septic system could be installed on them. Moreover, Nimmons, who was the owner of W.P. at that time, directed S. Pate and A. Wright to make the conveyance.

71. Lakemont Construction Company, which is owned by S.V. Pate, constructed the water system that services Lake Limestone Coves at no cost to the plan because Nimmons had advised the trustees that the plan could not operate a utility. Lakemont continued to operate the water system that services the development without charging the plan, and thereby enhanced the value of the pension plan's primary asset.

72. S. Pate purchased four (4) lots at Lake Limestone Coves upon the advice of Nimmons that there was no prohibition against the purchase of plan property by corporate officers. After becoming a trustee, in July of 1982, Pate attempted to sell his lots. However, the plan's attorney prepared closing documents that showed the plan rather than Pate as the seller. In order to correct the resulting title **[**30]** problems, the attorney recommended that Pate assign his lots to the plan. Nimmons concurred in this advice. While the documents reflect an assignment to the plan for a cash sales price, the transaction was in reality an attempt to cure problems created by the incorrect preparation of documents. Nimmons did not advise Pate that the

transaction might be prohibited by ERISA or that an exemption should be sought. Thus, Pate relied upon the advice of his attorney and on Nimmons in completing the transaction.

73. The counterclaims at issue in the instant case involve transactions which were entered into by the former principals of the corporation upon the advice of Nimmons. **[*1402]** Accordingly, this Court finds that Defendant's counterclaims are without merit.

III. *Conclusions of Law*

1. The participants and beneficiaries of the W.P. pension plan have commenced this action pursuant to 29 U.S.C. § 1132(a)(1)(B) to clarify their rights to benefits under the terms of the plan. A central issue in this case is whether the pension plan has been effectively amended to provide for the distribution of assets to the corporate sponsor after all liabilities to beneficiaries and participants **[**31]** have been satisfied. Specifically, this Court must determine who is the lawful claimant to approximately One Million Dollars ($ 1,000,000.00) of surplus assets in the plan. Although corporate sponsors are generally permitted to amend a plan to provide for the recapture of excess assets if certain conditions are met, the attempt to recapture excess assets upon the termination of a plan maintained by a close corporation raises issues of first impression under ERISA. In traversing uncharted territory, the source of the law to be applied to the facts in this case must be the underlying policies of the statutory scheme. This Court has jurisdiction of this cause of action pursuant to 29 U.S.C. § 1132(e), and 28 U.S.C. § 1331, and venue is proper in this district.

A. *The ERISA Fiduciary: The Duty of Loyalty and the Duty of Due Care*

2. Courts have consistently characterized the duty of pension plan administrators and trustees as fiduciary in nature. *See, e.g.,* Donovan v. Mercer, 747 F.2d 304 (5th Cir. 1984). However, to state that a person is a fiduciary only begins the analysis; it gives direction to further inquiry. SEC v. Chenery Corp., 318 U.S. 80, 85-86, 87 L. Ed. ***[**32]*** 626, 63 S. Ct. 454 (1943). To whom, and what obligations do individuals owe as ERISA fiduciaries? What are the consequences of their failure to discharge fiduciary obligations?

3. The Fifth Circuit has established that the concept of fiduciary duty is to be broadly construed within the ERISA context. *See* Donovan, 747 F.2d at 308. Thus, as an individual with authority and responsibility with respect to plan matters, Nimmons must be characterized as an ERISA fiduciary since the inception of the original W.P. plans.

4. In general, the duty of loyalty and the duty of due care are subsumed in the concept of fiduciary duty. The duty of loyalty, on the one hand, is rooted in intentional tort law. Thus, this aspect of fiduciary duty is commonly expressed in the form of a prohibitive rule. In short, a fiduciary *must not* treat the trust *res* as if it were his own property; the fiduciary must not abuse his position of trust in order to advance his own selfish interests. On the other hand, the duty of due care is rooted in negligence principles, and is commonly expressed affirmatively. The fiduciary, therefore, must exercise at least that degree of care that a reasonably prudent person **[**33]** would devote to his own affairs under like circumstances. In short, a fiduciary *must* treat the trust *res* as if it were his own property; the fiduciary must exercise his position of trust so that the beneficiary of the trust is not harmed as a consequence of his failure to exercise reasonable care.

5. These two principles, theoretically, exist in conflict. In practice, however, it is ordinarily not difficult to discern the governing principle in a given set of circumstances. The facts of the instant case do not raise close questions. As an enrolled agent and paid consultant, Defendant repeatedly breached his duty of due care. Defendant has also blatantly disregarded his duty of loyalty by consistently treating the trust assets as if they were his own property subsequent to his acquisition of the corporations.

6. These two seminal principles, the duty of due care and the duty of loyalty, pervade the statutory scheme enacted by Congress in ERISA. *See, e.g.*, 29 U.S.C. § 1104(a)(1). [2] Consequently, an ERISA fiduciary

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[2] The prudent person standard imposed by ERISA provides that the fiduciary shall discharge his duties with respect to the plan solely in the interest of the participants and beneficiaries and --

> (A) for the exclusive purpose of:
>
> (i) providing benefits to participants and their beneficiaries; and
>
> (ii) defraying reasonable expenses of administering the plan;
>
> (B) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and

[*1403] must discharge his duties with respect to a plan solely in the best interest of plan participants and beneficiaries, while meeting an objective **[**34]** standard of reasonable prudence.

[35]** 7. Defendant has willfully violated the prudent person standard imposed by Section 1104(a)(1) of ERISA. Defendant's grossly negligent conduct in failing to respond to IRS requests, and in failing to bring the plans into compliance with ERISA requirements directly caused the plans' loss of qualified status in December of 1981.

8. Following his acquisition of the corporations in 1982, Nimmons has directed the preparation of three (3) plans, yet failed to obtain qualification until 1985. Qualification of the Stark and Frahm plan would have minimized the damages caused by Nimmons' prior negligence. However, Defendant's withdrawal of the Stark and Frahm plan from IRS consideration, and his refusal to take action concerning requalification until after the commencement of this lawsuit, exacerbated the potential damages arising from disqualification and represents a blatant attempt to discredit a plan whose distribution provisions Defendant hoped to avoid.

9. Since Nimmons' acquisition of the corporations, the plans have not been administered for the exclusive purpose of providing benefits to participants and beneficiaries. The lengthy delay and refusal to pay benefits to L. A. Wright constitute **[**36]** a violation of § 1104(a)(1)(A) and (D). The fact that there was no dispute concerning Wright's entitlement to benefits underscores the malice that permeates Nimmons' conduct with respect to plan participants. Retaliatory motivation is simply impermissible under ERISA. Jiminez v. Pioneer Diecasters, 549 F. Supp. 677 (C.D. Cal. 1982).

10. The Stark and Frahm plan provides for participants to receive lump sum payments (§ 6.2(b)(1)), and for participants to be eligible for benefits upon termination of service with the company (§ 6.1(a)(3)) or at the end of the plan year in which a participant experiences a break in service (§ 6.1(f)). A fiduciary is obligated to administer the plans in accordance with the documents and instruments governing the plan, 29 U.S.C. § 1104(a)(1)(D), and may not amend the plan to impose different entitlement requirements after participants have brought suit to enforce their rights under the plan. Thus, Nimmons' continued refusal to pay undisputed vested benefits constitutes a breach of duty, and his offer to pay benefits under the Hutcheson and Grundy plan constitutes an additional breach since the participants' rights are to be determined by the plan **[**37]** in effect at the time of termination. The method of payment under the Stark and Frahm plan may be subject to amendment if it is in the best interest of plan participants. However, a trustee's exercise of discretion may not be motivated by self-interest, malice or retaliation. *See* Frary v. Shorr Paper Products, Inc., 494 F. Supp. 565 (N.D. Ill. 1980).

11. Nimmons' failure to pay the trust for his lakefront lots is a manipulation of plan assets to his own benefit in violation of 29 U.S.C. § 1106(b)(1). Similarly, the transfer of plan assets to InterFirst in exchange for the bank's agreement to finance his acquisition of the companies violates ERISA standards. Freund v. Marshall & Ilsley Bank, 485 F. Supp. 629 (W.D. Wis. 1979). Furthermore, execution **[*1404]** of the deed of trust in favor of InterFirst clouded title to trust assets, and is a conflict of interest transaction which is prohibited under Section 1106(b)(1).

12. Nimmons' payment to himself of over Ninety-Nine Thousand Dollars ($ 99,000.00) in trustee's fees is impermissible under ERISA. While a reasonable trustee's fee may be paid to one who is not a full-time paid employee of the sponsoring company, 29 U.S.C. **[**38]** § 1108(c)(2), the payments in this case were excessive, unwarranted, and unrelated to any services rendered as a trustee. Defendant is not permitted to pay himself at an exorbitant rate for time spent correcting his past mistakes.

13. In addition to the general obligations imposed by Section 1104, an ERISA fiduciary is subject to specific statutory obligations including reporting and disclosure requirements. Nimmons' failure to respond to requests for information and to prepare and file proper disclosure reports are further breaches of fiduciary duty. Defendant has willfully failed to comply with the requirements of 29 U.S.C. § 1021(a) and (b), and with the provisions of Section 1024(b)(3). By failing to respond to Plaintiffs'

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with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter.

29 U.S.C. § 1104(a)(1).

letters of March 12, 1984, Nimmons has also violated his obligation which arises under 29 U.S.C. § 1025.

14. All counterclaims are dismissed. The transactions complained of by Nimmons are not prohibited in substance, caused no injury to the plan, and were conducted with Nimmons' full knowledge and upon his advice. The assertion that the plan owes over Nine Hundred Thousand Dollars ($ 900,000.00) to the corporations is invalid, and was made in an attempt **[**39]** to manipulate the plan's assets for Defendant's own purposes.

B. *The Distribution Provisions of the Stark and Frahm Plan*

15. The initial pension plan adopted by W.P. provided that the employer could amend the plan by delivering a written instrument to the trustee after execution by the Board of Directors. Since the amendment became effective upon endorsement of the trustee's receipt (§ 6.1 of the original plan), the original plan was properly amended by the Stark and Frahm plan.

16. In detailed and explicit distribution provisions, the Stark and Frahm plan provides that if excess assets exist in the plan after vested benefits have been calculated, the excess assets must be apportioned pro rata and distributed to participants. [3] The irrevocable nature of this distribution provision is underscored by multiple references. Section 1.2 stresses that no portion of the trust shall ever revert to the company except as specifically provided. However, the plan provided for the entire trust to be distributed to participants upon termination. Furthermore, Section 7.9 stresses that the plan should never be construed to vest any rights in the corporation other than the rights which **[**40]** are expressly provided by the plan. In light of the elaborate distribution provisions for the benefit of participants, Section 7.9 limits the rights of the corporation to those specifically stated in the plan, notwithstanding any contrary amendment provision. In sum, the distribution provisions of the Stark and Frahm plan are so explicit that the intent of the grantors may not be avoided by Nimmons' subsequent attempts to amend the operative plan to allow recapture of excess plan assets.

[41]** 17. Although Nimmons argues that his resolution of April 14, 1983, and the Hutcheson and Grundy II plan executed **[*1405]** in May of 1984 are amendments that would permit the corporation to recapture excess assets, this Court concludes that the amendments are not valid with respect to the distribution of excess assets. The Court notes that the Stark and Frahm plan permitted amendment only to the extent that no amendment shall:

> (i) have the effect of vesting in the company any interest in any property held subject to the terms of this trust;
> (ii) cause or permit any property held subject to the terms of this trust to be diverted to purposes other that the exclusive benefit of the present or future members and their beneficiaries . . . [or]
> (iii) reduce the beneficial interest of a member in any of the assets of the trust at the time of such amendment . . .

Thus, this amendment provision includes more than the obligatory "exclusive benefit" language which has been construed to permit amendment allowing recapture of excess assets. The "exclusive benefit" requirement imposed by ERISA is met here by Subsection (ii) of § 13.1. Subsection (i) should not, **[**42]** therefore, be construed as a superfluous repetition of the exclusive benefit rule. Consequently, Nimmons' amendment permitting recapture of excess assets violates Subsection (i) of the Stark and Frahm amendment provision, and is void. *See* Bryant v. International Fruit Products Co., 793 F.2d 118 (6th Cir. 1986) (Reversing the district court's interpretation of 29 U.S.C. § 1344(d) premised upon similar language as is contained in § 13.1 of the Stark and Frahm plan, and holding that employer's amendment to recapture excess assets was impermissible).

18. Furthermore, the Stark and Frahm plan provides that the plan is to terminate as to any group of employees which is discharged as a group. Since all of W.P.'s employees were discharged prior to April 14, 1983, the date of Nimmons' purported amendment, the

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[3] In addition to the termination provision, *see* note 1 *infra*, the Stark and Frahm plan provides as follows:

> 7.9 *No benefit to the company*. No part of the income or corpus of the Trust shall be used for any purpose except for the exclusive benefit of the employees and their beneficiaries and the expenses of administration of the plan. Anything to the contrary herein notwithstanding, the plan shall never be construed to vest any rights in the company other than those specifically given hereunder.

Section 1.2 of the plan provides:

> . . . the trust shall be for the exclusive benefit of the employees of the company and in no event shall any portion of the trust ever revert to the company except as specifically provided herein upon termination of the plan.

discharge of all employees resulted in a constructive termination of the entire plan. At *that time*, the participants were entitled to a distribution of excess plan assets in accordance with the distribution formula set forth in Section 13.3 of the Stark and Frahm plan.

19. The W.P. pension plan ceased to operate as a bona fide plan in April of 1983, and there has been no subsequent **[**43]** indication of corporate intent or capacity to resume operations. The circumstances involved in the instant case clearly support the conclusion that the plan has not been continued for the exclusive benefit of participants. Rather, the unnatural and abusive prolongation of the plan solely for the purpose of supporting the Defendant's attempted amendments to permit the recapture of plan assets violates the broad remedial protections afforded by ERISA. In sum, the plan's continued existence since April of 1983 has been a sham.

20. In any event, Nimmons' attempted revocation of the Stark and Frahm plan on May 31, 1983 must be considered an *actual* plan termination since a written plan had not been effectively executed to replace the revoked plan and trust.

21. The Stark and Frahm plan was adopted by the Board of Directors on May 27, 1982 to redress the problems resulting from the IRS disqualification. Accordingly, equity does not now permit Defendant to complain about the effect of distribution provisions which are consistent with the intention of the grantors, and which were ratified by Nimmons when he instructed Stark and Frahm to submit their plan for IRS consideration.

C. **[**44]** *The Recapture of Excess Plan Assets*

22. Although this Court concludes that the contemplated amendments of the W.P. pension plan are barred by the operational plan itself, and that the plan's unnatural prolongation constitutes a violation of the spirit, if not the letter of Section 1106, which requires a fiduciary to guard the interests of the plan's participants, rather than those of the corporate sponsor, the statutory exception to the exclusive benefit rule will be examined as an alternative basis for the decision reached in this case. *See* 29 U.S.C. § 1344(d).

23. Corporate sponsors have the right to amend employee welfare plans to **[*1406]** provide for the recapture of excess plan assets *if* the plans can be amended consistently with the requirements imposed by ERISA. The statutory exception to the exclusive benefit rule provides that any residual assets of a defined benefit pension plan funded solely by employer contributions may be distributed to the employer upon plan termination provided that the following three conditions are met:

> (A) all liabilities of the plan to participants and their beneficiaries have been satisfied,
>
> (B) the distribution does **[**45]** not contravene any provision of law, and
> (C) the plan provides for such a distribution in these circumstances.

29 U.S.C. § 1344(d)(1). *See Washington-Baltimore Newspaper Guild*, 555 F. Supp. at 259.

24. In construing Section 1344(d)(1), courts have generally permitted corporate sponsors to recapture excess assets through plan amendment providing that all benefits under the existing plans are not thereby reduced. *See, e.g.,* In re C.D. Moyer Company Trust Fund, 441 F. Supp. 1128 (E.D. Pa. 1977), *aff'd*, 582 F.2d 1273 (3rd Cir. 1978); Washington-Baltimore Newspaper Guild Local 35 v. Washington Star Company, 555 F. Supp. 257 (D.D.C. 1983), *aff'd*, 234 U.S. App. D.C. 377, 729 F.2d 863 (D.C. Cir. 1984); Walsh v. Great Atlantic & Pacific Tea Company, Inc., 96 F.R.D. 632 (D.N.J. 1983), *aff'd*, 726 F.2d 956 (3rd Cir. 1983); *Pollock v. Castrovinci, 476 F. Supp. 606 (S.D.N.Y. 1979), aff'd, 622 F.2d 575 (2d Cir. 1980)*; Audio Fidelity Corp. v. Pension Benefit Guaranty Corp., 624 F.2d 513 (4th Cir. 1980); Eagar v. Savannah Foods & Industries, Inc., 605 F. Supp. 415 (N.D. Ala. 1984); Bryant v. International Fruit Products Company, Inc., 604 ***[**46]*** F. Supp. 890 (S.D. Ohio 1985).

25. While there is a minority position to the effect that the exclusive benefit language required by ERISA precludes the recapture of excess assets, *see, e.g.,* F.D.I.C. v. Marine Nat'l Exchange Bank of Milwaukee, 500 F. Supp. 108 (E.D. Wis. 1980); Calhoun v. Falstaff Brewing Corp., 478 F. Supp. 357 (E.D. Mo. 1979), the better reasoned position is that the "exclusive benefit" rule *standing alone* does not preclude an amendment which specifically directs the distribution of excess assets to the corporation in appropriate circumstances.

26. A controlling factor in the cases which have permitted recapture has been the absence of an excess asset distribution provision in the plan sought to be amended. In other words, to the extent that ERISA provisions do not expressly preclude a contemplated distribution, judicial interpretation is bottomed upon the

application of general contractual principles. Thus, courts which have permitted a recapture amendment have been influenced by the fact that the plans did not provide for the distribution of excess assets to participants. Washington-Baltimore Newspaper, 555 F. Supp. 257; *Pollock v. Castrovinci* ***[**47]*** *, 476 F. Supp. at 606*; In re C.D. Moyer Co. Trust Fund, 441 F. Supp. at 1128.

27. A fundamental legislative purpose was to assure that plan participants "actually receive benefits and do not lose benefits as a result of unduly restrictive forfeiture provisions or failure of the pension plan to retain sufficient funds to meet its obligations." 1974 U.S. Code Cong. & Ad. News 4676-77. To these ends, Congressional intent is embodied in the "exclusive benefit rule" requiring that plan assets be held for the exclusive benefit of participants. *See* 29 U.S.C. § 1103(c)(1). At the same time, residual assets that have been exclusively contributed by an employer may be recovered in certain situations. *See* 29 U.S.C. § 1344(d)(1).

28. Judicial interpretation of the interaction of Sections 1103 and 1344 suggests that a recapture amendment should be permitted in two situations. First, where a trust plan is silent regarding the distribution of excess assets, courts must ascertain the probable intent of the plan originators premised upon a factual inquiry. If an employer has exclusively funded a plan, the courts reason, the unbargained for distribution of excess assets to participants **[**48]** represents an unintended **[*1407]** windfall for employees. Secondly, and more significantly, where excess assets have accumulated as a consequence of actuarial error, courts have been reluctant to penalize employers for overfunding their plans.

29. The judicial outcome permitting an employer to recapture in these two situations is consistent with the policies underlying the enactment of ERISA. Common sense dictates that employers which fund plans under ERISA guidelines should not be penalized for overfunding in an abundance of caution or as a result of miscalculation by the actuary. The contrary judicial outcome would contravene congressional purpose by creating a disincentive for employers to adequately fund employee welfare plans.

30. The policy considerations which underlie the permissible recapture of excess assets are conspicuously absent from the case at bar. In contrast to the to the courts which have permitted recapture, the Fourth Circuit in Audio Fidelity Corp., 624 F.2d at 516-17 announced a rule that is more applicable to the present, analogous circumstances. The Fourth Circuit concluded that a recapture amendment is impermissible when a plan expressly provides **[**49]** for the distribution of excess assets to participants, particularly when an attempted amendment occurs subsequent to termination. Concluding that the right to benefits under a plan is earned, delayed compensation, and not gratuities, the Fourth Circuit rejected "Audio's claim that its employees would be unjustly enriched by receiving their equitable share of the fund's assets." Id. at 518, *quoting,* Rochester Corp v. Rochester, 450 F.2d 118, 121 (4th Cir. 1971). Reasoning that the plan fixed the rights of participants at the time of termination, the court held that the employer's post-termination attempt to divert surplus assets was prohibited by ERISA. Furthermore, an impermissible attempt to amend a distribution provision may itself constitute a breach of fiduciary duty. *See* Delgrosso v. Spang & Co., 769 F.2d 928 (3d Cir. 1985).

31. In contrast to the cases relied upon by Defendant, the relevant equitable factors in the present case overwhelmingly favor the plan participants and beneficiaries. Accordingly, this Court concludes that Defendant's purported amendment to permit recapture violates the express provisions and the spirit of ERISA, and would work a fraud upon **[**50]** the participants.

32. This Court concludes that the pension plan assets were not "sold" to Nimmons when he acquired the companies. *See* Foster Medical Corp. Employee's Pension Plan v. Healthco, Inc., 753 F.2d 194 (1st Cir. 1985). The excess assets were not subject to the bargaining and negotiation that led to the stock purchase agreement. The purchase price of the corporations was arrived at through an evaluation of equipment values, pending work, value of real property, and other traditional indices of a corporation's value. As a consequence of his superior knowledge and experience gained from serving as a paid plan consultant, Nimmons knew of the existence and the amount of excess plan assets. Yet, he failed to disclose his intention to control the excess plan assets through acquisition of the corporations. While the fiduciary relationship is consensual, and may be terminated at any time, there is a continuing obligation, under the circumstances involved in the instant case, to disclose material facts gained from years of experience as an ERISA fiduciary. To the extent that plan assets in excess of One Million Dollars ($ 1,000,000.00) were overlooked in the acquisition of **[**51]** the corporations,

their recapture by the employer, particularly in light of the Stark and Frahm distribution provisions, would constitute an unwarranted and unintended windfall to the Defendant, the corporations' sole shareholder, who neither made any contribution to the assets which have accumulated nor forthrightly bargained for them.

D. *Remedies*

33. Since the Court concludes that Defendant's failure to respond to written requests for information was malicious, and without justification, the Court holds Defendant liable for statutory damages in **[*1408]** the amount of One Hundred Dollars ($ 100.00) per day from April 13, 1984 until the date of trial. 29 U.S.C. § 1132(c).

34. Bearing in mind the admonition of the concurring Justices in Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134, 105 S. Ct. 3085, 3099, 87 L. Ed. 2d 96 (1985), [4] in accordance with the underlying statutory purposes of ERISA, this Court deems it appropriate for Defendant to repay to the W.P. pension plan all fees paid to himself after July of 1982. Although an agent is generally entitled to reasonable compensation for services, Defendant's obvious conflict of interest subsequent to **[**52]** his acquisition of the corporations and during the pendency of the present lawsuit rendered it wholly impossible for him to perform impartial service on the behalf of plan beneficiaries. Instead, Defendant's performance has been characterized by malice and by intentional disregard of his fiduciary duty. The unnatural prolongation of the life of the pension plan appears to have been motivated solely by Defendant's self-interest. Under the circumstances, the payment to himself of exorbitant fees, particularly when the plan has been charged for time spent by the Defendant in undoing the results of his own prior malfeasance and negligence, conflicts with Defendant's statutory duties. Defendant is further ordered to pay to the plan those payments on lakefront lots for which he is in default. *See* 29 U.S.C. §§ 1109(a), 1132.

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[4] The four concurring Justices in *Russell* instructed courts in fashioning equitable relief to bear in mind the "ultimate consideration whether allowance or disallowance of particular relief would best effectuate the underlying purposes of ERISA -- enforcement of strict fiduciary standards of care in the administration of all aspects of pension plans and promotion of the best interests of participants and beneficiaries." 105 S. Ct. at 3099.

[53]** 35. Reasonable attorneys' fees in the sum of Two Hundred Forty Thousand Dollars ($ 240,000.00) are jointly and severally assessed against Defendant, individually, who has acted in bad faith and in intentional disregard of his fiduciary obligations to Plaintiffs, and against the W.P. pension plan, in accordance with the principles established by the Fifth Circuit. *See, e.g.,* Donovan v. Cunningham, 716 F.2d 1455, 1475 (5th Cir. 1983); Ironworkers Local No. 272 v. Bowen, 624 F.2d 1255 (5th Cir. 1980). *See also Free v. Gilbert-Hodgman, Inc.*, No. 80-C-4492, slip op. (D. Ill. March 5, 1985) (president of employer corporation and trustee held jointly and severally liable for attorneys' fees and costs); Donovan v. Schmoutey, 592 F. Supp. 1361, 1406 (D. Nev. 1984)(award of costs and fees jointly and severally against defendants who participated in breach of duty by trustee); Teamsters Pension Trust Fund v. Philadelphia Fruit Exchange, 603 F. Supp. 877, 881 (E.D. Pa. 1985) (pension fund, corporation and employer individually held jointly and severally liable for costs and attorneys' fees).

36. A trustee must serve solely in the best interest of a plan's participants. Since **[**54]** Defendant's conflicts of interest have impaired his ability to serve as a trustee, *see* Donovan v. Bierwirth, 680 F.2d 263 (2d Cir. 1982), this Court concludes that he should be removed, and a substitute trustee shall be appointed. *See* Marshall v. Snyder, 572 F.2d 894, 901 (2d Cir. 1978).

37. Plaintiffs shall submit to the Court within twenty (20) days a list of three (3) proposed substitute trustees. From this list, the Court will appoint a substitute trustee and plan administrator who shall call a meeting of the members pursuant to § 13.6 of the Stark and Frahm plan, for the purpose of selecting a controlling committee to terminate the plan.

38. The controlling committee together with the substitute trustee shall proceed to terminate the plan in accordance with PBGC requirements and in accordance with the distribution provisions of the Stark and Frahm plan. Since termination at this time of the Stark and Frahm plan may present tax disadvantages to the Plaintiffs, the controlling committee may, upon advice of the substitute trustee, elect to proceed with termination of the Hutcheson and Grundy plan which must be reformed in accordance with these Findings and Conclusions **[**55]** to contain **[*1409]** Sections 13.3 and 13.6 of the Stark and Frahm plan.

39. In the event that the above Findings of Fact also constitute Conclusions of Law, they are adopted as

such. In the event that the foregoing Conclusions of Law also constitute Findings of Fact, they are adopted as such.

IV. *Conclusion*

In accordance with law and equity, this Court concludes that the relevant provisions of the Stark and Frahm plan, as originally presented for IRS consideration, must control the final disposition of assets which have accumulated in the W.P. pension plan. In light of Defendant's intentional and continuous breach of his duties as an ERISA fiduciary, this Court further concludes that a substitute trustee must be appointed to terminate the plan. Moreover, Defendant is to be held personally liable for the damages proximately caused by his misfeasance and deliberate violations of ERISA standards. This Court will retain continuing jurisdiction jurisdiction over this cause of action until assets have been distributed to the beneficiaries and participants of the plan. Accordingly, counsel for Plaintiff is directed to file a report with this Court every ninety (90) days until further **[**56]** notice.

SIGNED AND ENTERED at Houston, texas, on this the 18th day of August, 1986.

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29 USCS § 1344

Current through Public Law 116-68, approved November 8, 2019.

United States Code Service > TITLE 29. LABOR (Chs. 1 — 32) > CHAPTER 18. EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM (§§ 1001 — 1461) > PLAN TERMINATION INSURANCE (§§ 1301 — 1461) > TERMINATIONS (§§ 1341 — 1350)

§ 1344. Allocation of assets

(a) Order of priority of participants and beneficiaries. In the case of the termination of a single-employer plan, the plan administrator shall allocate the assets of the plan (available to provide benefits) among the participants and beneficiaries of the plan in the following order:

(1) First, to that portion of each individual's accrued benefit which is derived from the participant's contributions to the plan which were not mandatory contributions.

(2) Second, to that portion of each individual's accrued benefit which is derived from the participant's mandatory contributions.

(3) Third, in the case of benefits payable as an annuity—

(A)in the case of the benefit of a participant or beneficiary which was in pay status as of the beginning of the 3-year period ending on the termination date of the plan, to each such benefit, based on the provisions of the plan (as in effect during the 5-year period ending on such date) under which such benefit would be the least,

(B)in the case of a participant's or beneficiary's benefit (other than a benefit described in subparagraph (A)) which would have been in pay status as of the beginning of such 3-year period if the participant had retired prior to the beginning of the 3-year period and if his benefits had commenced (in the normal form of annuity under the plan) as of the beginning of such period, to each such benefit based on the provisions of the plan (as in effect during the 5-year period ending on such date) under which such benefit would be the least.

For purposes of subparagraph (A), the lowest benefit in pay status during a 3-year period shall be considered the benefit in pay status for such period.

(4) Fourth—

(A)to all other benefits (if any) of individuals under the plan guaranteed under this title (determined without regard to section 4022B(a) [*29 USCS § 1322b(a)*]), and

(B)to the additional benefits (if any) which would be determined under subparagraph (A) if section 4022(b)(5)(B) [*29 USCS § 1322(b)(5)(B)*] did not apply.

For purposes of this paragraph, section 4021 [*29 USCS § 1321*] shall be applied without regard to subsection (c) thereof.

(5) Fifth, to all other nonforfeitable benefits under the plan.

(6) Sixth, to all other benefits under the plan.

(b) Adjustment of allocations; reallocations; mandatory contributions; establishment of subclasses and categories. For purposes of subsection (a)—

(1) The amount allocated under any paragraph of subsection (a) with respect to any benefit shall be properly adjusted for any allocation of assets with respect to that benefit under a prior paragraph of subsection (a).

(2) If the assets available for allocation under any paragraph of subsection (a) (other than paragraphs (4), (5), and (6)) are insufficient to satisfy in full the benefits of all individuals which are described in that paragraph, the assets shall be allocated pro rata among such individuals on the basis of the present value (as of the termination date) of their respective benefits described in that paragraph.

(3) If assets available for allocation under paragraph (4) of subsection (a) are insufficient to satisfy in full the benefits of all individuals who are described in that paragraph, the assets shall be allocated first to benefits described in subparagraph (A) of that paragraph. Any remaining assets shall then be allocated to benefits described in subparagraph (B) of that paragraph. If assets allocated to such subparagraph (B) are insufficient to satisfy in full the benefits described in that subparagraph, the assets shall be allocated pro rata among individuals on the basis of the present value (as of the termination date) of their respective benefits described in that subparagraph.

(4) This paragraph applies if the assets available for allocation under paragraph (5) of subsection (a) are not sufficient to satisfy in full the benefits of individuals described in that paragraph.

(A) If this paragraph applies, except as provided in subparagraph (B), the assets shall be allocated to the benefits of individuals described in such paragraph (5) on the basis of the benefits of individuals which would have been described in such paragraph (5) under the plan as in effect at the beginning of the 5-year period ending on the date of plan termination.

(B) If the assets available for allocation under subparagraph (A) are sufficient to satisfy in full the benefits described in such subparagraph (without regard to this subparagraph), then for purposes of subparagraph (A), benefits of individuals described in such subparagraph shall be determined on the basis of the plan as amended by the most recent plan amendment effective during such 5-year period under which the assets available for allocation are sufficient to satisfy in full the benefits of individuals described in subparagraph (A) and any assets remaining to be allocated under such subparagraph shall be allocated under subparagraph (A) on the basis of the plan as amended by the next succeeding plan amendment effective during such period.

(5) If the Secretary of the Treasury determines that the allocation made pursuant to this section (without regard to this paragraph) results in discrimination prohibited by *section 401(a)(4) of the Internal Revenue Code of 1986* [*26 USCS § 401(a)(4)*] then, if required to prevent the disqualification of the plan (or any trust under the plan) under section 401(a) or 403(a) of such Code [*26 USCS § 401(a)* or *403(a)*], the assets allocated under subsections (a)(4)(B), (a)(5), and (a)(6) shall be reallocated to the extent necessary to avoid such discrimination.

(6) The term “mandatory contributions” means amounts contributed to the plan by a participant which are required as a condition of employment, as a condition of participation in such plan, or as a condition of obtaining benefits under the plan attributable to employer contributions. For this purpose, the total amount of mandatory contributions of a participant is the amount of such contributions reduced (but not below zero) by the sum of the amounts paid or distributed to him under the plan before its termination.

(7)A plan may establish subclasses and categories within the classes described in paragraphs (1) through (6) of subsection (a) in accordance with regulations prescribed by the corporation.

(c) Increase or decrease in value of assets. Any increase or decrease in the value of the assets of a single-employer plan occurring during the period beginning on the later of (1) the date a trustee is appointed under section 4042(b) [*29 USCS § 1342(b)*] or (2) the date on which the plan is terminated is to be allocated between the plan and the corporation in the manner determined by the court (in the case of a court-appointed trustee) or as agreed upon by the corporation and the plan administrator in any other case. Any increase or decrease in the value of the assets of a single-employer plan occurring after the date on which the plan is terminated shall be credited to, or suffered by, the corporation.

(d) Distribution of residual assets; restrictions on reversions pursuant to recently amended plans; assets attributable to employee contributions; calculation of remaining 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.

(2)

(A) In determining the extent to which a plan provides for the distribution of plan assets to the employer for purposes of paragraph (1)(C), any such provision, and any amendment increasing the amount which may be distributed to the employer, shall not be treated as effective before the end of the fifth calendar year following the date of the adoption of such provision or amendment.

(B)A distribution to the employer from a plan shall not be treated as failing to satisfy the requirements of this paragraph if the plan has been in effect for fewer than 5 years and the plan has provided for such a distribution since the effective date of the plan.

(C) Except as otherwise provided in regulations of the Secretary of the Treasury, in any case in which a transaction described in section 208 [*29 USCS § 1058*] occurs, subparagraph (A) shall continue to apply separately with respect to the amount of any assets transferred in such transaction.

(D) For purposes of this subsection, the term "employer" includes any member of the controlled group of which the employer is a member. For purposes of the preceding sentence, the term "controlled group" means any group treated as a single employer under subsection (b), (c), (m) or (o) of *section 414 of the Internal Revenue Code of 1986* [*26 USCS § 414(b)*, (c), (m) or (o)].

(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 described in subsection (a), such remaining assets shall be equitably distributed to the participants who made such contributions or their beneficiaries (including alternate payees, within the meaning of section 206(d)(3)(K) [*29 USCS § 1056(d)(3)(K)*]).

(B) For purposes of subparagraph (A), the portion of the remaining assets which are attributable to employee contributions shall be an amount equal to the product derived by multiplying—

(i)the market value of the total remaining assets, by

(ii)a fraction—

(I)the numerator of which is the present value of all portions of the accrued benefits with respect to participants which are derived from participants' mandatory contributions (referred to in subsection (a)(2)), and

(II)the denominator of which is the present value of all benefits with respect to which assets are allocated under paragraphs (2) through (6) of subsection (a).

(C) For purposes of this paragraph, each person who is, as of the termination date—

(i)a participant under the plan, or

(ii)an individual who has received, during the 3-year period ending with the termination date, a distribution from the plan of such individual's entire nonforfeitable benefit in the form of a single sum distribution in accordance with section 203(e) [*29 USCS § 1053(e)*] or in the form of

irrevocable commitments purchased by the plan from an insurer to provide such nonforfeitable benefit,

shall be treated as a participant with respect to the termination, if all or part of the nonforfeitable benefit with respect to such person is or was attributable to participants' mandatory contributions (referred to in subsection (a)(2)).

(4) Nothing in this subsection shall be construed to limit the requirements of *section 4980(d) of the Internal Revenue Code of 1986* [*26 USCS § 4980(d)*] (as in effect immediately after the enactment of the Omnibus Budget Reconciliation Act of 1990 [enacted Nov. 5, 1990]) or section 404(d) of this Act [*29 USCS § 1104(d)*] with respect to any distribution of residual assets of a single-employer plan to the employer.

(e) Bankruptcy filing substituted for termination date. If a contributing sponsor of a plan has filed or has had filed against such person a petition seeking liquidation or reorganization in a case under title 11, United States Code, or under any similar Federal law or law of a State or political subdivision, and the case has not been dismissed as of the termination date of the plan, then subsection (a)(3) shall be applied by treating the date such petition was filed as the termination date of the plan.

(f) Valuation of section 4062(c) liability for determining amounts payable by corporation to participants and beneficiaries.

(1) In general. In the case of a terminated plan, the value of the recovery of liability under section 4062(c) [*29 USCS § 1362(c)*] allocable as a plan asset under this section for purposes of determining the amount of benefits payable by the corporation shall be determined by multiplying—

(A)the amount of liability under section 4062(c) [*29 USCS § 1362(c)*] as of the termination date of the plan, by

(B)the applicable section 4062(c) [*29 USCS § 1362(c)*] recovery ratio.

(2) Section 4062(c) recovery ratio. For purposes of this subsection—

(A) In general. Except as provided in subparagraph (C), the term "section 4062(c) [*29 USCS § 1362(c)*] recovery ratio" means the ratio which—

(i)the sum of the values of all recoveries under section 4062(c) [*29 USCS § 1362(c)*] determined by the corporation in connection with plan terminations described under subparagraph (B), bears to

(ii)the sum of all the amounts of liability under section 4062(c) [*29 USCS § 1362(c)*] with respect to such plans as of the termination date in connection with any such prior termination.

(B) Prior terminations. A plan termination described in this subparagraph is a termination with respect to which—

(i)the value of recoveries under section 4062(c) [*29 USCS § 1362(c)*] have been determined by the corporation, and

(ii)notices of intent to terminate were provided (or in the case of a termination by the corporation, a notice of determination under section 4042 [*29 USCS § 1342*] was issued) during the 5-Federal fiscal year period ending with the third fiscal year preceding the fiscal year in which occurs the date of the notice of intent to terminate (or the notice of determination under section 4042 [*29 USCS § 1342*]) with respect to the plan termination for which the recovery ratio is being determined.

(C) Exception. In the case of a terminated plan with respect to which the outstanding amount of benefit liabilities exceeds $20,000,000, the term "section 4062(c) recovery ratio" means, with respect to the termination of such plan, the ratio of—

(i)the value of the recoveries on behalf of the plan under section 4062(c) [*29 USCS § 1362(c)*], to

(ii)the amount of the liability owed under section 4062(c) [*29 USCS § 1362(c)*] as of the date of plan termination to the trustee appointed under section 4042 (b) or (c) [*29 USCS § 1342(b)* or (c)].

(3) Subsection not to apply. This subsection shall not apply with respect to the determination of—

(A)whether the amount of outstanding benefit liabilities exceeds $20,000,000, or

(B)the amount of any liability under section 4062 [*29 USCS § 1362(c)*] to the corporation or the trustee appointed under section 4042 (b) or (c) [*29 USCS § 1342(c)*].

(4) Determinations. Determinations under this subsection shall be made by the corporation. Such determinations shall be binding unless shown by clear and convincing evidence to be unreasonable.

History

HISTORY:

Act Sept. 2, 1974, *P. L. 93-406*, Title IV, Subtitle C, § 4044, *88 Stat. 1025*.; Sept. 26, 1980, *P. L. 96-364*, Title IV, § 402(a)(7), *94 Stat. 1299*; April 7, 1986, *P. L. 99-272*, Title XI, § 11016(c)(12), (13), *100 Stat. 274*; Dec. 22, 1987, *P. L. 100-203*, Title IX, Subtitle D, Part II, Subpart B, § 9311(a)(1), (b), (c), *101 Stat. 1330*-359, 1330-360; Dec. 19, 1989, *P. L. 101-239*, Title VII, Subtitle G, Part V, Subpart C, § 7881(e)(3), Subpart D, §§ 7891(a)(1), 7894(g)(2), *103 Stat. 2440*, 2445, 2451; Nov. 5, 1990, *P. L. 101-508*, Title XII, Subtitle A, § 12002(b)(2)(B), *104 Stat. 1388*-566; Aug. 17, 2006, *P. L. 109-280*, Title IV, §§ 404(b), 407(b), 408(b)(2), *120 Stat. 928*, 930, 931; Dec. 23, 2008, *P. L. 110-458*, Title I, Subtitle A, § 104(c), *122 Stat. 5104*.

End of Document

§ 1211. Mutual insurance corporations; membership and dividends

(a) Every domestic mutual insurance corporation shall be organized, maintained and operated for the benefit of its members as a non-stock corporation. Every policyholder shall be a member of such corporation and shall, except as provided in subsection (d) hereof, be entitled to vote at any regular or special meeting of such corporation, to notice thereof pursuant to the by-laws and to share equitably in dividends declared by the board of directors. The board of directors may, subject to limitations in this chapter, from time to time declare a dividend from the corporation's surplus. No dividend shall be declared or paid if thereby the company's minimum or other required surplus will be impaired. In declaring and paying any dividend the board of directors may make reasonable classifications of policies, and shall declare and pay such dividend in a manner that is fair and equitable to the policyholders. Unless otherwise provided in the corporation's charter or by-laws, each member shall be entitled to one vote at any regular or special meeting. The charter or by-laws may, with the approval of the superintendent, provide for distribution of voting power among members on the basis of the amount of insurance held, number of policies held, amount of premiums paid by them or on any other basis the superintendent finds fair and equitable.

(b)A member of any such corporation may vote at any such meeting in person or by proxy. No proxy or power of attorney given by him, to vote at any meeting of such corporation, shall be valid or effective after the next meeting. No person shall directly or indirectly sell or purchase, or offer to sell or purchase, any proxy or power of attorney to vote at any such meeting, nor shall any person directly or indirectly give or receive, or offer to give or receive, any proxy or power of attorney to vote at any such meeting as an inducement to the negotiation or making of a contract of insurance or any renewal thereof, to the settlement of any claim thereunder, or to any other act relating thereto.

(c) All corporations, their directors and representatives and all persons, firms or corporations holding property in trust may insure the same in mutual insurance corporations and by so doing such directors, representatives or trustees, in their representative capacity, may assume the liabilities and be entitled to the rights of a member of such insurer, but shall not be personally liable as individuals upon such contract of insurance.

(d) The provisions of this section as to members' voting rights and the election of directors shall not apply to any domestic mutual life insurance company governed by the provisions of section four thousand two hundred ten of this chapter, nor shall they require any such company to hold a meeting of its members.

(e) As to any surety or fidelity bond or like obligation executed by a mutual property/casualty insurance company as a surety or guarantor, the principal, and not the obligee, shall be a member of such corporation.

History

Add, L 1984, ch 367, § 1, eff Sept 1, 1984.

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§ 7307. Conversion of domestic mutual property/casualty insurance companies or advance premium corporations into domestic stock property/casualty insurance companies; insurers not in rehabilitation

(a) In this article:

(1)"Affiliate" of a mutual insurer means any 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.

(2)"Control" has the meaning assigned to it in paragraph two of subsection (a) of section one thousand five hundred one of this chapter.

(3)A "domestic mutual insurer" or "mutual insurer" means a domestic mutual property/casualty insurance company organized under article twelve of this chapter and licensed under article forty-one of this chapter, or a domestic advance premium corporation organized and licensed under article sixty-six of this chapter, in either case authorized to issue non-assessable policies only and not operating under an order of rehabilitation.

(4)A "holder of a section 1307 agreement" means the holder of an agreement executed pursuant to section one thousand three hundred seven of this chapter.

(b)A domestic mutual insurer may apply to the superintendent for permission to convert into a domestic stock property/casualty insurer complying with the relevant organization and licensing provisions of articles twelve and forty-one of this chapter. The application to the superintendent shall be pursuant to a resolution, adopted by no less than a majority of the entire board of directors, specifying 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. A copy of the resolution, together with a statement of its adoption, both certified by the president and secretary, or officers corresponding to either of them, and affirmed by them as true under the penalties of perjury and under the seal of the mutual insurer, shall accompany the application. The superintendent may thereafter request any additional documents and information which he may reasonably require. Unless the superintendent finds that:

(1)the resolution is defective upon its face;

(2)the proposed conversion is contrary to law or is not in the best interests of the policyholders or the public; or

(3)the mutual insurer does not have a surplus to policyholders at least equal to the minimum capital and surplus required to be maintained for a newly organized stock insurer doing the same kinds of insurance, in which cases the proposed conversion shall terminate, the superintendent shall order an examination of the mutual insurer pursuant to section three hundred ten of this chapter as of the last day of the period covered in its latest filed statement. The superintendent may also examine any affiliate of the mutual insurer.

(c) The superintendent shall also appoint one or more qualified disinterested persons to appraise and report to the superintendent the fair market value of the mutual insurer and, to the extent necessary, its affiliates, on the

basis of its latest filed annual or quarterly statement, and of any significant subsequent developments. 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 appraisers shall receive reasonable compensation and be reimbursed for reasonable expenses incurred in discharging their duties. They may, as necessary, employ consultants to advise them on any technical matters.

(d) The superintendent shall make copies of such examination report and appraisal report available to the board of directors within fifteen days of his receipt of the reports. After receiving such reports the superintendent may grant or deny permission to the board of directors to submit to him a plan of conversion. If permission is granted, the plan shall include the provisions, and be submitted in the manner and under the conditions, required by subsection (e) hereof. If permission is denied, the superintendent shall make a written statement of his findings and the board shall have the right to a hearing before the superintendent within thirty days of the date of denial.

(e) Such plan shall be adopted by a majority of the entire board. It shall be signed by the president and attested by the secretary, or officers corresponding to either of them, under the corporate seal of the insurer. A copy of the plan and resolution, both certified by such officers as true under the penalties of perjury and under the seal of the insurer, shall be submitted to the superintendent not later than forty-five days after permission was granted under subsection (d) hereof. The plan shall include:

(1) The proposed charter and by-laws of the insurer as a stock corporation set out in accordance with paragraph five of subsection (a) of section one thousand two hundred one of this chapter.

(2) The manner of treating a holder of a section 1307 agreement, if any; such holder, if otherwise qualified, may, at its option, exchange such agreement for an equitable share of the securities or other consideration, or both, of the corporation into which the insurer is to be converted.

(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. 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 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 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 such date, provided such premium is paid timely. If the equitable share of the eligible policyholder entitles such policyholder to the purchase of a fractional share of stock, the policyholder shall have the option to receive the value of the fractional share in cash or purchase a full share by paying the balance in cash.

(4) The number of voting common shares proposed to be authorized for the 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 three hereof.

(5) Any other features requested by the superintendent.

(f) Prompt notice shall be given by the mutual insurer to all persons who become policyholders or holders of section 1307 agreements on or after the date of the adoption of the resolution described in subsection (b) hereof, of the pendency of a proposed conversion and of the effect thereof on them.

(g) 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 on the day preceding the date of adoption of the resolution described in subsection (b) hereof, accompanied by 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 described in subsection (b) hereof; such notice shall be accompanied by a summary approved by the superintendent of the plan and any comment the superintendent considers necessary for the adequate information of former policyholders and the public.

(h)

(1) 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 this chapter, 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 return the plan to the mutual insurer for modification to meet his stated objections.

(2) 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.

(i) After approval by the superintendent the plan shall be submitted to a vote of the persons who were policyholders of the mutual insurer on the day preceding the date of adoption of the resolution described in subsection (b) hereof. The 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 at a meeting thereof, by causing a full, true and correct copy 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.

(j) Each such policyholder eligible to vote pursuant to subsection (i) hereof 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 represented at the meeting in person or by proxy, shall be necessary for the adoption of the plan. 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 officers corresponding to either of them, under the corporate seal of the insurer, and affirmed by them as true under the penalties of perjury.

(k) No domestic mutual insurer which is affiliated with other mutual companies may be converted to a stock company unless all such affiliated companies are converted to stock companies at the same time, except to the extent the superintendent may determine that the interests of the policyholders of any of the other mutual companies can be permanently protected by limitations on the corporate powers of the stock corporation or on its authority to do business.

(l) 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 further transaction of business will be hazardous to its policyholders, its creditors, or the public, the proposed conversion shall terminate.

(m) If the conversion plan is adopted pursuant to subsection (j) hereof, the superintendent, upon being satisfied that the insurer will have at least the minimum capital and surplus required to be maintained for a newly organized domestic stock insurer doing the same kinds of insurance, shall issue a new certificate of authority to

the insurer, thereby converting the mutual insurer into a stock insurer. At the same time, the superintendent may issue such license as may be required pursuant to section one thousand two hundred four of this chapter.

(n) Upon such conversion, the stock insurer shall give notice thereof 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 shall be licensed to do business. The notice shall include a correct copy of the plan, or a summary thereof approved by the superintendent.

(o) 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 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.

(p) No action or proceeding, pending at the time of the conversion to which the mutual 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 stock corporation may be substituted in place of such mutual insurer by order of the court in which the action or proceeding may be pending.

(q) 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.

(r) The insurer, whether before or after conversion, shall pay no 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 department of financial services, shall be borne by the insurer.

(s) No voting common shares shall be subscribed by or issued to persons other than eligible policyholders or holders of section 1307 agreements until all subscriptions by such policyholders or agreement holders have been filled or other consideration has been provided in accordance with the plan. Thereafter, any new issue of common shares within three years after the conversion shall first be offered to the persons who have become voting common shareholders, pursuant to subsection (e) hereof in proportion to their holdings of such shares.

(t) No insurer becoming 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:

> **(1)**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 the insurer in consideration of the insurer’s agreement to pay him or it either commissions on premiums due the insurer or any other compensation for his or its services, or
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> **(2)**enter into any agreement with an officer or director of the insurer or with any firm or corporation in which any officer or director of the insurer is pecuniarily interested, directly or indirectly, under which agreement the insurer agrees to pay, for the acquisition of business, any commissions or other compensation which by the terms of such agreement varies with the amount of such business or with the earnings of the insurer on such business.

(u) Any action taken pursuant to the provisions of this section shall in no way impede or impair the exercise by the superintendent of his authority under any other provision of this chapter.

History

NY CLS Ins § 7307

Add, L 1984, ch 367, § 1, eff Sept 1, 1984; amd, L 1984, ch 805, § 168, eff Sept 1, 1984; *L 2011, ch 62, § 104* (Part A), eff Oct 3, 2011.

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