SUPREME COURT OF NEW JERSEY

AUGUSTINE W. BADIALI,	:	APPELLATE DIVISION DOCKET
	:	NO.: A-002795-11-T3
Plaintiff/Appellant,	:	
	:	LAW DIVISION DOCKET NO.:
v.	:	CAM-L-1751-11
	:	
NEW JERSEY MANUFACTURERS	:	SAT BELOW IN THE APPELLATE
INSURANCE COMPANY/NEW	:	DIVISION:
JERSEY INDEMNITY INSURANCE	:	HON. CARMEN H. ALVAREZ
COMPANY,	:	HON. CLARKSON S. FISHER, JR.
	:	HON. ALEXANDER P. WAUGH, JR.
Defendant/Respondent,	:	

BRIEF IN SUPPORT OF UNITED POLICYHOLDERS' MOTION TO APPEAR AS *AMICUS CURIAE* AND ON THE MERITS

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Preliminary Statement

It has been the settled law of New Jersey for many years that a cause of action for breach of the duty of good faith and fair dealing requires an inquiry into the subjective intent of the breaching party. That inquiry is inherently a question of fact. The subjective nature of an action for alleged breach of the duty by an insurance company has slowly eroded since this Court's 1993 decision in *Pickett v. Lloyds*. Except for cases involving a *Rova Farms* failure to settle a liability claim in good faith (or cases such as this one, where the carrier's behavior toward the insured appears particularly egregious), experienced policyholder counsel rarely bother any longer to bring claims for bad-faith claim handling in New Jersey. The Trial Court's decision in this case, affirmed by the Appellate Division, eliminates the insurer's intent altogether from the bad-faith inquiry.

In addition to denying the insured the right to take discovery concerning the carrier's subjective honesty and intent in handling the claim in this case, the Trial Court and Appellate Division ignored the requirements of the Unfair Claim Settlement Practices Act and its implementing regulations. In *Pickett*, this Court observed that, while "the regulatory framework does not create a private cause of action, it does declare state policy." The regulatory framework can, and

should, be used as a standard by which to judge an insurer's good faith in handling a claim. Under the standard articulated in *Pickett*, the insurer's knowledge of the lack of a reasonable basis for denying the claim can be inferred where there is a reckless indifference to the facts and proofs submitted. Proof that the carrier's conduct violated one or more of the regulatory requirements under the UCSPA should be admissible as tending to prove the carrier's reckless indifference to the fiduciary obligation it owed to its insured.

Here, the policyholder obtained a judgment that the carrier had wrongfully denied the coverage claim. The Trial Court granted summary judgment in favor of the carrier on the insured's subsequent bad-faith claim without permitting the insured even to inquire into the insurer's motives or intent in denying the claim. There is no legitimate dispute that the insurer's handling of the claim violated one or more provisions of the UCSPA regulations.

There is also no legitimate dispute that the carrier was unaware, at the time it denied the claim, of the unpublished Appellate Division decision that the lower courts cited as justification for the carrier's denial. What the insurer did not know at the time it denied the claim could not have had any bearing on its subjective intentions or honesty in fact in reaching the decision to deny. The lower courts should have

permitted the policyholder to develop a record, through discovery, of the knowledge, intent, and honesty of the insurer before deciding the bad-faith issue.

Procedural History and Statement of Facts

United Policyholders incorporates here the Procedural History and Statement of Facts set forth in the Plaintiff's Brief on this appeal.

Legal Argument

I. A claim for breach of the duty of good faith and fair dealing is an intentional one that requires inquiry into the motives, beliefs, and honesty of the breaching party.

"Bad Faith" is conduct that "imports a dishonest purpose and means a breach of a known duty (*i.e.*, good faith and fair dealing), through some motive of self-interest or ill will." *Black's Law Dictionary*, 139 (6th Ed. 1990). In *Pickett v. Lloyds*, 131 N.J. 457 (1993), this Court adopted the approach taken by the Rhode Island Supreme Court for determining a first-party insurance company's breach of the duty of good faith and fair dealing:

> To show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim. It is apparent, then, that the tort of bad faith is an intentional one. * * * [I]mplicit in that test is our conclusion that the knowledge of the lack of a reasonable basis may be inferred and imputed to an insurance company where there is a reckless * * * indifference to facts or to proofs submitted by the insured.

Pickett v. Lloyds, 131 N.J. 457, 473 (1993)(quoting *Bibeault v. Hanover Ins. Co.*, 417 A.2d 313, 319 (R.I. 1980)).

Defendant's knowledge, dishonest purpose, motive of self-interest, ill will; these are all subjective concepts that require discovery of intent and state of mind. Where intent of a party is the primary inquiry, it generally raises "a question of fact to be presented to the jury and summary judgment should not be granted." *Wells Reit II-80 Park Plaza, LLC v. Director, Div. of Taxation*, 414 N.J.Super. 453, 467 (App. Div. 2010)(citing *Fanucchi & Limi Farms v. United Agricultural Prods.*, 414 *F.*3d 1075, 1082 (9th Cir. 2005) ("Determining the parties' intent is a highly fact-specific inquiry.... Such inquiries are not generally suitable for disposition on summary judgment."). This Court has instructed that an inquiry into the subjective intentions of a party:

> must be sensitively treated in light of all the attendant facts and circumstances which give color and meaning to otherwise neutral conduct. The undertaking can rarely succeed except after a presentation of all the evidence through direct and cross-examination and until an opportunity has been afforded to observe the demeanor of the witness.

Fielder v. Stonack, 141 N.J. 101, 132 (1995) (quoting *Evans v. Elizabeth Police Dep't*, 236 N.J.Super. 115, 117 (App. Div. 1983).

II. The lower courts in New Jersey, including the Trial Court and Appellate Division in this case, have effectively eroded out of existence the subjective standard for determining bad-faith claim handling by an insurer.

As the brief submitted by proposed *amicus* party New Jersey Association for Justice correctly points out (at Point I.B.), courts in New Jersey have been granting summary judgment in favor of insurers on claims of bad-faith claim handling without even providing insureds an opportunity to take discovery on the issue of the insurer's intent. The erosion of the subjective inquiry in bad-faith claim handling cases has been slow and somewhat erratic. Indeed, the first court to consider a bad-faith claim in the wake of *Pickett* got it right. Many of the cases that followed, however, took an increasingly narrow view of an insurer's duty of good faith and fair dealing, as discussed more fully below.

The first published decision in New Jersey after *Pickett* was *Miglicio v. HCM Claim Management Corp.*, 288 N.J.Super. 331 (1995), in which the trial court correctly recognized the inherently fact-sensitive nature of a bad-faith inquiry. *Miglicio* involved an underinsured motorist claim. Similar to the behavior of New Jersey Manufacturers in this case, the carrier in *Miglicio* failed to pay the difference between its policy limits and the insured's settlement of the underlying claim, forced the insured to obtain an arbitration award, and

then compelled the insured to sue for coverage. The *Miglicio* court recognized that these facts were relevant to the determination of a claim for bad faith. "Whether the conduct of defendant resulted in delays in acknowledging the claim and offering payment is fairly debatable and is for a jury to consider under these circumstances." *Id.* at 343.

Unfortunately, very few decisions of the lower courts, after *Pickett* and *Miglicio* were decided, permitted insured's to develop the kind of factual record that would allow the "sensitive undertaking" of judging a carrier's subjective intentions, "treated in light of all the attendant facts and circumstances which give color and meaning to otherwise neutral conduct." *Fielder v. Stonack, supra*, 141 N.J. at 132. Instead, trial courts and the Appellate Division have increasingly judged the intentions of carriers in the claim-handling process by an objective "reasonableness" standard. Often, a carrier need only cite a policy exclusion -- even one that is ambiguous -- as a reason for the denial or delay in the payment of a claim and a court will bless the carrier's decision as "debatable."

The very next published opinion after *Pickett* and *Miglicio* marked the beginning of a slow but certain narrowing of the bad-faith cause of action in New Jersey, a process that has effectively eliminated claims for breach of an insurer's duty of good faith and fair dealing in all but the most egregious cases

of intentional insurer abuse of policyholders. In *Polizzi Meats, Inc. v. Aetna Life & Cas. Co.*, 921 N.J.Super. 328 (D.N.J. 1996), the federal district court would express the kind of fear of a viable cause of action for insurer bad faith that seems to have animated much of the subsequent jurisprudence on the issue in New Jersey.

Polizzi involved a fire that the carrier, Aetna, suspected might have been caused by arson. At the close of discovery, both parties cross-moved for summary judgment on the coverage claim, which the district court denied. *Id.* at 330. The court then granted Aetna's motion for summary judgment on the insured's bad-faith claim. It held that a carrier is entitled to litigate a claim whenever it believes that "there is a question of law or fact which needs to be decided before it in good faith is required to pay the claimant." *Id.* at 334-35 (citations omitted).

Significantly, the district court explained that the rationale for limiting a cause of action for insurer bad faith was the need to insulate insurance companies from the "*in terrorem* effect of 'bad faith' litigation." *Id.* at 334. The problem with this rationale, of course, is that it also eliminates the incentive insurers might otherwise have to comply with their regulatory and fiduciary obligations to treat the policyholder's interests as being at least as important as their

own.[1] It tips the balance between an insurer's right to raise legitimate coverage questions and the insured's right to fair and equitable treatment by its fiduciary decidedly -- and decisively -- in favor of the insurer. Subsequent litigation of insurance bad-faith claims have fairly consistently hewed to a standard and rationale that appears, at least *sub silentio*, to have adopted the *Polizzi* court's preference for protecting insurers from exposure to bad-faith causes of action.

For example, in *Universal-Rundle v. Commercial Union Ins. Co.*, 319 N.J.Super. 223 (App. Div. 1999), the Appellate Division raised the bar to a policyholder's claim for bad-faith claim handling, paving the way for subsequent decisions to narrow the circumstances under which a carrier may be found to have breached its fiduciary duty of good faith and fair dealing. In *Rundle*, a foundry where cast-iron and enamel bathtubs and sinks had been manufactured in Pennsauken, NJ sought coverage for the cleanup of sand and enamel waste -- essentially small chips of glass -- the by-products of the foundry operation.

The carrier's "investigation" of the claim consisted of a

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[1] It is also anomalous that courts should be less concerned about the allegedly stifling effect of a robust cause of action for bad faith as respects other contracting parties (Compare *Sons of Thunder, Inc. v. Borden, Inc.*, 148 N.J. 393 (1997) and its progeny) than the supposed *in terrorem* effect of such a claim on insurance companies -- which are, after all, supposed to comply with a heightened duty of utmost good faith toward their insureds.

young lawyer for the carrier making one telephone call from his office in California to the Risk Manager of the insured's parent company, whose office was in Rhode Island. The Risk Manager had never visited, much less ever worked, at the Rundle plant, which had been closed for many years by the time of the phone call. On the strength of this brief telephone discussion, the young California lawyer denied the claim for coverage on behalf of the carrier, citing a very long laundry list of defenses and exclusions.

The trial court dismissed Rundle's bad-faith claim on summary judgment and the case went to trial on the breach of contract claim. At the bench trial, a different Judge than the one who had handled pre-trial motions ruled in favor of the insured and awarded all costs of cleanup and defense to Rundle. The trial Judge also found after hearing all the evidence that, if the bad-faith claim had not been dismissed, he would have found that the carrier had breached its duty of good faith and fair dealing, as well. The carrier appealed the verdict and the insured cross-appealed the summary dismissal of the bad-faith claim.

The Appellate Division affirmed. It found that Commercial Union had "conducted some investigation" before denying the claim and, although the investigation was "not fool-proof," the carrier at least "did not ignore the claim." *Id.* at 249-250.

Thus, according to the Appellate Division, as long as the carrier does *something*, no matter how perfunctory -- as long as the claim is not completely *ignored* -- there is no bad faith as a matter of law.

In *HGM Communications, Inc. v. Hartford Fire Ins. Co.*, 2007 WL 120235 (App. Div.. 2007),[2] the insurance company sold a policy to the insured that contained an ambiguous endorsement and, on that basis, the trial court granted summary judgment in favor of coverage. With respect to the insured's subsequent bad-faith claim, the trial court concluded that the ambiguity provided the carrier with a "debatable" basis for denying the claim, as a matter of law. The Appellate Division affirmed, despite the existence of evidence tending to show that the carrier may have been less than perfectly honest and forthright in its denial. Specifically, the record contained evidence that the carrier had "ignored a similar prior instance when it paid full coverage, refused to speak with those who had different opinions, and ignored the very nature of mobile communications equipment [that is, the insured property at issue] as well as [the insured's] reasonable coverage expectations." *HGM*, slip op. at *5.

In affirming the trial court's dismissal of the bad-faith

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[2] All unpublished decisions are attached in the Appendix to this Brief. These decisions are not cited for their precedential value but, instead, as examples of the way lower courts have decided bad faith claims following this Court's *Pickett* decision.

claim, the Appellate Division applied what appears to be an objective standard, holding that such a claim will lie only upon a showing that "no debatable reasons existed for denial of the benefits." *Id.* at *6. Neither the trial court nor the Appellate Division found the evidence that tended to establish the carrier's lack of *bona fides* in handling the claim worth submitting to a jury. Notice that the insured's burden on a bad-faith claim appears to have evolved, since the time of *Pickett,* from showing that the carrier's denial was not "fairly debatable" to a showing that "no debatable basis existed for denial of the benefits." Moreover, the courts are no longer permitting policyholders to present any evidence of the carrier's behavior to a jury for the purpose of deciding the issue in light of all the attendant facts and circumstances.

Thus, in *Heller v. First Unum Life Ins. Co.,* 2012 WL 1868156 (Ap. Div. 2012), the trial court granted summary judgment in favor of the insurer on the policyholder's bad-faith claim on the basis of "evidence in the record" that the *policyholder* may have delayed presenting the claim to the carrier. The Appellate Division affirmed. Neither court, apparently, examined the *carrier's* behavior or any evidence that might bear upon that party's knowledge or intent.

The decision in *Villa Enterprises Management Ltd. v. Federal Ins. Co.,* 360 N.J.Super. 166 (L. Div. 2002) illustrates

how the lower courts of this State have, for practical purposes, interpreted the claim for bad-faith claim handling almost out of existence. In *Villa*, the policyholder had been held liable in an underlying action for infringement of the trademark of a company that was doing business as "Villa Pizza." The policy at issue excluded coverage for infringement of "trademark or service mark or certification mark or collective mark or trade name, *other than trademarked or service marked titles or slogans*." *Id.* at 175 (Emphasis in original). The carrier denied coverage, including its duty to defend, on the ground that "trademarked or service marked titles" means "titles to literary works."

On the insured's motion for summary judgment, the court found that this "tortured definition of 'title' in the context of this comprehensive general liability policy and New Jersey law governing construction of insurance policies cannot be sustained." *Id.* at 172. Indeed, it is not going too far to characterize the court's view of the carrier's interpretation as perfectly absurd. The court questioned: "Who, reading the policy at issue, would think for a second that it would cover infringement of *Catcher in the Rye* Bread ® but not Wonder Bread ®?" *Id.* at 186. The trial court also found "no factual basis" to support any of the carrier's other defenses to coverage. *Id.* at 187. Accordingly, it granted the insured's motion for

summary judgment on the coverage issues.

Nevertheless, it dismissed the insured's bad-faith claim on summary judgment, finding that, although the denial of coverage was wrongful, the carrier "was not acting in derogation of well settled New Jersey law." *Id.* at 189. This, of course, establishes yet another -- higher -- bar to recovery of bad-faith damages than anything required in *Pickett*. Not only must an insured prove that the denial lacked a fairly debatable basis, he or she must also prove that the basis was contrary to "well settled law in New Jersey." Finally, the court in *Villa* imposed yet one more hurdle to establishing a carrier's bad faith. It held that, although the carrier's basis for denial was sufficiently meritless as to warrant granting summary judgment on all coverage issues, "it was not such an obviously incorrect one that the court felt it could readily be resolved with an immediate decision on the bench at the end of oral argument." *Id.*

In other words, in the new regime that the lower courts in New Jersey have established for resolving insurance-company bad-faith claim handling since *Pickett*, a policyholder must establish: (1) that the carrier had no debatable basis for denying the claim; (2) that denial was contrary to "well settled New Jersey law," even if the carrier's interpretation of its own policy was so absurd that no one would believe it "for one

second;" and (3) that the denial was so obviously incorrect that it warranted an immediate ruling from the bench -- that is: if the trial judge reserves decision to write an opinion, there is no bad faith as a matter of law.

The case law on this issue since the decision in *Pickett* has reduced the fiduciary duty a carrier owes to its policyholder to a shadow. In the past, this Court has not hesitated to address issues that once appeared reasonably settled when experience suggests the need for a measure of additional guidance to the lower courts. In *Brill v. Guardian Life Ins. Co.*, 142 N.J. 520 (1995), this Court adopted a new standard for determining when an issue of fact is "genuine" for purposes of deciding summary judgment motions. It did so, in part, out of concern that prior summary judgment jurisprudence "may have permitted an encrustation of the *Judson* standard that obscured its essential import." *Id.* at 541. The decision noted that "some" had suggested that "trial courts out of fear of reversal, or out of an overly restrictive reading of *Judson*,…, or a combination thereof, allow cases to survive summary judgment so long as there is *any* disputed issue of fact." *Id.* (internal citation omitted; emphasis in original.)

Similarly, in *Owens-Illinois v. United Ins. Co.*, 138 N.J. 437 (1994), this Court tackled two of the issues that arise in long-tail latent-injury environmental insurance coverage

disputes, which had "spawned 'a bewildering plethora of authority'" interpreting the meaning of standard-form provisions in Comprehensive General Liability insurance policies. *Id.* at 448. *Owens-Illinois* announced new rules for determining when injury occurs for purposes of triggering liability coverage and for allocating damage from such injury among numerous potentially triggered policies. At the same time, this Court signaled that it would be watching how the lower courts applied the rule and would make course corrections as necessary: "If, after experience, we are convinced that our solution is inefficient or unrealistic, we will not hesitate to revisit the issue." *Id.* at 478.

Experience with the standard for an insurer's breach of the duty of good faith and fair dealing that this Court first announced in *Pickett* twenty years ago shows that a course correction is necessary. The lower courts in New Jersey no longer permit insured's to take discovery of an insurer's intent and honesty during the claim handling process. Courts have endorsed, as a matter of law, perfunctory investigations even when the evidence in a case suggests that the investigation was designed solely to justify a preordained decision to deny coverage. As long as a carrier can identify a policy exclusion, even one that a reasonable person would not believe "for a second" actually applies to the circumstances, a denial will be

deemed "debatable" as a matter of law.

If the fiduciary duty that an insurer owes to its policyholders to act in good faith is to have continued meaning, courts must permit the question to reach a jury at least in those cases where the evidence would tend to convince a reasonable person that the carrier's denial may have been pre-ordained or less than perfectly honest and objective. Perfunctory claim investigations -- those for which the best that can be said is that at least the carrier "did not ignore the claim" -- should not routinely pass muster. *See Griggs v. Bertram*, 88 N.J. 347, 360-61 (1980)(insurer's duty of good faith includes duty to fully investigate the matter within a reasonable time and duty of full and fair disclosure of results of investigation). When a carrier claims to have a fairly debatable basis for denying coverage, the carrier should have discovered substantial admissible evidence in support during the claim investigation, *before* it issues the denial. It should not be able simply to set forth in a denial letter a laundry list of exclusions that "might" apply and have it suffice to meet the "fairly debatable" standard.[3]

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[3] In a great many cases, an insurer will employ the "kitchen-sink" approach to claim denial following a perfunctory investigation and then use the discovery process in subsequent coverage litigation to search for evidence to justify the denial. Assessment of the carrier's good faith should rest upon what it discovered before the denial, not in the later coverage suit.

As guidance to lower courts in assessing whether a carrier conducted a thorough, objective, good-faith investigation, and whether a subsequent claim denial was fairly debatable, this Court should encourage the use of the regulatory framework set forth in the Unfair Claim Settlement Practices Act.

III. New Jersey insurance regulations declare state public policy and should provide a standard for judging whether an insurer has handled a claim in good faith.

The Unfair Claim Settlement Practices Act established a regulatory framework "to promote the fair and equitable treatment of claimants by defining certain minimum standards for the settlement of claims." *Miglicio v. HCM Claims Management Corp.*, 288 N.J.Super. 331, 341 (App. Div. 1995); N.J.S.A.. 17-29B-1, *et seq.*

Unfair practices under the UCSPA include, among other things:

> b. Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;
>
> ***
>
> e. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.
>
> f. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

> g. Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;
>
> ***
>
> m. Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;
>
> n. Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.
>
> *N.J.S.A.* 17:29B-4(9).

This Court has already held that the UCSPA declares the public policy of this State. *Pickett*, 131 N.J. at 467. The problem with the statute in the context of an insurer's breach of the duty of good faith and fair dealing is that there is no private cause of action under the UCSPA. Its provisions can only be enforced by the Commissioner of Banking and Insurance, whose stated mission, first and foremost, is to ensure the continued viability of the insurance industry in New Jersey. Moreover, investigation and enforcement of the UCSPA in the case of every claim by a policyholder of bad-faith treatment would likely impose an unreasonable and unsustainable drain on the

Commissioner's limited resources. These forces, both political and practical, favor consideration by our courts of insurers' compliance with their statutory duties as one factor in the evaluation of claims for breach of the duty of good faith and fair dealing.

There is precedent for the application of the UCSPA and its implementing regulations in judicial assessment of an insured's claim of bad faith. The trial court in *Miglicio* analyzed the insurer's conduct by reference to the insurance regulations: "The statute and regulations set forth a standard of conduct for insurers as to the settlement of claims with, or on behalf of, their insured. Dependent upon the underlying reasons for noncompliance, any deviation from the standards may be considered as evidence of bad faith." *Id.* at 341. Note that the court did not hold that any deviation from the standard would constitute bad-faith, *per se*. Nor did the decision establish a private right of action under the statute. Instead, a carrier's failure to comply with New Jersey's regulatory framework may be considered by the jury as evidence of bad faith. Conversely, where an insurer fully complied with the regulatory requirements, it should be able to present such evidence in defense of a claim of bad faith.

Explicit use of the regulatory framework of the UCSPA as a reference in assessing bad-faith claims would serve a number of

salutary purposes. It would breathe life back into the fiduciary duty of good faith and fair dealing that an insurer owes to its policyholders. It would lend a measure of uniformity and predictability to an area of the law that, as things presently stand, is uncertain to the point of near randomness. Since the UCSPA and its implementing regulations already declare the public policy of the State of New Jersey, applying the framework to the issue of bad-faith claim handling would be consistent with the intent of the legislature to protect policyholders' reasonable expectations in the coverage for which they have paid premiums.

Moreover, sending an explicit message to insurers that the courts will apply the regulations expressly in determining whether they have acted in good faith will provide a much-needed incentive for them to "raise their game" in New Jersey. It will also give them guidance in the training of their claim handlers. Carriers that comply with their statutory obligations will have little to worry about whenever the need arises to justify their claim-handling behavior.

IV. Applying a subjective standard to the bad-faith analysis, and using the regulatory framework of the UCSPA as a benchmark, would have precluded dismissal of Mr. Badiali's bad-faith claim in this case.

Neither the Trial Court nor the Appellate Division made any inquiry into the NJM's intent or honesty-in-fact in connection

with the denial of Mr. Badiali's claim for coverage. Indeed, the carrier's motion for summary judgment on the bad-faith claim was decided before Mr. Badiali had an opportunity to take any deposition discovery in the case.

The carrier in this case spent over $28,000 to avoid paying a claim of $14,000, a claim that was indisputably less than the $15,000 statutory minimum the carrier was required to pay under the circumstances. It is also undisputed that the carrier was aware of no New Jersey authority, either published or unpublished, at the time of its denial that might have justified taking the position it took on this claim. That both of the lower courts justified the denial on the basis of an unreported decision of which NJM was unaware shows that the courts do not consider the insurer's state of mind as relevant in analyzing a cause of action for bad faith.[4]

Even in the absence of discovery, the carrier's behavior both during and after the claim-handling process here suggests an improper failure to pay claims promptly, fairly, and equitably when liability had become reasonably clear. It does not take a fevered imagination to suspect that NJM's abrupt and

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[4] The decision also exposes a double-standard that has emerged in the analysis of bad-faith claims. Where the policyholder must establish that the denial of a claim is contrary to the "well settled law of New Jersey" (*Villa Enterprises Management Ltd. v. Federal Ins. Co.*, 360 N.J.Super. 166 (L. Div. 2002)), the carrier need only point to an unpublished, non-precedential decision to justify a denial.

unilateral cancelling of depositions may have been inspired by its own discovery of incriminating information that it feared might come to light in the sunshine of deposition testimony. At the very least, the protection afforded to all New Jersey policyholders under the UCSPA should permit the insured to discover what the carrier knew about the validity of the claim and when the carrier knew it. There is, in any event, a startling irony in NJM's position that there is no record evidence of a genuine issue of material fact concerning its alleged lack of good faith when its own actions were successful in hiding any evidence that might have existed.

If a proper balance were restored between the carrier's interest in questioning the validity of a claim and the insured's interest in fair, equitable, and forthright treatment by its insurance fiduciary, the lower courts would have permitted Mr. Badiali to take discovery. They would have considered, as bearing on the bad-faith inquiry, the carrier's state of mind and honesty-in-fact at the time of the denial. They would have ignored as irrelevant to the inquiry any information or case law about which the carrier was unaware at the time of the denial. And they would never have granted summary judgment in favor of the insured under these circumstances.

Conclusion

For all of the foregoing reasons, the decision of the Appellate Division should be reversed and this Court should revisit and revise the standard for determining when an insurance company has breached its duty of good faith and fair dealing.

Dated: June 17, 2013

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Attorneys for Amicus United Policyholders

By: Carl A. Salisbury
Carl A. Salisbury

APPENDIX A

Not Reported in A.3d, 2012 WL 1868156 (N.J.Super.A.D.)
(Cite as: 2012 WL 1868156 (N.J.Super.A.D.))

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Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Superior Court of New Jersey,
Appellate Division.
Peter A. HELLER, Plaintiff–Appellant,
v.
FIRST UNUM LIFE INSURANCE COMPANY, Unionmutual Stock Life Insurance Company of New York, and Unumprovident Corporation, Defendants–Respondents,
and
J. Harold Chandler, Thomas R. Watjen, Ralph Mohney, Nancy M. Smith, Esq., Suzanne Campbell–Lambert, Joel J. Saks, M.D., Jennifer T. Small, Anne Lorraine Beane, Neil A. Smoot, David Cohen, Jody Patrock, Nancy Brenerman, Alfred H. Blohm, Joel J. Jacobson, Christine L. Kromer, The State Of New Jersey, The New Jersey Department of Banking and Insurance, The New Jersey Commissioner of Insurance, Steven M. Goldman, The New Jersey Office of the Ombudsman, The New Jersey Insurance Ombudsman, and Ann Marie Marcini, Defendants.

Argued Jan. 11, 2012.
Decided May 24, 2012.

On appeal from the Superior Court of New Jersey, Law Division, Middlesex County, Docket No. L–6217–07.
Steven P. Marshall argued the cause for appellant.

Robert Wright argued the cause for respondents (White and Williams, L.L.P., attorneys; Mr. Wright and Michael J. Kozoriz, of counsel; Mr. Kozoriz, on the brief).

Before Judges AXELRAD, SAPP–PETERSON and OSTRER.

PER CURIAM.

***1** In this appeal, plaintiff Peter Heller (Heller) appeals from two orders of the trial court, the first denying his cross-motion for summary judgment against defendant First UNUM Life Insurance Company (First UNUM), and the second, following a bench trial, dismissing the counts in his complaint alleging breach of contract and violation of the Consumer Fraud Act (CFA), *N.J.S.A.* 56:8–1 to –195. We affirm.

Heller worked as a police officer for the Port Authority of New York and New Jersey. On January 15, 1993, he purportedly suffered disabling injuries in an accident while on duty at the Port Authority building in New York City. There were no witnesses, but he claimed that he fell down an entire flight of stairs, injuring his knee, back, and shoulder. Ten days later, he applied for accidental disability retirement with the State of New York. That application was subsequently approved.

At the time of the accident, Heller was insured by First UNUM under three policies (the policies). The policies provided for monthly payments while Heller was totally disabled and under the care of a physician other than himself, following an initial elimination period when no benefits were available. "Total disability" was defined as being injured to the point that, "as a result of sickness or injury, you are unable to perform the material and substantial duties of your occupation." The policies also provided for "own occupation" coverage, meaning he would still be eligible for monthly benefits even if he returned to some form of work other than that of police officer, as long as his injury still prevented him from being a police

officer.

Receipt of benefits under the policies required Heller to notify First UNUM of the claimed disability and to provide medical information relating to the injury as well as a summary of the events leading to the injury. When the January 15, 1993 accident occurred, Heller was under investigation by the federal government for illegally receiving disability payments in connection with another work-related injury he sustained in 1980. He was indicted and suspended without pay on February 2, 1993. He was tried that summer and convicted in August 1993 of conversion, fraud, and making false statements to the Social Security Administration. He was sentenced to eighteen months in prison and permanently banned from securing employment as a police officer. Before trial on the matter, Heller advised First UNUM in a letter dated "April 13, 199[3]" [FN1] that he had been injured in an accident on January 15, 1993 and was providing the required ninety-day notice, but stated he "[was] not, however, making a claim for benefits" and he would let First UNUM know "of any change in [his] condition should a claim ever be necessary."

FN1. The letter is dated April 13, 1992, which is presumably a typographical error.

Also in August 1993, following an independent medical examination, a determination was reached that Heller's January 15 accident resulted in permanent left shoulder disability. On September 27, 1993, Heller was granted accidental disability retirement. On January 10, 1995, an arbitrator determined that Heller was already retired when indicted, and therefore the Port Authority had no authority to discipline him and eliminate his post-retirement benefits.

*2 In early 1996, after being released from prison, Heller filed a claim with First UNUM seeking benefits for injuries sustained as a result of the January 15, 1993 accident. He later withdrew this claim. In 2000, however, he filed a new claim alleging that on July 11, 2000, he began experiencing pain in his back and knee, but made no mention of any shoulder injury. First UNUM denied this claim, and Heller took no further action.

In 2003, Heller filed another claim with First UNUM seeking disability benefits based upon his 1993 shoulder injury. First UNUM considered the claim untimely, but agreed to re-visit it. During its investigation, First UNUM learned about Heller's 1993 conviction. It denied Heller's claim on September 27, 2004, on the basis that: (1) it did not find the claim credible, (2) Heller provided false information on his applications for insurance coverage, and (3) it had been prejudiced by the lack of supporting evidence related to his claimed shoulder injury. Following this denial, Heller's attorney continued to engage in discussions with First UNUM's in-house counsel. In a letter dated March 13, 2006, in-house counsel advised Heller's attorney that the claim was time-barred because Heller failed to assert his claim within three years of the time when the proof of loss was required to be filed.

On July 16, 2007, Heller filed a complaint against First UNUM, a number of its affiliates and individual employees, and certain public officials of the State of New Jersey. The complaint contained counts for breach of contract (Count I), breach of the covenant of good faith and fair dealing (Count II), breach of fiduciary duty (Count III), declaratory relief (Count IV), intentional and negligent infliction of emotional distress (Count V), unlawful, unfair, and intentional violations of the Claims Settlement Practices Act (CSPA), N.J.S.A. 17B:30–13.1 (Count VI), violation of the CFA (Count VII), violation of the Racketeer Influenced and Corrupt Organizations Act (RICO), N.J.S.A. 2C:41–1 to –6.2 (Count VIII), and an action in lieu of protective writs (Count IX). Counts I–VIII were brought against the First UNUM defendants only, while Count IX was brought against the State defendants only. Defendants collectively filed a mo-

tion to dismiss, and on May 9, 2008, Judge Paley granted the motion to dismiss with respect to Counts III, VIII, and IX.[FN2]

> FN2. Count III was dismissed because Judge Paley did not believe there was a fiduciary obligation owed to plaintiff. Judge Paley dismissed Count VIII because he felt "the numerous alternative causes of action pleaded ... incorporate[d] all of [plaintiff's claims] and that having RICO in this case is mere surplusage." Count IX was dismissed because the parties mutually agreed to drop the State defendants from the case.

Defendants then answered the complaint on June 13, 2008, denying all allegations. On August 12, 2009, defendants moved for summary judgment on all remaining counts. Heller filed a cross-motion for summary judgment on December 11, 2009. Judge Paley denied Heller's cross-motion and **granted** First UNUM's motion for **summary judgment** with respect to Counts II and V,[FN3] leaving only Counts I (breach of contract), IV (declaratory relief), VI (CSPA), and VII(CFA) to be tried.

> FN3. Judge Paley dismissed Count II for breach of the covenant of good faith and fair dealing because he found First UNUM's denial of benefits was **fairly debatable** and thus not in bad faith. He dismissed Count V alleging intentional and negligent infliction of emotional distress after concluding he knew "of no authority which permits emotional distress damages in a breach of contract action[.]"

Trial commenced in April 2010 after Heller waived his right to a jury trial. On August 20, 2010, Judge Paley dismissed all remaining claims, although he awarded Heller a return of premiums paid to keep the policies in effect from the last denial of his claim. Heller filed a Notice of Appeal on October 4, 2010.

***3** On appeal, Heller raises the following points for our review:

POINT I

WHETHER **SUMMARY JUDGMENT** SHOULD HAVE BEEN **GRANTED** TO HELLER ON HIS CROSS [-]MOTION.

POINT II

HELLER SHOULD HAVE A JUDGMENT OF BAD FAITH BECAUSE THE DENIAL OF HIS CLAIM WAS NOT FAI[R]LY DEBATABLE.

POINT III

THE FINDINGS OF THE TRIAL COURT ARE NOT SUPPORTED.

I.

Heller first claims the trial court erroneously denied his cross-motion for summary judgment. We disagree.

We review the **grant** or denial of **summary judgment** decisions de novo, utilizing the same standard employed by the trial court. *Agurto v. Guhr*, 381 *N.J.Super.* 519, 525 (App.Div.2005). Specifically,

> [i]n deciding a motion for summary judgment, the trial court must determine whether the evidence, when viewed in a light most favorable to the non-moving party, would permit a rational fact-finder to resolve the dispute in the non-moving party's favor. *Brill v. Guardian Life Ins. Co. of Am.*, 142 *N.J.* 520, 540 (1995). The trial court cannot decide issues of fact but must decide whether there

are any such issues of fact. *Ibid.; R.* 4:46–2(c). Our review of a trial court's summary judgment decision is de novo, applying the *Brill* standard. *Prudential Prop. Ins. v. Boylan,* 307 *N.J.Super.* 162, 167, (App.Div.), *certif. denied,* 154 *N.J.* 608, (1998).

[*Ibid.*]

This standard requires that we, as a reviewing court, first determine whether the evidence presents genuinely disputed issues of material fact sufficient to require submission to a jury or bench trial, or whether the evidence is "so one-sided that one party must prevail as a matter of law." *Brill, supra,* 142 *N.J.* at 540 (quoting *Anderson v. Liberty Lobby, Inc.,* 477 *U.S.* 242, 251–252, 106 *S.Ct.* 2505, 2512, 91 *L. Ed.*2d 202, 214 (1986)).

"Bare conclusions in the pleadings, without factual support in tendered affidavits, will not defeat a meritor[i]ous application for summary judgment." *United States Pipe & Foundry Co. v. Am. Arbitration Ass'n,* 67 *N.J.Super.* 384, 399–400 (App.Div.1961). Therefore, **summary judgment** should be **granted** "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 challenged and that the moving party is entitled to a judgment or order as a matter of law." *R.* 4:46–2.

Heller urges that because his policies were in effect at the time of his injury, he was **granted** disability, and he timely filed his 2003 claim, his cross-motion for **summary judgment** should have been **granted**. He contends his 2003 claim for benefits was timely because First UNUM "expressly waived its right to contest the lateness of Heller's 2003 application for benefits in 1993 by expressly inviting him to file a new application for those benefits in 2003." He argues that when he received permission to re-file his claim in 2003, it constituted a waiver of the timeliness and legal action provisions in the policies.

***4** "Waiver is traditionally defined as the voluntary relinquishment of a known right evidenced by a clear, unequivocal and decisive act from which an intention to relinquish the right can be based." *Country Chevrolet, Inc. v. North Brunswick Planning Bd.,* 190 *N.J.Super.* 376, 380 (App.Div.1983). "The party waiving a known right must do so clearly, unequivocally, and decisively." *Knorr v. Smeal,* 178 *N.J.* 169, 177 (2003). "The intent to waive need not be stated expressly, provided the circumstances clearly show that the party knew of the right and then abandoned it, either by design or indifference." *Ibid.*

In New Jersey, within the context of insurance policies,

> an insurer may waive any provision for its benefit and may waive any representation, warranty, condition or limitation in the policy upon which it would otherwise be entitled to rely.... A waiver of a forfeiture clause is predicated upon the acts or conduct of the insurer with knowledge of a breach tending to show a recognition of the policy, or an intent to relinquish the right to declare a forfeiture for the known breach.

[*Englishtown Auction Sales, Inc. v. Mt. Vernon Fire Ins. Co.,* 112 *N.J.Super.* 332, 337 (App.Div.1970) (quoting *Bruni v. Prudential Ins. Co.,* 100 *N.J.Super.* 154, 163–64 (App.Div.1967) (J. Carton, dissenting), *rev'd,* 51 *N.J.* 408 (1968)).]

Judge Paley found that permitting Heller to re-file his claim in 2003, at the very least, raised a genuine issue of material fact as to whether or not First UNUM waived any policy provisions. That decision is supported by the record.

The letter to Heller notifying him that he would be permitted to re-file his claim did not simultaneously

advise Heller that First UNUM was waiving its defenses to the claim. Rather, the letter made clear that First UNUM was merely considering what, if any, benefits to which he was entitled. Further, the letter advised Heller of his appeal rights in the event of an adverse decision. Hence, there is sufficient evidence in the record, when viewed most favorably towards First UNUM, demonstrating that permitting Heller to re-file his claim was not an unequivocal and decisive waiver of its defense. *Knorr, supra,* 178 *N.J.* at 177.

Likewise, the facts, when viewed in the light most favorable to First UNUM, show that a genuine issue of material fact existed as to whether the delay in giving First UNUM notice and filing any proof of loss claim prejudiced First UNUM and occurred because Heller intended to hide his criminal conviction. Therefore, Heller's motion for summary judgment was properly denied.

II.

Heller also argues that the dismissal of his bad faith claim was improper. In the insurance context, an insurer or insured will typically be **granted summary judgment** on a bad faith claim if the disputed claim is not "**fairly debatable.**" *Pickett v. Lloyd's,* 131 *N.J.* 457, 473 (1993). If there is any factual or legal dispute, **summary judgment** will not be **granted** to either party. *Ibid.*

*5 To show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim. It is apparent, then, that the tort of bad faith is an intentional one. [I]mplicit in that test is our conclusion that the knowledge of the lack of a reasonable basis may be inferred and imputed to an insurance company where there is a reckless indifference to facts or to proofs submitted by the insured.

[*Id.* at 473 (citations omitted).]

"[B]ad faith denotes a reckless disregard or purposeful obliviousness of the known facts suggesting impropriety by the fiduciary. It is not established by negligent or careless conduct or by vague suspicion." *N.J. Title Ins. Co. v. Caputo,* 163 *N.J.* 143, 155 (2000). Additionally, if the underlying claim is even "**fairly debatable,**" a bad faith claim can not succeed. ***Pickett,*** *supra,* 131 *N.J.* at 473.

Here, Heller submitted a claim for benefits under the policies ten years after he sustained the purported injuries. There was evidence in the record that he failed to satisfy a number of the conditions for the receipt of benefits, including inexplicably submitting his proof of loss well beyond the time frame set forth in the policies and failing to respond to First UNUM's April 26, 1996 request for an explanation for the delay. Further, there was little evidence of any continuing treatment for his left shoulder after September 1993. As such, Judge Paley properly concluded that Heller's entitlement to benefits was "**fairly debatable.**" *Ibid.*

III.

Turning to Heller's claim that the findings of the trial court were not supported by the weight of the evidence, we initially note that at the conclusion of the presentation of all the evidence, Heller's attorney advised the court that if the court were to entertain motions at that time, he would urge that Heller was entitled to judgment as a matter of law. Because counsel apparently agreed to incorporate their motions in their written summations, the motions were not heard. We have not been provided with a copy of the written summations. We are therefore uncertain whether Heller's counsel proceeded with this motion. Nonetheless, we find no merit to Heller's contention.

Generally, findings by the trial court, following a bench trial, are binding on appeal when supported by

adequate, substantial, credible evidence. *Rova Farms Resort, Inc. v. Investors Ins. Co.*, 65 N.J. 474, 484, (1974). The deference a reviewing court accords to those findings is particularly appropriate "when the evidence is largely testimonial and involves questions of credibility." *In re Return of Weapons to J.W.D.*, 149 N.J. 108, 117 (1997). "Because a trial court 'hears the case, sees and observes the witnesses, [and] hears them testify,' it has a better perspective than a reviewing court in evaluating the veracity of witnesses." *Pascale v. Pascale*, 113 N.J. 20, 33, (1988) (quoting *Gallo v. Gallo*, 66 N.J.Super. 1, 5 (App.Div.1961)) (alterations in original). Therefore, we will not disturb the "factual findings and legal conclusions of the trial judge unless [we are] convinced that they are so manifestly unsupported by or inconsistent with the competent, relevant and reasonably credible evidence as to offend the interests of justice." *Rova, supra*, 65 N.J. at 484.

*6 Heller first asserts his credibility was not an issue in this case. When a witness takes the stand to testify, the witness places his credibility in issue. *See State v. Daniels*, 182 N.J. 80. 92–93 (noting " '[i]t is well-settled that when a defendant waives his right to remain silent and takes the stand in his own defense, he thereby subjects himself to cross-examination as to credibility of his story' ") (quoting *State v. Robinson*, 157 N.J.Super. 118, 120 (App.Div.), *certif. denied*, 77 N.J. 484 (1978)); *see also* N.J.R.E. 607 ("for the purpose of impairing or supporting the credibility of a witness, any party including the party calling the witness may examine the witness and introduce extrinsic evidence relevant to the issue of credibility"); *State v. Brunson*, 132 N.J. 377, 383 (1993) (stating that under *N.J .S.A.* 2A:81–12,[FN4] evidence of any testifying witness's conviction of any crime can be presented to attack his credibility).

FN4. *N.J.R.E.* 609, which was adopted two weeks after *Brunson* was decided, echoes the language of *N.J.S.A.* 2A:81–12.

He additionally contends that because his own expert's testimony was not helpful to him, Judge Paley should have disregarded the testimony. Heller offered this expert's testimony, and his attorney did not object to any questions posed to the expert on cross-examination. Under *Rule* 1:7–2, if a party does not raise an objection at trial, that party cannot object to that same point on appeal.

Heller also asserts the trial court erred in determining he did not receive medical treatment to the level required under the policies. The policies required that Heller "is receiving medical care from someone other than himself which is appropriate for that injury". Heller presented no such evidence. Consequently, the court correctly found:

> Mr. Heller has presented little proof of continuing medical treatment for his left shoulder injury, or, indeed, any medical care after September 1993. The Attending Physician Statement of 2000 did not refer to a shoulder injury and was not completed by a shoulder specialist.... [T]here is virtually no evidence of medical care following 1993.

Regarding Heller's claim that First UNUM was not prejudiced by the ten-year delay in filing his claim for benefits, there is substantial credible evidence in the record to support Judge Paley's conclusion that First UNUM was appreciably prejudiced by Heller's conduct. The delay prevented First UNUM from obtaining a description of Heller's job duties from the Port Authority. Likewise, it was deprived of the opportunity to have Heller undergo a medical examination reasonably close in time to the purported injury. Judge Paley therefore properly determined at trial that First UNUM satisfied its burden of demonstrating it was prejudiced by Heller's ten-year delay in providing notice and filing his proof of loss forms.

IV.

Heller additionally argues that his count against

First UNUM alleging a violation of the CFA was erroneously dismissed. "The act, use or employment by any person of any unconscionable commercial practice, deception, fraud, false pretense, false promise, misrepresentation, or the knowing, concealment, suppression, or omission of any material fact with intent that others rely upon, ... is declared to be an unlawful practice." N.J.S.A. 56:8–2.

*7 Heller claims First UNUM engaged in an unconscionable practice by selling insurance to him and never intending to pay any claims, no matter what it would uncover in its investigation. There is, however, no evidence First UNUM violated the CFA. Heller asserts there "is a fair inference that [First UNUM] knew about his conviction in 1996," but he points to no evidence in the record in support of this conclusion. What the record reveals is that First UNUM never completed its investigation in 1996 because Heller withdrew his claim after First UNUM sought certain information.

Moreover, to be considered unconscionable, an action must be performed with a lack of good faith, honesty, and fair dealing. *Cox v. Sears Roebuck & Co.*, 138 N.J. 2, 18 (1994). When a court determines as a matter of law that an insurer's denial of a claim is **fairly debatable**, as it has here, there has been no bad faith. ***Pickett, supra,*** 131 N.J. at 473. When a trier of fact does "not detect any bad faith or lack of fair dealing, ... the breach of contract does not rise to the level of an 'unconscionable commercial practice.' " *Cox, supra,* 138 N.J. at 20.

V.

Heller also contends Judge Paley committed reversible error by excluding a letter First UNUM wrote to the New Jersey Office of Insurance Claims Ombudsman, which Heller, in his brief, claims is evidence that First UNUM waived the ten-year delay. Judge Paley excluded it after determining it was duplicative because it referred to other correspondence already introduced into evidence that provided more thorough information.

When issues arise regarding evidentiary rulings, " '[g]enerally, appellate courts review a trial court's determination of the admissibility of evidence for an abuse of discretion.' " *Estate of Hanges v. Metro. Prop. & Cas. Ins. Co.*, 202 N.J. 369, 383 (2010) (quoting *State v. Harvey*, 151 N.J. 117, 166 (1997), *cert. denied*, 528 U.S. 1085, 120 S.Ct. 811, 145 L. Ed .2d 683 (2000)).

We agree the excluded letter did not provide any new information not already disclosed in other documents admitted into evidence. The letter simply mentions that the reasoning behind the denials is contained in attached correspondence, and each of those attachments was admitted into evidence. He then claims the letter demonstrates that the only reason First UNUM denied his claim was due to a violation of the policies' conditions and time limits. However, while the letter does state that the policies' time limits and legal action provisions were reasons for denying benefits, it also refers to Heller's legal problems. Therefore, Judge Paley did not abuse his discretion by excluding the letter.

VI.

Heller contends further that Judge Paley erred in dismissing the RICO count. We disagree.

Under N.J.S.A. 2C:41–1(a), forgery and fraudulent practices are included in the definition of racketeering activity. A "[p]attern of racketeering activity" requires:

*8 (1) Engaging in at least two incidents of racketeering conduct one of which shall have occurred after the effective date of this act and the last of which shall have occurred within 10 years (excluding any period of imprisonment) after a prior incident of racketeering activity; and

(2) A showing that the incidents of racketeering activity embrace criminal conduct that has either the same or similar purposes, results, participants or victims or methods of commission or are otherwise interrelated by distinguishing characteristics and are not isolated incidents.

[*N.J.S.A.* 2C:41–1(d).]

Heller claimed First UNUM violated RICO, but he fails to satisfy the minimal pleading requirements of both sections of the statute. *R.* 4:5–8(a). He pleads no specific facts that, if true, would constitute violations of RICO.

VII.

The remaining arguments advanced by Heller, not specifically addressed in this opinion, have been considered in light of the record and applicable legal principles. We are satisfied they are without sufficient merit to warrant discussion in a written opinion. *R.* 2:11–3(e)(1)(E).

Affirmed.

N.J.Super.A.D.,2012.
Heller v. First Unum Life Ins. Co.
Not Reported in A.3d, 2012 WL 1868156 (N.J.Super.A.D.)

END OF DOCUMENT

APPENDIX B

Not Reported in A.2d, 2007 WL 120235 (N.J.Super.A.D.), 61 UCC Rep.Serv.2d 781
(Cite as: 2007 WL 120235 (N.J.Super.A.D.))

H

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Superior Court of New Jersey,
Appellate Division.
HGM COMMUNICATIONS, INC., a Corporation of New Jersey, Plaintiff-Appellant/Cross-Respondent,
v.
HARTFORD FIRE INSURANCE CO., a Corporation of Connecticut, Defendant-Respondent/Cross-Appellant,
and
Prime Kidney Stone Treatment, Inc., Prime Medical Services, Inc., and AK SPecialty Vehicles, Inc., a Corporation of Texas, Defendants-Respondents,
and
Harwell Green Insurance Services, Inc., Frontline Communications, Mobil Tech, Inc., and Mt. Liquidation Corp., Defendants.

Argued Dec. 6, 2006.
Decided Jan. 19, 2007.

On appeal from the Superior Court of New Jersey, Law Division, Middlesex County, Docket No. L-6161-02.
Lawrence N. Lavigne argued the cause for appellant-cross-respondent (Norris, McLaughlin & Marcus, attorneys; Mr. Lavigne, of counsel; Rachel A. Wingerter, on the brief).

Thomas E. Schorr argued the cause for respondent-cross-appellant (Smith, Stratton, Wise, Heher & Brennan, attorneys; Mr. Schorr and Amanda M. Foster, on the brief).

Carole A. DePinto argued the cause for respondents (Killian & Salisbury, attorneys; Heather A. Korsgaard and Eugene Killian, Jr., of counsel and on the brief).

Before Judges LEFELT, PARRILLO and SAPP-PETERSON.

PER CURIAM.

*1 Plaintiff HGM Communications, Inc. sought to recover property damage and loss of business income from its insurer, defendant Hartford Fire Insurance Company, after its specially designed satellite communications truck sustained damages returning from broadcasting an out-of-state sports event. Hartford paid the property damages but refused to pay the $180,000 policy limit for business interruption, claiming the policy restricted coverage to $50,000 because the truck was damaged away from HGM's premises.

HGM sued Hartford and its insurance agent for improperly obtaining insurance that limited the lost-business coverage. During the suit, HGM amended its complaint to also sue the truck manufacturers for breach of warranty. Even though HGM prevailed on its main contention that Hartford should not have limited the recovery for business interruption to $50,000, HGM now appeals from an order **granting summary judgment**, based on the statute of limitations, to the truck manufacturers; an order **granting summary judgment** in favor of Hartford on its bad faith claim; and the final judgment, which applied the policy's co-insurance provision to limit HGM's recovery for business interruption. We affirm.

I.

Brian Loy was HGM's founder, president, 100% shareholder, and only employee. He ran the business from his home in Freehold, and provided mobile satellite communication services or "transportable communications," for news and sports television

networks from events on the east coast from Maine to Florida. HGM did not transmit any satellite communications from its Freehold office.

Sometime in 1991, HGM contracted with BAF Corporation to install a communications system on the frame of a Volvo truck. With the assistance of Mobile Tech, Inc.,[FN1] the truck's wheel base and frame were extended to hold a specially designed coach, large enough to hold "[h]undreds of thousands of dollars of highly sophisticated satellite equipment." The truck's deck was also modified to support a 4.5 meter antenna, capable of broadcasting internationally as well as domestically.

FN1. AK Specialty Vehicles, Inc., a subsidiary of Prime Medical Services, Inc., subsequently purchased certain assets of BAF and Mobile Tech. Defendants Prime Medical, AK Specialty, and Prime Kidney Stone Treatment, Inc., thereby became successors in interest to defendants BAF and Mobile Tech., the manufacturers HGM had dealt with.

According to Loy, he took possession of the truck in February or March of 1992 at a cost of $568,000. At the time of purchase, plaintiff received a warranty that the truck would be free from defects in material and workmanship for twenty-four months.[FN2] The warranty was limited to "inspection of the Goods and repair or replacement of defective apparatus or equipment."

FN2. The parties could not locate the actual warranty, but are in agreement that its duration was two years.

Within two months of driving the truck, Loy noticed that the frame was twisting and the rivets attaching the antenna to the chassis were coming loose on the aluminum deck. Loy also noticed that the truck had a "very stiff" or "rough" ride.

On March 11, 1992, Loy advised Mobile Tech by letter that, among other things, "a number of rivets" had come out on the antenna deck. Mobile Tech replaced the rivets, but the problem kept recurring. Mobile Tech's representatives repeatedly told Loy that the problem was cosmetic and the truck was sound. Loy believed that the rivets came loose because of problems related to adherence of the aluminum decking to the steel-frame rails.

*2 In 1996, Loy sought commercial insurance for his business through its broker, Bill Harwell, of Collier Insurance Company. Harwell eventually formed defendant Harwell Green Insurance Services, which retained HGM as one of its clients. At that time, Harwell had an agency agreement with Hartford, which was one of the few companies that insured satellite communications companies. After consulting with Harwell, HGM decided to seek business interruption coverage of $180,000, which represented four months' gross sales of one communications truck.

Hartford issued HGM a Commercial Inland Marine policy, the policy at issue in this appeal. The policy provided property damage coverage for HGM's "communications equipment," including the modified truck. The policy stated "[t]he most we will pay for 'loss' in any one occurrence is the smallest applicable Limit of Insurance shown in: a. The Schedule(s); b. the Coverage Form; or c. The Endorsement(s)."

The Schedule, also referred to as the declarations page, provided property damage coverage for "mobile transmitting or receiving equipment" at the premises listed as the Freehold office with a limit of $1,408,953, and business income coverage for loss of communications equipment "at your premises above" with a limit of $180,000. HGM paid a premium of $2,034 for the $180,000 of business-loss protection, along with "coinsurance" of 100%.[FN3]

Not Reported in A.2d, 2007 WL 120235 (N.J.Super.A.D.), 61 UCC Rep.Serv.2d 781
(Cite as: 2007 WL 120235 (N.J.Super.A.D.))

FN3. The record contains poorly reproduced copies of the schedule showing the coinsurance figure as "10%" and other copies showing the figure as 100%.

The policy also contained an endorsement for business income-communications operations. The endorsement "modifie[d] insurance provided under the ... COMMUNICATIONS EQUIPMENT COVERAGE FORM" and "added to [c]overage" the following: "We will pay for the actual loss of 'Business Income' you sustain due to the necessary total or partial suspension of your 'operations' during a 'period of restoration.' " This clause then went on to state "[t]he suspension must be caused by direct physical 'loss' to property at the premises listed by a Covered Cause of Loss under your Communications Equipment Coverage Form." The provision then stated "[b]ut this coverage only applies to premises for which a Limit of Insurance, applicable to 'Business Income', is listed in the Schedule."

The endorsement also contained a provision that stated:

2. Coverage Extensions

a. "Extra Expense"

...

b. Off Premises Power Interruption

...

c. Mobile Equipment

We will extend this insurance to pay for the actual loss of "Business Income" you sustain due to direct physical "loss" to mobile communications transmitting, recording or receiving equipment listed in the Schedule, resulting from a Covered Cause of Loss under your Communications Equipment Coverage Form.

But the most we will pay under this Coverage Extension is $50,000 for any one "loss" to covered mobile equipment.

After reviewing this policy, Harwell contacted a Hartford underwriter to confirm that Hartford had provided HGM with $180,000 of business income coverage without limitations. The underwriter, according to Harwell, verified the coverage and stated that "at the premises," which was not defined in the policy, meant HGM's "normal area of operations," i.e., a 400-mile radius of the Freehold office. The underwriter had no recollection of any discussions with Harwell concerning this policy, and indicated that normally such discussions would have resulted in a written document.

***3** Throughout all the renewal periods, however, Harwell believed that HGM was covered for $180,000 in the event that its truck was damaged while being used for business. Until the incident in 2001, HGM never filed any insurance claim for losses.

On June 4, 2001, about nine years after Loy had purchased the truck, he was driving through the Bronx after broadcasting from a New York Yankees game when the truck hit an uneven surface. Though the fender wheel was rubbing the tire and the truck was listing, Loy drove the truck about forty miles to his home and the next day took it for service and maintenance.

The left frame rail of the chassis had bent and cracked in the area around the rear drive wheels. The broken frame rail rendered the truck inoperable. At the time of the incident, the truck had approximately 74,000 to 76,000 miles on its odometer and Loy es-

timated he had put an additional $150,000 to $200,000 worth of equipment into the truck by that point, bringing its total cost to about $735,000.

The truck was out of service until the end of December, and during this period the network and cable customers stopped offering HGM work. This layoff destroyed HGM's business, though Loy attempted to keep working by utilizing another smaller communications truck owned by the company. As Loy explained, however, "[o]nce they found other people to replace me, they replaced me." Eventually, Loy filed for bankruptcy and HGM's business terminated.

Hartford paid HGM $107,742 for the property damage portion of the claim, but limited the business income interruption claim to $50,000, despite the fact that HGM's loss was well in excess of $180,000, because the damage to the vehicle occurred away from the Freehold office. HGM then brought the lawsuit which resulted in this appeal.

In the trial court, Judge Waugh **granted** HGM's and Harwell's **summary judgment** motions against Hartford and found the insurer responsible for HGM's business interruption loss up to the $180,000 maximum. The judge found the policy ambiguous because it did not adequately alert Loy about the limitation on full coverage to only those incidents that occurred at the Freehold office. The judge found it significant that HGM only made money when its equipment was "out in the field," that Harwell understood at the time that the policy provided the coverage that plaintiff sought, and that Harwell asserted, without dispute by Hartford, he had represented another mobile communication company that had obtained similar insurance from Hartford and received full coverage for an off-premises incident.

In its lawsuit, HGM had also alleged, by amended complaint in 2003 and 2004, that the manufacturers of the truck, Prime Kidney Stone Treatment Inc., Prime Medical Services, Inc., and AK Specialty Vehicles, Inc., had negligently designed and manufactured the communications truck, and had breached expressed and implied warranties.[FN4] The trial court found that HGM's claims against these defendants sounded in contract rather than tort, and that, under the Uniform Commercial Code (UCC), the controlling statute of limitations was four years. *N.J.S.A.* 12A:2-725.

FN4. Prime Medical and Prime Kidney design and manufacture specialty vehicles for use in the medical, broadcast, and communication industries. AK Specialty, a subsidiary of Prime Medical, purchased certain assets of the manufacturers Loy had originally dealt with, BAF and Mobile Tech.

*4 Because there were contested issues of fact concerning the running of the statute of limitations, the court conducted an evidentiary hearing, pursuant to *Lopez v. Swyer*, 62 *N.J.* 267 (1973), to determine whether HGM was entitled to the benefit of the discovery rule.

Only Loy testified at the *Lopez* hearing. After hearing the testimony, the court determined that the warranties issued to HGM constituted warranties for future performance, but the discovery rule did not apply because "the defect that rendered the hybrid truck unusable, the cracked frame, did not take place until years after the one year [FN5] 'future period' had expired." Even if the discovery rule applied, based upon HGM's position that the defect was the placement of the antenna, the court further concluded that there were sufficient facts to show that Loy knew or should have known about the latent defect more than four years before the filing of the complaint against these defendants.

FN5. The court utilized a one-year warranty period, though the parties seem to agree that a two-year warranty had been issued.

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After Judge Waugh rendered the judgments regarding coverage for the business interruption loss and the statute of limitations, the matter was transferred to Judge Ryan for consideration of HGM's bad faith claim against Hartford. Because Judge Waugh had found the policy ambiguous, Judge Ryan found Hartford's decision to limit coverage to be "**fairly debatable**" and rejected the bad faith claim.

In the process of obtaining a final judgment, Hartford wrote to HGM explaining that under the policy's coinsurance provision it had calculated the total judgment as $37,747. HGM responded that it was entitled to judgment in the amount of the full coverage limit of $180,000 minus the $50,000 already paid. Without explanation, Judge Ryan adopted the proposed form of final judgment submitted by Hartford.

HGM's appeal challenges the dismissal, on summary judgment, of the bad faith claim against Hartford, and argues that Judge Ryan improperly relied upon Judge Waugh's prior ruling that the policy was ambiguous, and contends that Judge Ryan misapplied the **fairly debatable** standard articulated in ***Pickett*** *v. Lloyd's,* 131 *N.J.* 457, 481 (1993). In its cross-appeal, Hartford contends that Judge Waugh erred by concluding that the policy was ambiguous and by failing to assess properly the relationship between a declarations page and the policy's text. HGM also challenges the dismissal of the claim against the truck manufacturers on statute of limitations grounds, and Judge Ryan's application of the coinsurance provision. We consider the statutory interpretation, bad faith, statute of limitations, and coinsurance issues in turn.

II.

In interpreting insurance policies, their words are to be given their plain, ordinary meaning. *Zacarias v. Allstate Ins. Co.*, 168 *N.J.* 590, 595 (2001). When the express language of the policy is clear and unambiguous, courts will enforce it as written. *Botti v. CNA Ins. Co.*, 361 *N.J.Super.* 217, 224 (App.Div.2003); *Christafano v. N.J. Mfrs. Ins. Co.*, 361 *N.J.Super.* 228, 235 (App.Div.2003). Ambiguous language in an insurance policy, however, is often construed in favor of the insured. *President v. Jenkins,* 180 *N.J.* 550, 563 (2004). "When an insurance policy's language fairly supports two meanings, one that favors the insurer, and the other that favors the insured, the policy should be construed to sustain coverage." *Ibid.* Thus, we must interpret insurance contracts with ambiguous language to comport with the insured's reasonable expectations. *Ibid.*

***5** Our Supreme Court has also noted that the declaration page is "the one page most likely to be read and understood by the insured." *Zacarias, supra,* 168 *N.J.* at 603. The Court relied on *Lehrhoff v. Aetna Cas. & Sur. Co.*, 271 *N.J.Super.* 340, 347 (App.Div.1994), where we found that it was "the declaration page, the one page of the policy tailored to the particular insured and not merely boilerplate, which must be deemed to define coverage and the insured's expectation of coverage." *Zacarias, supra,* 168 *N.J.* at 602.

In *Zacarias,* the Court found no ambiguity, contradiction or inconsistency between the declarations sheet and the plaintiff's policy. *Ibid.* Importantly, the Court noted that the declarations page alerted the insured that the coverages and limits of liability were subject to the provisions of the policy and that the exclusion at issue was written in direct and ordinary terms. *Id.* at 602-03.

In the instant matter, the policy contained conflicting coverage limits. From its issuance in 1996 through its termination in 2001, the policy's declarations page stated that the limit of insurance for business income coverage was $180,000, the insured's "premises" was the Freehold office, and the coverage included "mobile transmitting or receiving equipment." The declaration page did not alert HGM to the

fact that the business interruption coverage was subject to any endorsement, nor did it reflect the significant reduction in coverage for off-premises incidents.

It is significant to acknowledge that HGM purchased this policy to insure mobile equipment that would be operated away from the Freehold office. Hartford created an ambiguity by failing to alert the insured, via the declarations page, to the significant reduction in coverage for the normal operation of HGM's mobile communications equipment. This is so especially because there were simple steps that could have been taken to conform the declarations page to the policy. *Skeete v. Dorvius*, 184 *N.J.* 5, 11 (2005)(Albin, J., concurring) (noting insurer could have easily incorporated additional information into the declarations page to give the insured a full understanding of her coverage limits). Had the insured been so advised, we sincerely doubt this dispute would have developed. Instead, the policy would have been rejected or reformulated well before the unfortunate incident. Accordingly, we affirm Judge Waugh's finding of liability against Hartford and deny Hartford's cross-appeal.

III.

HGM's bad faith claim against Hartford is essentially based on its assertion that the decision limiting coverage to $50,000 was so egregiously wrong that bad faith is evident. In other words, to limit HGM's coverage, HGM ignored a similar prior instance when it paid full coverage, refused to speak with those who had different opinions, and ignored the very nature of mobile communications equipment as well as Loy's reasonable coverage expectations.

*6 Although there is some appeal to this argument, we cannot accept it. When an insurer has denied benefits, "bad faith is established by showing that no debatable reasons existed for denial of benefits." ***Pickett***, *supra*, 131 *N.J.* at 481. *See also Universal-Rundle Corp. v. Commercial Union Ins. Co.*, 319 *N.J.Super.* 223, 249 (App.Div.), *certif. denied*, 161 *N.J.* 149 (1999).

Here, Judge Ryan dismissed the bad faith claim based upon his review of the relevant portions of the policy and the transcript of Judge Waugh's prior decision. There were sufficient facts upon which the judge could base his finding that the language in the policy made the denial of benefits "**fairly debatable**" as a matter of law. Specifically, though the declarations page provided a limit of insurance of $180,000 for business income coverage, a specific endorsement stated that the most Hartford would pay was $50,000 for any "direct physical loss" to mobile equipment property off the premises. Although we have found the failure to refer to this endorsement on the declarations page as ambiguous, we agree with Judge Ryan that the existence of the endorsement rendered Hartford's coverage decision "**fairly debatable.**"

Furthermore, because this finding was based upon the judge's understanding of the law, HGM's expert opining to the contrary is not controlling. *Perez v. Rent-A-Ctr., Inc.*, 375 *N.J.Super.* 63, 73 (App.Div.2005), *rev'd on other grounds*, 186 *N.J.* 188 (2006) (recognizing that expert witnesses may not render opinions on questions of law). In addition, though HGM complains that Judge Ryan acted before discovery had been fully completed, HGM failed to explain how further discovery would have been productive. *Kaczorowska v. Nat'l Envelope Corp.*, 342 *N.J.Super.* 580, 591 (App.Div.2001). Consequently, we affirm Judge Ryan's determination rejecting HGM's bad faith claim.

IV.

HGM also contends Judge Waugh erred by finding that its breach-of-warranty actions against the manufacturers were time-barred under *N.J.S.A.* 12A:2-725(1). Essentially HGM argues that the communications truck had a latent defect, the placement of the antenna behind the rear wheels, and it did not discover this defect until the frame rail cracked in June 2001.

The limitation period under the UCC for breach of a sales contract is "four years after the cause of action has accrued." N.J.S.A. 12A:2-725(1). Furthermore, "[a] cause of action accrues when the breach occurs, regardless of the aggrieved party's lack of knowledge of the breach[,]" and "[a] breach of warranty occurs when tender of delivery is made[.]" N.J.S.A. 12A:2-725(2). The UCC, however, provides an exception to the general rule, commencing the limitations period from the date of the breach, if "a warranty explicitly extends to future performance of the goods and discovery of the breach must await the time of such performance the cause of action accrues when the breach is or should have been discovered." *Ibid.*

*7 In this case, the tender of delivery took place in late 1991 or 1992, and the frame rail did not crack until the incident in 2001. Thus, if the warranties did not explicitly extend to future performance, the action would be barred by the UCC's four-year statute of limitations. If the warranties extended, however, the limitation period would run from the date that the defect was or should have been discovered by plaintiff, provided the defect arose within the warranty period. *Comm'rs of Fire Dist. No. 9, Iselin, Woodbridge, N.J. v. Am. La France*, 176 N.J.Super. 566, 572 (App.Div.1980).

The question in a discovery situation "is whether the facts presented would alert a reasonable person, exercising ordinary diligence, that he or she was injured due to the fault of another." *Caravaggio v. D'Agostini*, 166 N.J. 237, 246 (2001). The standard is an objective one, i.e., whether a plaintiff "knew or should have known" of sufficient facts for the statute of limitations to start running. *Ibid.*

In this case, the warranties obligated the manufacturers to inspect and repair or replace any defective apparatus or equipment during a specific period beyond the date of delivery. Thus, the warranties were not "a mere representation of the [communications truck's] condition at the time of delivery," but rather a promise relating to "performance at a future time." *Ibid.*

However, there is ample evidence in the record to find that HGM knew or should have known about the latent defect during the first year after delivery or, at least, no later than 1994. Loy testified that within the first two months of driving the truck, he noticed that the rivets attaching the antenna to the chassis were coming loose on the aluminum deck in the area of the fender wells. In a letter to Mobil Tech dated March 11, 1992, Loy indicated his pleasure with the way the truck turned out considering the fact that the bulk of the decisions had been made by telephone, and he also outlined a list of problems that needed to be addressed, including the fact that "a number of rivets" came out of the antenna deck. Although Mobil Tech representatives repeatedly told him that the rivet problem was only cosmetic, Loy knew the problem was persistent and that the rivets had to be constantly replaced.

Loy also became aware of the flexing or twisting motion in the truck's rear, which continued after the truck had stopped. Although Mobil Tech representatives told him that the truck was sound and such movement was to be expected, Loy continued to raise the issue whenever he took the truck for repairs. He certainly was aware of the phenomenon-which he referred to as "a tail wagging the dog"-in 1994 when he informed the employees of Allied Diesel, who "made a comment a time or two on the engineering and configuration of the rear deck of the truck." Also in 1994, Loy evidently knew that the antenna could be moved forward for $3,500. Loy testified that he never had the antenna moved because every time he brought up the problems, Mobil Tech "did something and shut me up or pacified me or whatever."

*8 Given those facts combined with Loy's automotive background, having worked for BAF; his input

into the decision-making about the truck's design; and his knowledge that its wheel base and frame were extended to accommodate the custom-designed coach, it is reasonable to conclude, as did Judge Waugh after conducting the *Lopez* hearing, that Loy knew or should have known of sufficient facts regarding the alleged defect to start the statute of limitations running no later than 1994. *Caravaggio, supra,* 166 N.J. at 246.

HGM also argues that Hartford ignored its own expert's opinion rejecting HGM's allegations of defect and thereby supporting HGM's contention that it could not have reasonably known of any defect until the 2001 road incident. However, Judge Waugh was not bound by any expert on this point, especially after conducting a *Lopez* evidentiary hearing. *County of Middlesex v. Clearwater Village, Inc.,* 163 N.J.Super. 166, 174 (App.Div.1978), *certif. denied,* 79 N.J. 483 (1979).

Therefore, because HGM filed its first pleading naming the manufacturers in June 2003, the breach-of-warranty claims were time barred. In sum, Judge Waugh properly dismissed the action against the manufacturers.

V.

Finally, HGM argues the trial court erred by failing to find that Hartford had waived the 100% coinsurance provision by not raising it below and by applying the 100% coinsurance provision in the policy without the benefit of briefs or oral argument.

Coinsurance provides insureds with an incentive to obtain appropriate levels of insurance by limiting the recovery amount in the event the insured does not obtain insurance equal to the full value of a potential loss. The policy warned that "Covered Property must be insured for its total value as of the time of 'loss' or you will incur a penalty." The policy then explained "[t]his penalty is that we will pay only the proportion of any 'loss' that the applicable Limit of Insurance shown in the Schedule for the Covered Property bears to the value of the Covered Property as of the time of the 'loss.' " Such clauses are enforceable in New Jersey. *See Miller v. N.J. Ins. Underwriting Ass'n,* 188 N.J.Super. 175, 188, 192 (App.Div.) (affirming trial court's application of coinsurance clause to mean that coinsurer was responsible for covering two thirds of the estimated cost of restoring building to its pre-fire condition), *certif. denied,* 94 N.J. 508 (1983).

Considering the coinsurance clause contained in Hartford's policy, HGM would have had to insure the truck at 100% of its replacement cost to avoid triggering the penalty. HGM does not challenge the formula Hartford used to reach the judgment amount. Hartford explained that "the net income and operating expenses that HGM utilized to estimate its $368,000 business interruption claim approximates $755,000." Accordingly, Hartford utilized HGM's own figures for the coinsurance formula. Hartford divided the business income policy limit of $180,000 by the net income and operating expenses of the truck, $755,000. It then took the result, 23.8%, and multiplied by the covered loss, claimed by HGM, of $368,000. This resulted in a total covered business income loss of $87,747 [FN6]. Since Hartford previously paid $50,000, that sum was deducted from the total covered loss resulting in the remaining covered amount of $37,747, which is the judgment entered by the trial court.

FN6. The calculation actually results in $87,584.

*9 A waiver is the intentional relinquishment of a known right. *Borough of Closter v. Abram Demaree Homestead, Inc.,* 365 N.J.Super. 338, 354 (App.Div.) (citing *W. Jersey Title & Guar. Co. v.. Indus. Trust Co.,* 26 N.J. 144, 152-53 (1958)), *certif. denied,* 179 N.J. 372 (2004). There is no evidence in the record supporting HGM's contention that Hartford waived application of the coinsurance provision. Judge Waugh's summary judgment dealt only with liability

and not damages. Thus, there was no cause for Hartford to raise the coinsurance issue before Judge Waugh. When the damages issue finally arose, Hartford promptly notified HGM of its intention to rely upon the provision.

Although the trial court did not support its determination by any discernible analysis of the relevant evidence, HGM does not object to the formula utilized by Hartford. This is probably because the insurer claims to have utilized HGM's own estimates of net income and operating expenses and total business loss. In addition, HGM did not request of the trial court an opportunity to file a brief or present oral argument on the coinsurance issue. Thus, there is no reason to conclude that Judge Ryan improperly decided this issue on the papers. *Cf.* *Fusco v. Fusco*, 186 *N.J.Super.* 321, 328-29 (App.Div.1982).

In its reply brief, HGM claims that the coinsurance provision was unreasonable because Hartford's own agent, Harwell, advised HGM to obtain a policy covering only $180,000 of business loss. This issue was not raised before the trial court and consequently is not properly before us. *Nieder v. Royal Indem. Ins. Co.*, 62 *N.J.* 229, 234 (1973); *Twp of Warren v. Suffness*, 225 *N.J.Super.* 399, 412 (App.Div.1988) (raising an "issue initially in a reply brief is improper"). Consequently, we conclude that HGM has not presented any viable basis to overturn the judgment amount.

VI.

Accordingly, for the reasons we have explained above, we affirm Judges Waugh and Ryan and reject all arguments by HGM on the appeal and by Hartford on its cross-appeal.

Affirmed.

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