Overview of Insurance Law in the State of New Jersey

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I. Handling of Property & Casualty Insurance Claims

A. **Acknowledgment of Claim**

Under New Jersey law, insurers must acknowledge the receipt of a notification of claim within 10 working days after receiving it, unless payment is made within such period of time. *See* N.J. A.C. § 11:2-17.6(b).

Furthermore, insurers must promptly provide all necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with policy conditions. Compliance with this paragraph within 10 working days of notification of a claim shall constitute compliance with the above paragraph. *See* N.J. A.C. § 11:2-17.6(c).

Every insurer, upon receipt of any inquiry from the Department respecting a claim shall, within 15 working days of receipt of such inquiry, furnish the Department with, based on the information available to the insurer, a complete and accurate written response to the inquiry. *See* N.J. A.C. § 11:2-17.6(d).

Also, insurers must make an appropriate reply within 10 working days to all other pertinent communications from a claimant which reasonably suggest that a response is expected. *See* N.J. A.C. § 11:2-17.6(e).

B. **Settlement of Claims**

Under New Jersey law, insurers must commence an investigation on all claims other than auto insurance physical damage within 10 working days after receipt by the insurer of notification of claim. *See* N.J. A.C. §. 11:2-17.7(a).

N.J.A.C. § 11:2-17.7(c)(1) requires insurers to complete investigation of first-party claims and make payments within 30 calendar days from receipt of proof of loss; N.J.A.C. § 11:2-17.7(c)(2) requires insurers to complete investigation of third-party property damage claims and make payment within 45 calendar days from receipt of notice; and N.J.A.C. § 11:2-17.7(c)(3) requires insurers to complete investigation of third-party bodily injury claims and make payment within 90 calendar days from receipt of notice.

If the insurer is unable to settle the claim within the time period specific in the preceding paragraph, the insurer must send the claimant written notice by the end of such period of time. The written notice must state the reasons additional time is needed, and must include the address o f the office responsible for handling the claim and the insured's

policy number and claim number. The notice shall include a telephone number which is toll free, which can be called collect, or which is within the claimant's area code. *See* N.J. A.C. § 11:2-17.7(e).

The insurer must send the claimant an updated written notice setting forth the reasons additional time is needed within 45 days from the date of initial notification and every 45 days thereafter until all elements of the claim are either honored or rejected. See N.J. Admin. Code tit. 11, § 2-17.7(e).

C. **Denial Letter**

A denial letter is required to be clear and unequivocal and cannot be ambiguous or open to multiple interpretations. *Toto v. Princeton Township*, 404 N.J. Super. 604, 617 (App. Div. 2009); *Azze v. Hanover Ins. Co.*, 336 N.J. Super. 630, 641-43 (App. Div. 2001). When denying claims, insurance companies should provide a specific reference to the policy and a written statement of facts explaining the denial.

When a claim is denied, the insurance company must notify the policyholder of any limitation on the right to sue. If the claimant's right to sue may be affected by a statute of limitation, the insurance company must advise the claimant of the statute of limitations within 60 days before the expiration of the statute, unless the claimant is an attorney or represented by an attorney.

D. **Reservation of Rights Letter**

1. Insured Right to Reject Defense

Under New Jersey law, insurers wishing to control the defense of an insured while simultaneously reserving the right to dispute liability can do so only with the consent of the insured. *Merchants Indemnity Corp. v. Eggleston*, 27 N.J. 114, 127 (1962). The insured's consent can be inferred from the insured's failure to reject an offer to defend, but if the insured consents by silence, the reservation of rights letter "must fairly inform the insured that the offer may be accepted or rejected." *Id.* at 127-28. When an insurer fails to inform an insured of the ability to accept or reject the terms of the defense, the insurer is estopped from later denying coverage.

In *Nazario v. The Lobster House, et al.*, Docket No. A-3025-07T1 (N.J. Super. Ct. App. Div. May 5, 2009) (unpublished decision), the Appellate Division expounded on that doctrine and held that two insurers were estopped from denying coverage because their reservation of rights letters were inadequate.

The *Nazario* case involved a bodily injury claim by a contractor's employee against Cold Spring Fish & Supply Co., d/b/a The Lobster House. Cold Spring had two primary policies that could potentially provide coverage: one from Essex Insurance Company and

one from Sirius America Insurance Company. Both insurers responded to the notice of claim by Cold Spring with reservation of rights letters. Neither insurer advised the insured that their offers to defend may be accepted or rejected. Several months later, Cold Spring, Essex and Sirius all moved for summary judgment on the issue of coverage. The court found that Essex and Sirius were both right and that Cold Spring did not have coverage under either policy. However, the court held that both insurers were estopped from withdrawing coverage because both reservation of rights letters failed "to inform [Cold Spring] that the offer[s] (to defend) may be accepted or rejected."

The Appellate Division affirmed. Like the trial court, the Appellate Division relied on the simple rule that unless a reservation of rights letter specifically stated that the insured had the right to accept or reject the defense under those terms, it was inadequate. The court relied principally on the New Jersey Supreme Court's decision in *Merchants Indem. Corp. v. Eggleston*, 37 N.J. 114 (1962). The court found that since the insurers did not inform the insured that it had the right to reject the defense that they offered, the court found that the insured was in the same position as though the insurers had assumed the defense without a reservation of rights.

In *Gomez v. First Jersey Cas. Ins. Co.*, No. A-3928-08T1 (N.J. Super. Ct. App. Div. April 1, 2010)(unpublished decision), the insurer provided a defense to the insured under a reservation of rights to deny coverage based on late notice and the intentional act exclusion. The reservation of rights letter informed the insured of the coverage issues and advised that the insured may want to retain personal counsel, as coverage may be disclaimed in the future. The letter did not inform the insured that the offer of defense could be accepted or rejected. The insured did not respond to the letter.

After a verdict was entered against the insured, the insurer advised that it would not indemnify him because the intentional act provision of the policy excluded coverage. A declaratory judgment action was brought to challenge the denial. The Appellate Division held that the insured's silence in response to the reservation of rights letter could not be deemed consent to the defense under Eggleston because the insurer failed to inform the insured that he could reject the offer. Thus, the insurer was precluded from disclaiming coverage for a claim that could have been excluded under the policy.

The implications of these holdings could be damaging to an insurer defending a case under a reservation of rights, if an insurer fails to advise an insured that the insured has the right to accept or deny a defense offered under a reservation of rights.

2. Reservation of Rights Triggers Right to Independent Counsel

A reservation of rights letter will effectively inform the insured of potential conflicts with its insurer. In some jurisdictions, such potential conflicts may give the insured the right to independent counsel. The leading national case addressing the rights of policyholders with the respect to the right to independent counsel in "conflicts" cases is *San Diego Federal Credit Union v. Cumis Ins. Society*, 162 Cal. App.2d 358 (1984). Under the *Cumis* doctrine, when an insurer agrees to defend its insured under a reservation of rights,

a conflict exists between the insurer and insured. In those instances, the insured has a right to retain independent counsel to be paid for by the insurer, commonly referred to as "cumis counsel."

New Jersey addressed the selection of counsel scenario long before the California court's opinion in *Cumis*. *See Burd v. Sussex Mut. Ins. Co.*, 56 N.J. 383 (1970). New Jersey does not recognize the insured's right to unilaterally select defense counsel to be paid concurrently by the carrier when a carrier issues a reservation of rights letter. If the carrier desires to defend under a reservation of rights, the carrier cannot assume control of the defense absent the specific agreement by the insured to the reservation of rights after being informed of the conflict. In New Jersey, in the event the insured does not accept a defense or reservation of rights, the insured is allowed to select its own defense counsel with a right of reimbursement from the carrier if it is later found in the underlying lawsuit that the claim falls within the ambit of coverage under the policy. *Burd*, 56 N.J. 383; *Hartford Accident & Indemnity Co. v. Aetna Life & Casualty Insurance Co.*, 98 N.J. 18 (1984).

3. Insurer's Ability to Reserve Rights to Seek Reimbursement of Defense Costs

The California Supreme Court's decision in *Buss v. Superior Court*, 16 Cal. 4th 35 (CA) (1997) is one example of the "majority" position on reimbursement under reservation of rights. Even though the California Supreme Court was not the first to hold that insurers could recoup defense fees for a defense provided under reservation of rights once it determined no coverage existed, its decision in *Buss* remains the most well-known case to so hold. Though widely considered the majority position, only seven states have actually permitted such reimbursement. New Jersey is one of those states. New Jersey permits reimbursement. *See Hebela v. Healthcare Ins. Co.*, 370 N.J. Super. 260 (App. Div. 2004) (applying equitable principle of "unjust enrichment," court allowed recoupment of defense costs). The New Jersey Supreme Court held in *SL Indus., Inc. v. America Motorists Ins. Co*., 128 N.J. 188 (1992) that an insurer can seek reimbursement if it can carry the burden to show defense costs that are allocable to non-covered claims. However, it has been argued that *Buss*'s duty to reimburse rule is inconsistent with New Jersey's broad duty to defend.

E. **Conflict of Interest - Independent Counsel**

A conflict of interest between an insurer and an insured arises when their common lawyer's representation of the one is rendered less effective by reason of the representation of the other. When multiple defendants-insureds are involved, a conflict exists between two clients when the representation of one client will be directly adverse to another, or, there is a significant risk that the representation of one client will materially limit to lawyer's responsibilities to another.

If a conflict of interest arises, and the insurer has a duty to cover multiple defendants-insureds, the Insurer must appoint separate independent counsel for each. An insurer's failure to provide separate independent counsel free of conflicting interests may result in a finding that the Insurer violated its duty of good faith.

II. **Bad Faith**

New Jersey does not have a bad faith statute. In addition, New Jersey's Unfair Trade Practices Act (N.J. Stat. Ann. 17:29B-1) does not support private causes of action.

A. **First Party Claims**

There is a common law cause of action for bad faith. *Pickett v. Lloyd's*, 131 N.J. 457 (1993). *Pickett* provided that "An insurance company owes a duty of good faith to its insured in processing a first-party claim. It may be liable to a policyholder for its bad faith failure to pay benefits. ... If a claim is 'fairly debatable,' bad faith is not established. Under the 'fairly debatable' standard, 'a claimant who could not have established as a matter of law a right to summary judgment on the substantive claim would not be entitled to assert a claim for an insurer's bad-faith refusal to pay the claim.' The insurer must have no valid reason to deny benefits or delay processing of the claim, and must have known or recklessly disregarded the fact that no reasonable basis existed for denying the claim." *Pickett*, 131 N.J. 457.

"Although a fairly debatable claim is a necessary condition to avoid liability for bad faith, it is not always a sufficient condition. Rather, we are satisfied that the appropriate inquiry is whether there is sufficient evidence from which reasonable minds could conclude that in the investigation, evaluation, and processing of the claim, the insurer acted unreasonably and either knew or was conscious of the fact that its conduct was unreasonable." *Taddei v. State Farm Indem. Co*., 401 N.J. Super. 449 (App. Div. 2008).

B. **Third Party Claims**

Rova Farms Resort, Inc. v. Investors Insurance Co. of America, 65 N.J. 474, 323 A.2d 495 (1974) recognizes a common law bad faith cause of action for failure to settle claims against insured under liability policy. The *Rova Farms* Court, in employing tort and contract principles, did not enunciate a fairly debatable standard and imposed an affirmative obligation on the insurer to act in good faith to settle litigation against its insureds. The case, *Taddei v. State Farm*, 401 N.J. Super. 449 (App. Div. 2008) (cert. granted 2010) makes clear that "the Rova Farms model simply does not apply in the first party coverage context." *Id.* at 459.

In the third party liability context, bad faith claims may be brought by an insured against an insurance carrier that refuses to tender policy limits to a plaintiff in settlement of the action against the insured. New Jersey courts have established that an insurer who contractually restricts the independent negotiating power of its insured has a positive fiduciary duty to attempt to negotiate a settlement within the policy limits. *Rova Farms*,

323 A.2d 495. Although an insurer will not be held per se liable for judgments in excess of policy limits when it failed to offer the policy limits, a "decision not to settle must be a thoroughly honest, intelligent and objective one." *Id*. at 503.

The court in *Rova* also held that "any doubt as to the existence of an opportunity to settle within the face amount of the coverage or as to the ability and willingness of the insured to pay any excess required for settlement must be resolved in favor of the insured unless the insurer, by some affirmative evidence, demonstrates there was not only no realistic possibility of settlement within policy limits, but also that the insured would not have contributed to whatever settlement figure above that sum might have been available." *Id*. at 501.

C. **Burdens of Proving Bad Faith**

To show a claim for bad faith, the policyholder has the burden of showing the absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of reasonable basis for denying the claim. *Pickett, supra*.

The Unfair Claims Practices Act 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."

Unfair claim settlement practices N.J.S.A. 17B:30-13.1, et seq.

No person shall engage in unfair claim settlement practices in this State. Unfair claim settlement practices which shall be unfair practices as defined in N.J.S.17B:30-2, shall include the following practices:

Committing or performing with such frequency as to indicate a general business practice any of the following:

a. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

b. Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

c. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

d. Refusing to pay claims without conducting a reasonable investigation based upon all available information;

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;

h. Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

i. Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

j. Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made;

k. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

l. Delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

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.

No private cause of action in New Jersey for alleged violation of unfair claims practice act.

Courts have often cited the unreported opinion, *Princeton Gamma-Tech, Inc. v. Hartford Insurance Group*, No. SOM-L-1289-91 (N.J. Super. Law Div. June 5, 1997), where the court held that no fairly debatable reason can exist to deny a claim where the insurance company: (1) employs a system that prohibits the claims handler from devoting an adequate amount of time to the claims for which he or she is responsible; (2) engages in irrelevant and non-responsive communications with its policyholder; (3) fails to conduct

a meaningful search for missing policies; or (4) does not undertake an independent investigation to determine the facts material to the claim.

D. **Statute of limitations**

In New Jersey, the applicable statute of limitations for insurance claims is six years. N.J.S.A. 2A:14-1. The statute of limitations accrues on the date of the incident, but is tolled from the time the insured gives notice until the insurer formally declines liability. *Gahnney v. State Farm Ins. Co*., 56 F. Supp.2d 491, 495-96 (D.N.J. 1999).

E. **Damages**

Consequential damages

Consequential damages are recoverable. *Pickett, supra.* Policyholders can recover for emotional distress only in "egregious circumstances" involving outrageous conduct on the part of the insurer. *Pickett, supra*.

Attorney's fees

Attorney's fees are allowed under N.J.R. 4:42-9(a)(6). However, N.J.R. 4:42-9(a)(6) "has been limited to 'third party' claims as a matter of policy." *Shore Orthopaedic Group, LLC v. Equitable Life Assur. Soc. of U.S.*, 938 A.2d 962, 969 (N.J. Super. App. Div. 2008).

Punitive damages

Punitive damages are available, but only in "egregious circumstances." The action must be wantonly reckless or malicious. The wrongfulness of the defendant's intentional act is critical.

New Jersey's Punitive Damages Act that limits the amount of punitive damages in any civil action to the greater of $350,000 or "five times the liability of that defendant for compensatory damages." N.J.S.A. 2A:15-5.9 *et seq*.

G. RECENT CASE LAW

1. <u>Notice of Claim</u>

The New Jersey Appellate Division recently examined the notice requirements provided in a claims-made insurance policy in *Templo Fuente De Vida Corp. v. National Union Fire Insurance Company of Pittsburgh, P.A.*, No. A-4516-12, 2014 N.J. Super.. Lexis 1303 (App. Div. June 6, 2014), an unpublished opinion. The court made it more difficult for insureds to secure insurance coverage when timely notice is at issue. It is a well-established approach in New Jersey that with a claims-made policy, the policyholder

must provide notice of a claim during the same policy period in which the policyholder received the claim. Otherwise, coverage is forfeited.

In addition to requiring that policyholders notify insurance companies during the policy period of claims made against the policyholder, the typical claims-made policy also states that notice must be made "as soon as practicable." The "as soon as practicable" language has frequently been addressed by New Jersey courts in the context of occurrence-based policies rather than claims-made policies. In *Cooper v. Government Employees Insurance Company*, 51 N.J. 86 (1968), the Supreme Court held that a court should only allow forfeiture of coverage under the phrase "as soon as practicable" in an occurrence-based policy if the insurance company could demonstrate that it had incurred appreciable prejudice.

In *Templo Fuente*, the policy period was January 1, 2006, to January 1, 2007. The policyholders received a claim on or about February 21, 2006, and gave notice to its insurance company on August 28, 2006, well within the policy period. However, the trial court found that the notice was inexplicably six months late and therefore not "as soon as practicable." The Appellate Division affirmed the trial court decision and denied coverage, rejecting the argument that the insurance company could "only disclaim coverage if it can demonstrate that it was prejudiced by the insureds' failure to provide notice as soon as practicable."

The trial court relied on the case *Associated Metals & Minerals Corp. v. Dixon Chemical & Research, Inc.*, 82 N.J. Super. 281 (App. Div. 1963), *cert. denied* 42 N.J. 501 (1964), in which the Appellate Division denied coverage because notice that was six months late was not "as soon as practicable." However, the court's reliance on Associated Metals is misplaced, as *Associated Metals* concerned an occurrence-based policy, not a claims-made policy.

The trial court and Appellate Division also relied upon *Zuckerman v. National Union Fire Insurance Company*, 100 N.J. 304 (1985). *Zuckerman* is the leading decision that establishes that late notice under a claims-made policy results in a forfeiture of coverage. However, *Zuckerman* dealt with notice that was given after the policy had lapsed. It is well established that a policyholder forfeits coverage by first giving notice after the policy period. As *Zuckerman* dealt solely with notice provided after the policy expired, its application in cases where notice is provided during the policy period is unjustified. In addition, *Zuckerman* noted that the *Cooper* doctrine has "no application whatsoever to a 'claims made' policy" because "claims-made" policies were specifically written and sold to only cover claims made during that policy period. The court reasoned that allowing claims made after the policy period would in essence broaden, without payment of additional premiums, the coverage sold.

2. Insurance Agent and Broker Liability

New Jersey law broadly protects insureds against errors by their insurance agents and brokers and also provides considerable scope for findings of broker liability. In *Aden v.*

Fortsh the state's Supreme Court held that a policyholder need not even read its insurance policy, but rather can rely upon its broker. 169 N.J. 64 (1999). Importantly, the court also held that an insurance broker is in a fiduciary relationship with a policyholder.

Two recent cases again addressed the issue of broker liability and provide additional guidance to brokers on their obligations. *See Huggins v. Liberty Mut. Ins. Co.*, No. A-1187, 2014 N.J. Super. LEXIS 1102 (N.J. App. Div. May 14, 2014); *Duffy v. Certain Underwriters at Lloyds of London*, No. A-5797, 2014 N.J. Super. LEXIS 1789 (N. J. App. Div. July 21, 2014).

In *Huggins*, the homeowner requested from the sales agent the most inclusive coverage available. The homeowner testified that she wanted "all beneficial coverage options" and advised the agent that the house had a sump pump. The policy that Liberty Mutual ultimately sold did not provide sump pump coverage, although such coverage was available by endorsement. The following year, the policyholder's sump pump failed, resulting in a $35,000 loss.

The homeowner sued Liberty Mutual for failure to advise them of the availability of sump pump coverage. Liberty Mutual's sales agent testified that the homeowner had been offered such an endorsement, but had decided not to purchase the sump pump coverage. While the agent claimed he had taken notes regarding this discussion, on his initial interview questionnaire he testified that he had lost those notes. Liberty Mutual was granted summary judgment by the trial court. The Appellate Division reversed finding that there was no dispute that the insured did not specifically ask for the sump pump option, but there was a dispute as to whether it was offered to the homeowner.

Huggins heightened the burden on agents and brokers in New Jersey when offering and issuing insurance policies.

On the other hand, the agents and brokers burden was limited by *Duffy*. There the policyholder changed brokers and insisted that the new broker issue a policy that would not increase the policyholder's premium. The policyholder gave information during the insurance application process, but much of the information was inaccurate. A policy was issued that offered coverage in the amount of $150,000. When the policyholder's house burnt down, the damage was valued at $460,000. The policyholder sued the broker for professional negligence as a result of procuring inadequate insurance coverage, but the trial court granted summary judgment and the Appellate Division affirmed. The Appellate Division reasoned that the amount of insurance coverage was "clearly and prominently stated and easily understood. Were plaintiff dissatisfied with the extent of coverage, an opportunity to raise such concerns presented itself with each annual renewal." *Duffy*, 2014 N.J. Super. Unpub. LEXIS 1789, at * 18-19.

3 <u>Superior Court Decision Addresses Issue of Allocation of Defense Costs in Long Tail Claims</u>

In *IMO Industries, Inc. v. Transamerica Corp.*, 437 N.J.Super. 577 (App. Div. September 30, 2014), Plaintiff, IMO, a manufacturer of industrial machinery, was faced with thousands of personal injury claims related to the manufacturing of products that contained asbestos. Defendants are primary and excess liability insurers, as well as Transamerica Corp., the former parent company of the predecessor manufacturer.

Over the years, IMO purchased a total of $1.85 billion in insurance coverage from all the defendant insurers. After tens of millions of dollars had been paid by IMO's primary carriers IMO sued its primary carriers and later added its excess carriers as additional claims were filed to establish its rights under those insurance policies and to recover money damages

The lower court ruled that the excess carriers must pay the defense costs of IMO in its underlying cases. Several parties appealed. On appeal, the court considered the amount of coverage IMO was entitled to, how that coverage should be allocated between the carriers, and for what period primary insurers must cover defense costs. These issues had not been previously addressed in the New Jersey Supreme Court's insurance allocation decisions OwensIllinois, Inc. v. United Insurance Co. and CarterWallace, Inc. v. Admiral Insurance Co. Additional issues included whether IMO was entitled to a jury trial on its claims for money damages, and numerous challenges to the trial court's interpretation of insurance policies within the OwensIllinois and CarterWallace allocation methodology.

The Appellate Court upheld the lower court's decision that the excess carriers must pay the defense costs of IMO in its underlying cases, and also rejected the carriers' attempt to reduce the amount they collectively owed, finding that multiyear policies provide separate peroccurrence limits for each year of coverage. The Court said that allowing excess carriers to contest coverage "is not feasible for longtail, multiclaim coverage cases," and that to revisit settled claims for reallocation purposes would "greatly complicate the already complex allocation process."

4. <u>Claims that an Insurer Acted Unreasonably Are Alone Insufficient to Support a Bad Faith Claim, but CFA Claim Allowed to Proceed</u>

In *Beekman v. Excelsior Ins. Co.*, 2014 U.S. Dist. LEXIS 21864 (D.N.J. February 21, 2014), plaintiff was a homeowner residing in Union Beach, New Jersey whose home was damaged by Superstorm Sandy. In addition to his breach of contract claim, plaintiff also alleged that the defendant insurers improperly adjusted his claim, misrepresented the cause, scope, and cost of repairs to the insured premises, underpaid the claim without any reasonable basis, conducted an inadequate, biased, and result-oriented investigation of Plaintiff's claim, and unreasonably delayed full payment of Plaintiff's claim. Plaintiff further alleged that the insurers violated the New Jersey Consumer Fraud Act ("CFA") through their deceptive acts during the adjustment. Defendants filed motions to dismiss the claims.

In the second count of the complaint, plaintiff pleaded a breach of the implied covenant of good faith and fair dealing. The court noted that under New Jersey law, a duty of good

faith and fair dealing is implicit in every contract of insurance. The party claiming a breach of the covenant of good faith and fair dealing "must provide evidence sufficient to support a conclusion that the party alleged to have acted in bad faith has engaged in some conduct that denied the benefit of the bargain originally intended by the parties." However, here the plaintiff's allegations were couched in terms of what was, or was not, "reasonable" on the part of the Defendant insurers. The court held that claims that insurers acted unreasonably are insufficient alone to support a finding that Defendants breached the covenant of good faith and fair dealing. As such, the court dismissed the claim.

Plaintiff also alleged a violation of the New Jersey Consumer Fraud Act (CFA) against Defendants. Plaintiff alleged that Defendants were deceptive in the adjustment of Plaintiff's claim and that Defendants' deception was part of an ongoing general business practice by the Defendants. Defendants argued that the Consumer Fraud Act does not apply to disputes about insurance benefits coverage. The court noted that in the past, New Jersey Courts have held that the CFA does not apply to insurance benefits coverage. However, the court provided that in Weiss v. First Unum Life Ins. Co., 482 F.3d 254 (3d Cir. 2007), the Third Circuit stated that it did not share previous Court decisions with "that the CFA and its treble damages provision are inapplicable to schemes to defraud insureds of their benefits." In Weiss, the plaintiff alleged that his insurance carrier "embarked on a fraudulent scheme to deny insureds their rightful benefits . . . ." Id. The Third Circuit concluded that "while the New Jersey Supreme Court has been silent as to this specific application of CFA, its sweeping statements regarding the application of the CFA to deter and punish deceptive insurance practices makes us question why it would not conclude that the performance in the providing of benefits, not just sales, is covered, so that treble damages would be available for this claim under the CFA." Id.

In light of the Third Circuit's holding in Weiss, the Court held that Plaintiff may bring a claim under the CFA and denied Defendants' motion to dismiss the CFA claim.

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