



LITIGATION UPDATE 2007

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LIABILITY

Campisi v. Acme Markets, Pa. Super., 915 A.2d 117 (2006).

A customer and a blind employee converged at an intersection of shopping aisles in an Acme Market. The customer tripped over the blind employee's cane, suffering serious injuries. After a plaintiff verdict, the trial court entered JNOV in favor of Acme, finding Acme owed no duty to the customer to avoid this type of incident. The Superior Court affirms. Blind spots at intersections of shopping aisles in supermarkets are known and obvious dangers from which the property owner has no duty to protect business invitees.

Smith v. Commonwealth of Pennsylvania, Pa. Cmwlth, 892 A.2d 36 (2006).

Smith, a minor, drove his grandmother's car while intoxicated and crashed it into a local high school. Smith survived, but later indicated under oath that he had intended the crash as a means of suicide. The crash caused more than \$61,000.00 in damages to the high school building. The automobile liability carrier successfully denied coverage based on Smith's admission that his conduct was intentional. The school district obtained a judgment against Smith for the property damage. When Smith did not pay the judgment, his license was revoked. On appeal, he claimed that since the damage to the high school building was not the result of an "accident" (since he intended the collision), he did not fall within the statutory provision for license revocation for failure to pay accident-related claims. The Commonwealth Court disagrees. "Accident" as used in the license revocation statute does not exclude intentional acts.

Campbell v. Eitak, Inc., Pa. Super., 893 A.2d 749 (2006).

A restaurant patron choked on food lodged in his throat. He asked a restaurant employee to call 911. In response to the 911 call, an ambulance took the patron to the hospital where he was treated for a tear in his esophagus. He underwent surgery for esophageal repair. The patron sued the restaurant for inadequate policies and procedures to respond to a choking emergency and for failure to have personnel on premises trained to administer appropriate first aid. Since the duty of the restaurant in such circumstances presented a case of first impression in Pennsylvania, the Superior Court took note of decisions from Wyoming, Nevada, and Florida, all of which determined the prompt summoning of medical assistance satisfies the restaurant's duty to a choking patron. The Superior Court affirmed summary judgment in favor of the restaurant.

Capoferri v. Children's Hospital of Philadelphia, Pa. Super, 893 A.2d 133 (2006), allocatur denied, Pa., - A.2d - (2006).

During jury selection in a medical malpractice suit, plaintiffs were precluded during open voir dire from questioning prospective jurors about media coverage of an alleged medical malpractice crisis and the alleged flight of physicians from the Philadelphia area. Following a defense verdict, plaintiff sought a new trial based on the restricted jury voir dire. The Superior Court, without actually endorsing the questions proposed by plaintiff, agrees and awards a new trial. The trial judge should have asked preliminary questions designed to detect whether any of the prospective jurors had been exposed to tort reform and medical negligence propaganda. The attorneys thereafter could have followed up with private voir dire questioning of individual prospective jurors.

Zelenak v. Mikula, Pa. Super., 911 A.2d 542 (2006)

After rejecting a pretrial offer of \$11,500, plaintiff obtained a verdict of \$7,000. The trial court awarded costs to plaintiff, including, pursuant to local rule, the cost of deposition transcripts. On appeal by defendant, the Superior Court affirms in general the award of costs even though plaintiff's recovery was less than the pretrial offer. The plain meaning of "prevailing party" for purposes of imposing costs is "the party who wins the lawsuit." Awardable costs, however, are "record costs" not "actual costs." The former are simply those amounts necessary to proceed in court (prothonotary fees, sheriff fees, etc.) while the latter involve preparation, consultation, and other fees (e.g. deposition transcripts, expert witness fees, etc.). "Actual costs" are only awardable where there has been a violation of a court rule or order.

Wisniski v. Brown & Brown Insurance Company, Pa. Super., 906 A2d 571 (2006), allocatur denied, Pa., - A2d - (2007).

On remand from the Pennsylvania Supreme Court, the Pennsylvania Superior Court must determine whether insurance brokers have a duty to inspect a business property for purposes of offering flood insurance. The Superior Court concludes that there is no such duty and, as a result, the insured's negligence claim against the broker was properly dismissed. In a footnote, the Superior Court states that it has not decided whether a claim for breach of contract, fraud, or breach of fiduciary duty could have been stated.

McCandless v. Edwards, Pa. Super., 908 A.2d 900 (2006).

Girard Medical Center prescribed methadone to a patient. The nephew of that patient stole the methadone and sold it to a third party. The third party used the methadone and died. The estate sued Girard Medical Center on the theory it over-supplied the patient with methadone, thus increasing the chances the methadone would be stolen and sold as a street drug. Plaintiffs at trial argued that Girard Medical Center owed a general duty of care to the public at large. The Superior Court affirms the directed verdict in favor of Girard Medical Center. The Center owed no duty of care to either the decedent or the public at large with regard to prescription of methadone for patients.

Clark v. Wakefern Food Corp, Pa. Super, 910 A.2d 715 (2006).

Plaintiff fell on ice and snow outside a Shop Rite supermarket. Her attorney wrote to the Shop Rite store manager advising of the incident. The carrier for Shop Rite acknowledged the claim in writing, listing the insured as "Shop Rite #411." Later, an adjusting company on behalf of the carrier identified the insured as "Wakefern Food Corporation." Plaintiff filed suit against "Wakefern Food Corporation t/a Shop Rite #411." The Shop Rite store in question, in fact, was not owned by Wakefern but, instead, by a different corporate entity. After the statute of limitations expired, plaintiff sought to amend the complaint to add the proper corporate owner. The Superior Court agrees that plaintiff should have had an opportunity to amend the complaint. Since plaintiff sued the Shop Rite store where she fell, effected service at that location, wrote to the store manager at that location, and used names in the caption of the complaint provided to her by the store's insurance carrier and adjustment company, plaintiff was not so much adding a party after the statute of limitations had run as correcting the name of the party she had already sued.

Jenkins v. Wolf, Pa. Super., 911 A.2d 568 (2006).

Jenkins, a pedestrian in a crosswalk, was struck by Wolf's vehicle as he made a right turn into the crosswalk. The trial court refused to give a negligence per se charge. The jury found Jenkins more than 50 percent at fault. On appeal, the Superior Court reverses and remands for a new trial. Under §3112 of the Motor Vehicle Code, vehicular traffic turning right must yield to pedestrians in a crosswalk. Since Jenkins was in a crosswalk, she was entitled to a jury charge that Wolf was negligent per se.

COVERAGE

Continental Casualty Company v. Pro Machine, Pa. Super., - A.2d - (2007).

Pro Machine was a Pennsylvania partnership. Massey and Egbert were the partners. Pro Machine purchased a commercial automobile policy from Continental which did not identify either Massey or Egbert as Named Insureds and which did not list the motorcycle involved in the accident as a specifically covered auto. After an accident and after exhausting the tortfeasor's liability coverage and the motorcycle UIM coverage, Massey sought excess UIM coverage from the Continental policy. Since a partnership is not a legal entity separate from the partners, Massey and Egbert necessarily qualified as Named Insureds under the Continental policy in their capacity as partners in Pro Machine. Massey accordingly qualified under the WHO IS AN INSURED section of the policy for purposes of UIM coverage. In addition, since the Continental policy treated as a "covered auto" any vehicle owned by a Named Insured, the motorcycle itself qualified under the policy and the "household vehicle" exclusion accordingly was not applicable. The Superior Court remands the case for a determination of whether Massey was in the course of partnership business (a prerequisite to coverage) at the time of the accident.

Mee v. Safeco Insurance Company, Pa. Super., 908 A.2d 344 (2006).

Mee had a homeowner's policy with Safeco. His home suffered direct physical loss due to an overflowing toilet. The policy provided replacement cost coverage but also allowed for loss settlement based on actual cash value. Safeco arranged for an estimate and then paid the actual cash value less a deductible and less 20 percent for overhead and profit. Safeco indicated it would pay the overhead and profit if Mee identified the general contractor who would be doing the repairs. Mee, however, was not using a general contractor. The Superior Court rules that actual cash value includes overhead and profit where use of a general contractor is reasonably likely, even when no general contractor is ultimately employed. Whether use of a general contractor is reasonably likely depends on the nature and extent of the damage and the number of trades necessary to make repairs. The general contractor then becomes necessary for coordination or supervision of trades required to complete the repairs. That Mee chooses to make the repairs himself does not necessarily preclude recovery of overhead and profit if Mee can establish that the repairs were such that use of a general contractor would have been reasonable.

Donegal Mutual Insurance Company v. Baumhammers, Pa. Super, 893 A.2d 797 (2006), allocatur granted, Pa., 908 A.2d 265 (2006).

In less than two hours, Baumhammers went on a shooting spree across four municipalities and two counties, killing five people and wounding a sixth. Baumhammers was convicted of first degree murder. In the civil suits that arose out of the shooting spree, the victims alleged Baumhammers was negligent in his conduct and his parents were negligent in failing to control his conduct. The parents had liability coverage through Donegal Mutual and umbrella coverage through USAA. Both policies contained exclusions for intentionally caused harm. The Donegal policy excluded coverage for bodily injury expected or intended by "the insured." The USAA policy, however, excluded coverage for bodily injury expected or intended by "any insured." Distinguishing or reversing prior case law to the contrary, the Superior Court rules Donegal must provide coverage to the parents for the negligence allegations against them even if the alleged negligent conduct precipitated or failed to prevent intentional conduct by Baumhammers. With regard to USAA, however, since the exclusion in that policy extended to the intentional conduct of "any insured," the intentional conduct of Baumhammers triggered the exclusion and justified denial of coverage to the parents. The Superior Court further ruled each of the shooting incidents constituted a separate occurrence under the Donegal policy.

Prudential v. Sartno, Pa., 903 A.2d 1170(2006).

Sartno performed various duties for a pizza shop, including delivery. Sartno was paid the same hourly wage regardless of what work he performed. The pizza shop did not charge for delivery. Sartno was allowed to keep any tips he received while making deliveries. Sartno was involved in an accident while making such a delivery. Prudential, his liability carrier, denied coverage, asserting Sartno was delivering property for a fee and thus fell within a policy exclusion. The Pennsylvania Supreme Court determines the "for a fee" language is subject to both a broad interpretation (e.g. where Sartno is being paid while he is making the delivery) and a narrow interpretation (e.g. where Sartno is paid a specific extra fee only for delivery). Since the exclusionary clause can be reasonably interpreted more than one way, the clause is ambiguous and must be interpreted in the manner most favorable to Sartno. Since Sartno received no direct benefit and was paid no direct fee for making a delivery, the exclusion was not triggered and coverage was in order.

Kvaerner Metals v. Commercial Union Insurance Company, Pa., 908 A.2d 888 (2006).

Bethlehem Steel brought suit against Kvaerner Metals asserting claims of breach of contract and breach of warranty. Kvaerner had contracted to design and build a coke oven battery. Bethlehem alleged that the battery did not meet contract specifications and that Kvaerner had failed to remedy problems. The CGL carrier for Kvaerner denied coverage because the Bethlehem complaint did not allege any "occurrence" (defined as an "accident") and further because, in any event, any coverage would have been excluded by various business risk exclusions. The trial court granted summary judgment in favor of the CGL carrier. The Superior Court reversed, considering evidence beyond the allegations of the complaint to find that an "occurrence" or "accident" may have transpired. The Supreme Court, however, reinstates the summary judgment in favor of the CGL carrier. First, the court should not look beyond the allegations of the complaint to determine whether coverage, including a duty to defend, had been triggered under the CGL policy. Second, an "accident" for coverage purposes indicates something "unexpected" and requires a degree of fortuity that is not present in a claim for faulty workmanship. To hold otherwise would be to convert a policy of insurance into a performance bond. Since the Bethlehem complaint alleged only property damage from poor workmanship to the work product itself, no "occurrence" or "accident" was alleged and no coverage was required.

Donegal Mutual Insurance Company v. Raymond, Pa. Super., 899 A.2d 357 (2006).

On 8/28/97, Raymond was placed as a foster child with the Deckers where he remained until 6/12/98. On 9/28/98, Raymond's mother and her children were evicted from their home and Raymond phoned the Deckers to ask if he could again live with them. The Deckers agreed and picked him up that day. Later that same day, Raymond was involved in an automobile accident for which he sought PIP and UIM benefits. Donegal, the personal auto carrier for the Deckers, declined coverage, asserting Raymond did not qualify as an "insured" under the Donegal policy. Under the policy language, Raymond would qualify as an "insured" only if he was "a ward or foster child" of the Deckers living in their household. Donegal contended the absence of a court order or formal placement of Raymond with the Deckers on 9/28/98 prevented him from attaining "a ward or foster child" status. Unlike the Donegal policy, the MVFRL defines "insured" to include "a minor in the custody of either the named insured or relative of the named insured." The Superior Court rules Raymond meets the MVFRL definition of an "insured" and accordingly is provided coverage under the Donegal policy. Only a formal or court designation was absent to prevent the status of "ward." The factual relationship between Raymond and the Deckers, however, was clearly that of a minor in the custody of the insured. The court took notice that after the 9/28/98 accident, Raymond continued to live with the Deckers until 6/10/99, a continuing residence consistent with his status as a minor in the custody of the Deckers.

Insurance Adjustment Bureau v. Allstate Insurance Company, Pa.,
905 A.2d 462 (2006).

IAB, a public adjustment company, entered into a contract with the Allstate insured following a fire loss. The insureds agreed to pay IAB a 10% commission on monies paid under the policy for the fire loss. After IAB did work on the fire claim, the insureds terminated the agreement with IAB. IAB advised Allstate of its fee agreement and assignment and asked that Allstate place IAB as a co-payee on any check issued to the insureds. Allstate did not do so. IAB sued Allstate for breach of contract, conversion, and breach of assignment. The trial court granted Preliminary Objections. The Superior Court affirmed. The Supreme Court, however, reverses. For purposes of resolving Preliminary Objections, the court had to accept certain factual allegations (e.g. that there had been an assignment of 10% as security) as fact. If, as alleged, the assignment was for purposes of security, then the assignment would be irrevocable and Allstate had to honor the IAB request. If, on the other hand, the assignment was only for purposes of collection, then the assignment was revocable and Allstate would not owe money to IAB. The Supreme Court does not judge the ultimate outcome of the litigation, only the propriety of dismissal of the case at the Preliminary Objection stage.

Mitsock v. Erie Insurance Exchange, Pa. Super, 909 A.2d 828(2006).

The mother was insured by Erie under a homeowner's policy. Her daughter and her daughter's fiancée moved in with mother. The daughter and fiancée expected to purchase a new home and eventually move out. In the interim, mother, daughter and fiancée all stored personal goods in a storage facility. The storage facility burned down. Erie paid the personal property claims of the mother and the daughter but denied the claims of the fiancée since he did not qualify as "any one we protect" under the policy language. More particularly, he did not qualify as "in the care of" the named insured. The trial court granted summary judgment in favor of the fiancée. The Superior Court reverses and remands the case for discovery and trial to resolve factual issues. "In the care of" means a level of support, guidance, and responsibility that is most often present in situations where an insured cares for a minor child, an elderly person, or an incapacitated individual. "In the care of," however, is broader than status as a ward, foster child, or someone "in the custody" of another.

Russock v. AAA Mid-Atlantic Insurance Company, Pa. Super., 898 A.2d 636 (2006), allocatur denied, Pa., - A.2d - (2007).

AAA issued a personal auto policy to Russock on a leased car. Premium payments were handled through Citizens Bank with a requirement from AAA that all premium payments be made by mail. At least a month prior to a 6/13/03 renewal date, Russock received a bill requiring payment on or before 6/13/03 or the policy would be cancelled. Russock was also warned by AAA and by Citizens Bank that he should allow up to five days for check processing. The premium payment was mailed on 6/10/03 by Citizens Bank but was not received by AAA until 6/17/03 by which date the policy had been cancelled. An accident occurred on 6/20/03. AAA, although having cancelled the policy, nonetheless cashed the late premium check. The Superior Court rules the cancellation to be invalid and requires coverage through the 6/20/03 accident. Where the use of mail as a means of acceptance is authorized or implied from the surrounding circumstances, the acceptance is complete by posting the letter in normal mail channels. In the present case, use of the mails to submit premium payments was not merely authorized, but required. There was no evidence that Russock had knowledge of the payment due date yet refused to pay. Instead, the payment was placed in transit to AAA which had dictated the method of transport.

Atlantic States Insurance Company v. Northeast Networking Systems, Pa. Super., 893 A.2d 741 (2006), allocatur denied, Pa., 911 A.2d 932 (2006).

A supervisor and employee were sent on an out-of-state business trip by their employer. The supervisor, driving a company car while intoxicated, caused a single-vehicle accident which injured the passenger employee. In workers' compensation proceedings, the employee was ruled to have been in the course of employment and thus entitled to compensation. The supervisor, however, was denied compensation because of his violation of a positive work rule prohibiting driving a company car after drinking alcohol. Atlantic States provided the commercial auto coverage for the employer. Relying on a series of exclusions in the policy, Atlantic States sought to deny coverage to the supervisor driver for the tort claim by the injured employee passenger. The Superior Court agreed the standard "workers' compensation" exclusion did not apply because the injured employee passenger was not in the tort case seeking to recover under any workers' compensation law. The Superior Court also agreed the exclusion for employee claims against an employer was not applicable because the tort claim was not against the employer but rather against the supervisor driver. The Superior Court further agreed Section 1724 of the MVFRL (which voids exclusions for driving under the influence of drugs or alcohol) applied to prevent any denial of coverage based on non-permissive use. Finally, however, the Superior Court accepted one of the bases for denial of coverage. The "fellow employee" exclusion avoided coverage for any bodily injury claim to a fellow employee (in this case, the employee passenger) arising out of and in the course of the fellow employee's employment. Since that was the precise fact pattern presented, the Superior Court ruled Atlantic States provided no coverage to the supervisor driver for tort claims by the employee passenger.

BAD FAITH

Condio v. Erie Insurance Exchange, Pa. Super, 899 A.2d 1136 (2006), allocatur denied, Pa., 912 A.2d 838 (2006).

Breen was killed and Sailer was injured in a single vehicle accident. Based on inconclusive evidence, opinions varied as to whether Breen or Sailer was driving at the time of the accident. Sailer and the Estate of Breen each presented claims against the other and each also sought UIM benefits. Erie was the UIM carrier for Breen. Since the tort litigation settled, there was no judicial determination as to who was driving. Breen and Erie arbitrated the UIM claim, with the arbitrators finding in favor of Breen and Erie paying its policy limits with interest. Breen thereafter sued Erie for bad faith. The trial court entered a bad faith Award based, at least in part, on the theory Erie as UIM carrier owed a heightened duty of good faith to Breen. On appeal, the Superior Court reverses. There is no special duty of good faith in the UM/UIM context. The carrier always has a duty of good faith and fair dealing. The carrier may not protect its interests at the expense of the insured's interests. A carrier, however, is not required to sacrifice its own interests by blindly paying submitted claims just to avoid a bad faith lawsuit. The court reviews in detail its earlier rulings on bad faith. Bad faith exists where the insurer does not have a reasonable basis for denying benefits and the insurer knows or recklessly disregards its lack of reasonable basis in denying a claim. Bad faith is a frivolous or unfounded refusal to pay the proceeds of a policy done with dishonest purpose, motivated by self-interest or ill will. Bad faith conduct includes a lack of good faith investigation into facts and a failure to communicate with the claimant. Bad faith can arise where an insurer intransigently refuses to settle a claim that could have been settled within policy limits where the insurer lacked a bona fide belief it had a good possibility of winning at trial. Bad faith may extend to an insurer's investigative practices. Bad faith can be established where the insurer misrepresents the amount of coverage, arbitrarily refuses to accept evidence of causation, secretly places the insured under surveillance, acts in a dilatory manner, and forces the insured into arbitration by presenting an arbitrarily low offer bearing no reasonable relationship to the insured's medical expenses, particularly where the offer proves to be 29 times lower than the eventual arbitration Award. On the other hand, there is no bad faith where the insurer makes a low but reasonable estimate of the insured's losses or where the insurer makes a reasonable legal conclusion based on an area of the law that is uncertain. In the absence of a dishonest purpose or ill will, there is no bad faith when a carrier takes a stand with a reasonable basis or aggressively investigates and protects its interests. Mere negligence or bad judgment does not result in bad faith. The insurer's conduct, to support a bad faith finding, must import a dishonest purpose. Any bad faith must be established by clear and convincing evidence.

In the present case, the trial court applied an improper standard to establish bad faith. In addition, the Superior Court notes the demand for UIM arbitration, by its very nature, put Erie in an adversarial position against its insured. Given that adversarial position, Erie's management and investigation of the claim would not follow the normal course for investigating a first party claim. Erie immediately retained counsel. Erie did not hide behind its relationship with counsel to avoid obligations to the estate. Instead, Erie worked with defense counsel to analyze the claim and prepare for arbitration. UIM claims are inherently adversarial. In addition, to the extent defense counsel may have delayed in reviewing materials or scheduling discovery, the record did not support a finding that such delay was attributable to Erie. On the contrary, reminders sent by Erie to defense counsel indicate Erie's continued active involvement in evaluating the case. Although the record contained some critical comments made by the Erie adjuster about claimant's counsel, such comments, while perhaps unprofessional and regrettable, do not rise to the level of bad faith. Nor was Erie acting in bad faith when it waited for its insured to move the case forward. The plaintiff always has the burden of advancing his case.

MVERL

Long v. Mejia, Pa. Super., 896 A.2d 596 (2006).

Long, a limited tort plaintiff, alleged neck, back, left shoulder, and left wrist injuries from an accident. More particularly, Long claimed his left wrist injury amounted to a serious impairment of bodily function so as to allow him full tort status. Long went to the emergency room on the date of the accident and started treatment with a physician within a week. He treated for seven months. He started wearing a wrist brace during treatment and was still using the brace by the time of trial three years later. Because of the wrist injury, Long could no longer use certain tools, jackhammers, and compressors at work. He could not lift more than 35 pounds. He had to be careful when playing with his grandchildren, nieces, and nephews. Changes in the weather caused pain. He could not work the clutch on his dirt bike. The treating physician confirmed the above restrictions and noted that Long also had problems with simple things such as wringing out a washcloth or pouring a pitcher of water. The Superior Court, citing the Supreme Court *Washington v. Baxter* decision, noted the "serious impairment" test involved the effect a particular injury had on plaintiff and how that injury negatively impacted his or her ability to perform his or her chosen profession or daily activities. A broken finger, for example, might prove a serious impairment of bodily function to a violinist but not to a lawyer. The award in favor of Long was affirmed.

Progressive Halcyon Insurance Company v. Kennedy, Pa. Super., 908 A.2d 911 (2006).

Kennedy was insured on a full tort policy with Progressive Halcyon. He owned another vehicle which was uninsured. He was occupying the insured vehicle at the time of an accident. The Superior Court rules that Kennedy was entitled to full tort status since, in the face of conflicting tort options (full tort on the policy and deemed limited tort because of the uninsured vehicle), the tort option on the vehicle occupied at the time of the accident controls.

Wheeler v. Nationwide, Pa. Super., 905 A.2d 504 (2006), allocatur denied, Pa., - A.2d - (2007).

Wheeler, a named insured on a policy without wage loss benefits, was injured in an accident while driving a vehicle owned by his mother. His mother's coverage did provide wage loss benefits. Wheeler's wage loss claim, however, was denied. The Superior Court affirms the denial. Since Wheeler had coverage as a named insured, he had to seek all first party benefits from coverages at that highest priority level. The coverage on his mother's vehicle was at a lower priority level which he was not permitted to access, regardless of the absence of or exhaustion of coverages at the highest priority level.

Wirth v. Aetna U.S. Healthcare, Pa., 904 A.2d 858(2006).

Wirth was injured in a motor vehicle accident and received care covered under his HMO plan. The HMO contract provided for subrogation rights such as given under the Federal HMO Act. After Wirth settled his tort claim, Aetna, the HMO carrier, sought recovery of its medical payments. Wirth contended Section 1720 of the MVFRL barred the subrogation claim. Aetna contended the HMO contract and the HMO Act gave subrogation rights. On referral of the question from the Third Circuit Court of Appeals, the Pennsylvania Supreme Court agrees that subrogation claims by HMO organizations governed by the Federal HMO Act are not barred by the MVFRL.

Santorella v. Donegal Mutual Insurance Company, Pa. Super., 905 A.2d 534 (2006), allocatur denied, Pa., - A2d - (2007).

Son, who previously lived in Pennsylvania, moved to California where he purchased, registered, and insured a car. He returned to Pennsylvania and allowed the insurance on the car to lapse since he did not plan to drive the vehicle in Pennsylvania. He was then involved in an accident while a passenger in another motor vehicle. He applied for first party benefits under the policy issued to his parents in Pennsylvania with whom he then lived. The Superior Court denies first party benefits. The MVFRL provides that the owner of a currently registered but uninsured motor vehicle is ineligible to receive first-party benefits. That the uninsured vehicle was registered in California, not Pennsylvania, does not avoid the bar to recovery.

Progressive Insurance Company v. Universal Underwriters Insurance Company, Pa. Super., 898 A.2d 1116 (2006), allocatur denied, Pa., 909 A.2d 1290 (2006).

A Progressive insured was operating with permission a vehicle owned by a car dealership and insured by Universal Underwriters. After an accident, the two insurers disputed which policies provided coverage. Progressive acknowledged liability coverage since its insured was covered for any vehicle he operated with permission. Universal Underwriters, however, denied coverage since its omnibus insured section extended coverage to permissive users only when "required by law." Universal Underwriters relied on the earlier Pennsylvania Supreme Court decision in *State Farm v. Universal Underwriters*, Pa., 701 A.2d 1330 (1997) which had ruled the MVFRL then in effect did not impose the "required by law" obligation. In the current appeal, however, the Superior Court noted the MVFRL had since been amended to require financial responsibility from the owner of a motor vehicle not only when the owner operated the vehicle but also when the owner permitted the vehicle to be operated in the Commonwealth. By implication, coverage for permissive users is now "required by law" and thus Universal Underwriters' omnibus insured provision is triggered. Both Progressive and Universal Underwriters provided coverage for the loss.

Glikman v. Progressive Casualty Insurance Company, Pa. Super., - A.2d - (2007).

Glikman suffered psychological and emotional injuries by witnessing the accident that killed her husband. She sought First-Party Benefits from her Progressive personal auto policy. Relying on *Zerr v. Erie*, Progressive denied coverage. In *Zerr*, the Erie policy, mirroring the MVFRL language, defined "bodily injury" or "injury" as "accidental bodily harm to a person and that person's resulting illness, disease, or death." As a result, the *Zerr* claim for First Party Benefits was properly denied because the psychological or emotional harm was not caused by "accidental bodily harm" to the claimant. The Progressive policy, however, defined "bodily injury" as "bodily harm, sickness, or disease, including death that results from bodily harm, sickness, or disease." The Progressive policy, by covering illness or disease regardless of whether it is preceded by "accidental bodily harm," extends greater coverage than the MVFRL requires. Providing greater than required coverage does not violate the MVFRL. Glikman was entitled to First Party Benefits.

UM/UIM

Blood v. Old Guard Insurance Company, Pa. Super., 894 A.2d 795 (2006), allocatur granted, Pa., - A.2d - (2007).

In 1986, Blood purchased coverage with a \$500,000 liability limit and a \$35,000 UM/UIM limit. In 2000, Blood requested a reduction of the liability limits from \$500,000 to \$300,000. The form through which they requested this reduction in liability limits also had available sections for selecting different UM or UIM limits. The Bloods made no selections in those portions of the form. After the change in the liability limits, Blood's son was injured in an accident and sought UIM benefits. Old Guard conceded the \$35,000 stacked limits but Blood contended the UIM limits were actually \$300,000. The Superior Court reviews the rules on selecting UM/UIM coverage amounts. An insured may request UM/UIM limits lower than the liability limit. While there is no specific format for such a request, the request must be made in writing and must specifically state the amount of UM/UIM coverage sought. UM/UIM coverage may also be rejected by using statutory forms. A change in the liability limit after such a valid rejection does not reinstate the UM/UIM coverage. In the present case, the Superior Court stated the coverage selection form used to reduce the liability coverage potentially confused the insured by having sections also applicable to UM/UIM coverage amounts. There was no statement on the form that changing one coverage would or would not have an effect on other coverages. In such circumstances, Old Guard, by using an ambiguous form, would be required to provide \$300,000 stacked UIM coverage.

Hartford Insurance Company v. O'Mara, Pa. Super., 907 A.2d 589 (2006).

The insureds purchased automobile coverage with a \$100,000/\$300,000 liability limit and a \$15,000/\$30,000 UM/UIM limit. The insured signed an appropriate form requesting the lower limits. At arbitration of a subsequent claim, the arbitrators determined the coverage reduction form was inadequate and accordingly reformed the policy limits to \$100,000/\$300,000 stacked. On appeal, the Superior Court en banc determined that §1734 the MVFRL requires that the Named Insured sign the "writing" requesting lower limits and that the "writing" include an express designation of the amount of UM and UIM coverage requested. To comply with §1734, the writing need only convey the insured's desire to purchase UM and UIM coverage in amounts less than the liability limits of the policy. The Court found that the Hartford form, read as a whole, satisfied the requirements for requesting a lower limit.

Pennsylvania National Mutual Casualty Insurance Company v. Black, Pa., - A.2d - (2007).

The Penn National policy sought to reduce the amount of available UIM limits by the amount received by the same claimant for the same injuries and the same accident under the liability portion of the policy. This is usually stated in ISO policies as:

The limit of liability under this coverage is reduced by any amount paid to the same person for the same accident under Part A or Part C.

The Pennsylvania Supreme Court upholds the validity of the setoff provision.

Nationwide Insurance Company v. Schneider, Pa. Super, 906 A.2d 586 (2006), allocatur granted, Pa., - A2d - (2007).

Schneider, a police officer, was injured in a police vehicle in a motor vehicle accident. He obtained the policy limits from the tortfeasor. He then settled with the primary UIM carrier for \$750,000 out of a \$1,000,000 coverage. He then presented an excess UIM claim to his personal carrier, giving a credit against damages for all the underlying coverage (i.e. \$1,015,000). The personal UIM carrier denied the excess UIM claim, asserting Schneider failed to obtain its consent to settle with the tortfeasor and had also failed to exhaust the primary UIM coverage. The Superior Court en banc disagrees. The rules for consent to settle (i.e. the carrier must show actual prejudice caused by any breach) and exhaustion (i.e. there is no breach if claimant offers a credit for the full amount of coverage available) apply in the primary UIM/excess UIM context as well as the BI/primary UIM context.

Tannenbaum v. Nationwide, Pa. Super., - A.2d - (2007).

In an appeal from a UIM Award, the Superior Court addresses whether benefits from a self-paid disability coverage can be used as a setoff against damages in claims arising out of a motor vehicle accident. Citing *Panichelli* (which addressed a similar question with regard to sick pay and Social Security benefits), the Superior Court concludes that the victim of a motor vehicle accident is entitled to benefits for which he has paid either directly by paying premiums or indirectly by receiving lower wages in return for employer-provided benefits. As a result, the amount Tannenbaum received in disability benefits could not be used to reduce the amount of his loss of earnings or loss of earning capacity claim in the UIM case.

Pantelis v. Erie Insurance Exchange, Pa. Super, 890 A.2d 1063 (2006).

Pantelis was involved in an accident on 1/19/01 in which she suffered injuries for which Erie paid PIP benefits. On 4/29/01, Pantelis was involved in a second accident for which she again sought PIP benefits from Erie. After Erie paid the PIP benefits, Pantelis also sought UIM benefits for the second accident. When arbitrators awarded what Pantelis viewed as an inadequate amount, Pantelis sought to set aside the Award of Arbitrators, arguing, in particular, Erie should not have been permitted to contest medical causation since it paid the PIP bills after the second accident. The Superior Court affirms the Award of Arbitrators. Payment of first party benefits does not preclude an insurer from later denying third party UM/UIM benefits or contesting medical causation in such claims. Payment of UM/UIM claims is subject to a different analysis than payment of first party benefits.

Progressive Northern Insurance Company v. Gondi, 165 Fed. App. 217 (3rd Circuit, 2006).

Gondi left his car unattended with the engine running as he ran into a restaurant to pick up food. He saw someone stealing his car and attempted, unsuccessfully, to stop the theft. In the process, he was run over by his own vehicle. Gondi sought UM benefits from Progressive Northern, the carrier on his stolen vehicle. The Progressive Northern policy defined a UM vehicle to not include any vehicle owned by Gondi. The court found the policy language unambiguous and denied coverage. The court also rejected Gondi's public policy argument in favor of coverage since his own negligent conduct had facilitated the theft.

Craley v. State Farm, Pa., 895 A.2d 530 (2006).

Craley was killed in an accident caused by a UM driver. Her estate collected UM benefits from her State Farm policy on the vehicle she owned and operated. Her husband had a separate State Farm policy from which the estate sought excess UM benefits. To defeat the excess UIM claim, State Farm raised both the "household vehicle" exclusion and also the waiver of stacking which, it contended, applied not only to intra-policy stacking but also to inter-policy stacking. The Superior Court denied the excess UIM claim on the basis of the household exclusion. The Supreme Court, however, does not rely upon the household exclusion but rather holds a waiver of stacking bars both intra-policy stacking and inter-policy stacking, a holding which reverses several earlier Superior Court decisions.

Lowery v. Port Authority of Allegheny County, Pa. Cmwlth., 914 A.2d 953 (2006).

Plaintiffs were passengers in a Port Authority bus involved in an accident with an uninsured motorist. The Port Authority is a self-insured Commonwealth agency protected by sovereign immunity. The Port Authority contended, and the trial court ruled, that although the Port Authority as a self-insured entity had to provide UM coverage, plaintiffs' UM claims were barred by sovereign immunity. The Commonwealth Court reverses. Although there is an apparent conflict between the UM requirements imposed on a self-insured Commonwealth agency by the MVFRL and statutory sovereign immunity, requiring the Port Authority to provide UM coverage was the only reasonable resolution of that conflict.

For an identical result, see *Paravati v. Port Authority of Allegheny County, Pa. Cmwlth.*, 914 A.2d 946 (2006).

WORKERS COMPENSATION

Costello v. WCAB, Pa. Cmwlth., - A.2d - (2007).

In this workers' compensation case, claimant established a valid common law marriage to the deceased employee as of 11/26/03. The employee died on 6/28/04. On 9/17/03, the Commonwealth Court in *PNC Bank v. WCAB* abolished the doctrine of common law marriage prospectively for any common law marriages allegedly entered into after that date. On 11/24/04, however, the Pennsylvania Legislature amended the Marriage Law effective 1/1/05 invalidating common law marriages on and after 1/1/05. The issue on appeal was the validity of common law marriages allegedly created in the 15½-month period between the 9/17/03 *PNC Bank* decision and the 1/1/05 effective date of the amended Marriage Law. In a split opinion, the Commonwealth Court en banc rules the 1/1/05 date controls for determining when common law marriages are prospectively banned.

Urmann v. Rockwood Casualty Insurance Company, Pa. Super., 905 A.2d 513 (2006).

Urmann, injured in a work-related accident, settled his tort claim for \$300,000. Because the proposed settlement allocated \$50,000 to Urmann for his injuries and \$250,000 to Mrs. Urmann on the loss of consortium claim, the mediator who negotiated the settlement recommended that the parties seek court approval of the settlement terms. The trial court held an evidentiary hearing, concluding that, due to the nature of the injuries, the consortium claim was indeed worth much more than Urmann's direct claim. Urmann had suffered mental injuries which left him unaware of many of his disabilities, although his wife had to cope with the ramifications of the disabilities. The trial court determined the proposed settlement was fair and reasonable. Rockwood, the workers' compensation carrier, appealed, arguing it had been improperly divested of subrogation rights against the full settlement fund. Since the trial court conducted an evidentiary hearing and took testimony which supported the proposed settlement, the Superior Court affirms, finding that the trial court neither abused its discretion nor erred as a matter of law in approving the settlement agreement.

Kidd-Parker v. WCAB, Pa. Cmwlth., 907 A.2d 33 (2006).

Kidd-Parker, after suffering a work related injury, brought and settled a third party action. In the interim, her employer had not only paid Workers' Compensation benefits, it had overpaid such benefits during the pendency of termination proceedings. The employer recovered the overpayment from the Supersedeas Fund. The employer nevertheless presented a Workers' Compensation subrogation claim of the full amount it had paid to *Kidd-Parker*, unreduced by any recovery from the Supersedeas Fund. The Commonwealth Court agrees that the subrogation claim was proper. All payments made by the employer to a claimant, both before and after the official termination date eventually established, constitute compensation for purposes of pursuing the subrogation.

Agnello v. WCAB, Pa. Cmwlth., 907 A.2d 676 (2006).

Agnello fell at work, suffering injuries to her neck, jaw, and teeth. Her injuries required removal of three teeth. For non-work related injury reasons, claimant also had her remaining lower teeth removed and replaced with a full lower denture. She already had a full upper denture for non-work related injury reasons. Claimant presented a disfigurement claim based on loss of the three lower teeth. She presented the trial judge with a pre-injury photograph showing her three lower teeth. The WC judge denied the disfigurement claim, stating he was not able to see any difference in her smile with or without the lower teeth. The WCAB affirmed. The Commonwealth Court, however, reverses and remands the case for entry of a disfigurement award. When reviewing disfigurement cases involving teeth, the WC judge must evaluate the claimant without the prosthesis. In short, the WC judge may not conclude that the lower denture actually improved claimant's appearance. Because claimant had no teeth when she removed her lower denture, she proved that she had a disfigurement that was serious and permanent and she was entitled to some type of award.

RELEASES

Brannam v. Reedy, Pa. Cmwlth., 906 A.2d 635 (2006).

At the final pretrial conference in an automobile accident case, the parties, assisted by the court, negotiated a settlement of \$210,000. Plaintiffs, however, subsequently contended their attorney (Allen L. Feingold) was not authorized to enter into the settlement. The court, without holding an evidentiary hearing, marked the case settled. The Commonwealth Court vacates the order of settlement. Whenever one party to a purported settlement disputes the existence of an agreement, the court must hold an evidentiary hearing. In the present case, Feingold's authority to settle had to be proven, not simply inferred, once it was disputed by plaintiffs in their Motion to Strike the Order of Settlement.

Nissley v. Candytown Motorcycle Club, Pa. Super., 913 A.2d 887 (2006).

Plaintiff joined a motorcycle club which provided a track for use by its members. The Application for Membership form included a release agreement under which the member "gave up all rights to sue or make claim against the Candytown Motorcycle Club." Plaintiff was injured when he collided with a maintenance tractor on the track. The Superior Court affirmed summary judgment in favor of Candytown Motorcycle Club. While releases are not favored at law, releases will be upheld if they do not contravene public policy, are between persons relating to their own personal affairs, and are not contracts of adhesion.

Griest v. Pennsylvania State University, Pa. Super., 897 A.2d 1186 (2006).

As Penn State and Dickinson Law School merged, Griest, an employee of Dickinson, was asked to resign. As part of a separation agreement, he received several months of pay and in return released any claims he might have under the Pennsylvania Human Relations Act. Griest nevertheless filed a suit against Penn State and Dickinson under the PHRA. Griest claimed the release was void as against public policy because it did not comply with the specific release requirements found in the Older Worker's Benefits Protections Act. The Superior Court ruled, however, the OWBPA, a Federal statute, affects releases only as to claims made under the Federal Age Discrimination in Employment Act. Griest was not presenting any such claim in the lawsuit. Common law principles applied to interpretation of the release as to the PHRA claim. Since the release was not ambiguous and there was no allegation it was procured by fraud, duress, or mutual mistake, the release was valid to bar the PHRA claim.

VENUE

Kisak v. Wheeling Park Commission, Pa. Super., 898 A.2d 1083 (2006), allocatur denied, Pa., 912 A.2d 838 (2006).

Plaintiffs alleged injuries while playing miniature golf at Oglebay Park in West Virginia. The park is operated by the Wheeling Park Commission. Suit was brought in Allegheny County on the theory the Commission advertised extensively in Allegheny County and such advertising amounted to "regularly conducting business" in Allegheny County for purposes of venue. The Superior Court disagrees. Relying on the *Purcell* Pennsylvania Supreme Court decision, the Superior Court distinguishes between direct acts necessary to the defendant's business (which give rise to proper venue) and collateral or incidental acts which are simply in aid of the main business purpose (which do not give rise to proper venue). Advertising is collateral and incidental, not direct, with regard to operating Oglebay Park. Since no county in Pennsylvania had proper venue, granting the preliminary objections was affirmed.

Zappala v. Brandolini Property Management, Pa., 909 A.2d 1272 (2006).

In a trip and fall case, plaintiff filed suit in Philadelphia against Chester County defendants and Philadelphia County defendants. No defendant filed Preliminary Objections to venue. Ultimately, the Philadelphia County defendants were dismissed. The Chester County defendants then filed a motion to transfer venue on the theory that venue was never proper in Philadelphia County since plaintiff never had a valid claim against the Philadelphia County defendants. The trial court transferred venue to Chester County. The Superior Court reversed. The Supreme Court affirms the Superior Court, keeping venue in Philadelphia County.

Challenges to improper venue must be made by Preliminary Objection. If venue is proper at the time suit is filed (i.e. at least one defendant is amenable to venue in the chosen county), then venue remains proper throughout the litigation. Since venue in this case was proper in Philadelphia County where the Philadelphia County defendants were amenable to venue, then the subsequent dismissal of those Philadelphia County defendants did not affect the propriety of the original chosen venue. Challenges to venue based on convenience or inability to obtain a fair trial are **not** raised by Preliminary Objections but rather can be raised at any time.

DISCOVERY

McNeil v. Jordan, Pa., 894 A.2d 1260 (2006).

A brother sued his sister for alleged intentional interference with testamentary expectancy. Their father died leaving a will splitting the estate among his children, except the brother. Suit was started by complaint that was dismissed through preliminary objections, but with a right to file an amended complaint. The brother sought discovery to obtain information necessary to draft an amended complaint. Defendants opposed the discovery as tantamount to a "fishing expedition." The court declined to order the discovery absent a showing of a reasonable basis to support the underlying claim. Without the discovery, no amended complaint was filed and the suit was dismissed. The appeal involved the extent to which pre-complaint discovery is permitted under Pennsylvania procedure. PRCP 4001(c) clearly contemplates pre-complaint discovery. When taking a deposition to aid in preparation of a complaint, the plaintiff in the notice of deposition must include "a brief statement of the nature of the cause of action and the matters to be inquired into." Pre-complaint discovery, however, should be restrictively allowed, narrowly drafted, and permitted only when a complaint capable of surviving preliminary objections cannot be filed without aid of the requested discovery. The Supreme Court adds a further element of "probable cause" taken from the Wrongful Use of Civil Proceedings statute. In seeking pre-complaint discovery, the moving party must set forth probable cause that, based on facts known to him, the evidence sought prior to the filing of the complaint will support a cognizable cause of action under existing or developing Pennsylvania law. The Supreme Court remands this case for determination as to whether the brother can make such a showing.

Cooper v. Schoffstall, Pa. 905 A.2d 482 (2006).

Dr. Eagle performed an IME in connection with a tort lawsuit. In discovery, the plaintiff sought, and the trial court ordered, production of Dr. Eagle's 1099 tax records for a three-year period related to defense reports, examinations, and depositions. The Superior Court affirmed the trial court ruling. The Supreme Court, however, reverses. Discovery against expert witnesses is restricted by P.R.C.P. 4003.5. Before any discovery beyond the subject matter of the IME can be permitted, plaintiff must first demonstrate a significant pattern of compensation supporting a reasonable inference the witness has become biased due to substantial financial incentives. Upon such a showing, the plaintiff may then conduct a deposition by written interrogatories to inquire as to the following:

The approximate amount of compensation received and expected in the pending case; the character of the witness' litigation related activities and, in particular, the approximate percentage devoted to specific types of litigation and/or work on behalf of a particular litigant, class of litigant, attorney, and/or attorney organizations; the number of examinations, investigations, or inquiries performed in a given year, for up to the past three years; the number of instances in which the witness has provided testimony within the same period; the approximate portion of the witness' overall professional work devoted to litigation related services, and the approximate amount of income each year, for up to the past three years, garnered from the performance of such services.

The witness will not be required to give information about overall total income or percentage of income derived from litigation related services.

Smith v. SEPTA, Pa. Cmwlth., 913 A.2d 338 (2006).

Plaintiff alleged injury after his car was rear ended by a SEPTA bus. In response to Expert Witness Interrogatories, plaintiff indicated that expert testimony would be offered by the treating physicians, in accordance with their treatment records. Plaintiff did not specifically name any treating physician either in the Answers to Interrogatories or in the final Pre Trial Memo. SEPTA objected to causation testimony offered at trial through one of the treating physicians. The Superior Court upholds the trial court decision to restrict the testimony of the treating physician, in particular to delete testimony on causation. The Pennsylvania Rules of Civil Procedure require expert witness disclosures either through specific Answers to Interrogatories or a separate report outlining the intended testimony. The expert must sign either the Answers to Interrogatories or the separate report.