FORTHRIGHT

In the Matter of the Arbitration between

Fort Lee Rehab, LLC a/s/o J.C.

CLAIMANT(s),

v.

Forthright File No: NJ1406001562849
Proceeding Type: In Person
Insurance Claim File No: 0380279970101044
Claimant Counsel: Law Offices of Sean T. Hagan
Claimant Attorney File No: 14-5656
Respondent Counsel: Law Office of Robert Raskas
Respondent Attorney File No: 14-02056-ST
Accident Date: 01/24/2013

GEICO Insurance Company

RESPONDENT(s).

Award of Dispute Resolution Professional

Dispute Resolution Professional: Anthony M. Aloi Esq.

I, the Dispute Resolution Professional assigned to the above matter, pursuant to the authority granted under the "Automobile Insurance Cost Reduction Act", *N.J.S.A. 39:6A-5, et seq.*, the Administrative Code regulations, *N.J.A.C. 11:3-5 et seq.*, and the *Rules for the Arbitration of No-Fault Disputes in the State of New Jersey* of Forthright, having considered the evidence submitted by the parties, hereby render the following Award:

Hereinafter, the injured person(s) shall be referred to as: JC

In Person Proceeding Information

A proceeding was conducted on: April 2, 2015.

Claimant or claimant's counsel appeared by telephone. Respondent or respondent's counsel appeared by telephone.

The following amendments and/or stipulations were made by the parties at the hearing:

The Demand was amended to $2,502.19 for dates of service 02/02/13 through 05/21/13.

Findings of Fact and Conclusions of Law

This matter arises from an automobile accident that occurred on 01/24/13 involving JC. On that date, JC was insured under an insurance policy issued by respondent. Claimant, Fort Lee Rehab, LLC, proceeds by way of an assignment from JC. Respondent has not challenged the validity of the assignment. Claimant seeks $2,502.19 for dates of service 02/02/13 through 05/21/13.

The following documentation was submitted by claimant for review and consideration: Demand for Arbitration with attachments; pre-hearing submissions dated 03/23/15 and 03/27/15; and Certification of Services.

The following documentation was submitted by respondent for review and consideration: pre-hearing submission dated 03/19/15.

I have also considered the oral arguments of counsel. At the conclusion of the oral hearing, the hearing was held open for a submission by respondent followed by claimant's comments. Respondent was given until 04/10/15 to submit proof that the insured was sent a Coverage Selection Form for the policy period covering the date of loss, *i.e.* 10/19/12 through 04/19/13, and EOBs. On 04/13/15 Forthright acknowledged respondent's submission and advised, pursuant to Rule 48, that the submission was untimely and would not be sent to the Dispute Resolution Professional for consideration. Claimant also did not submit post-hearing.

The issues presented are whether the claimant has standing to contest the coverage selection made by the insured; whether the DRP has authority to reform the policy; whether a reduced medical expense benefit option must be affirmatively chosen in writing at the time of policy renewal; and whether the policy limits have been exhausted.

No other issues were presented by the parties.

As a preliminary matter respondent argues that claimant does not have standing to contest the coverage selection made by the insured and the DRP does not have authority to reform the policy. With respect to standing, I find that claimant as an assignee stands in the shoes of the assignor and can assert any and all claims and reply to any and all defenses raised by respondent. The assignee stands in the shoes of the assignor along with all the rights that are afforded by the policy and law. *Tirgan v. Mega Life*, 304 N.J. Super. 385 (Law Div. 1997). With respect to the DRP's authority to reform a policy, I find that in fact claimant is not seeking reformation of the policy but rather enforcement of the terms of the policy based on the statutory, regulatory and policy requirements related to PIP coverage limits and the coverage selection form.

With respect to the policy limits, respondent argues that JC selected a reduced medical expense benefit of $15,000.00 and that $15,000.00 has been paid.

With respect to coverage selection, respondent has submitted the Standard Automobile Policy Declarations Page for Policy Number 4174-59-40-53 for the policy period 10/19/12 through 04/19/13 indicating medical expense benefits of $15,000. Respondent has also submitted the "Coverage Selection Form – Standard Policy" that is electronically signed and dated 06/04/11 by the insured, JC. The Coverage Selection Form indicates the insured selected PIP Medical Expense Limits of $15,000. The

form indicates that it applies to "Mid-Term Change". Respondent has also submitted the PIP payment ledger documenting medical expense benefits totaling $14,881.90.

Respondent argues that the forms clearly show that the insured selected medical expense benefits of $15,000 on 06/04/11 and did not request any changes for the policy period 10/19/12 through 04/19/13. Respondent argues that the administrative code requires the insurer to obtain a written and signed coverage selection form when a new policy is obtained and when a mid-term policy change is made in the PIP medical expense coverage limit. The respondent notes that the regulation essentially requires that certain policy terms, including PIP limits, be effective only after a signed form is secured electing these terms. The respondent notes that there is no requirement in the administrative code that the insured must re-sign the coverage selection form to keep the limit selected. The respondent argues that the opposite is actually true and that the regulation specifically states that a form need only be obtained when the policy is a new policy or a policy is being changed. In support of its position respondent relies on *Baldassano v. High Point Ins. Co.,* 396 N.J. Super. 448 (App. Div. 2007) where the court held that an insured is not obligated to return a signed coverage selection form upon renewal of a policy unless the insured is making a change to the coverage limits. Id. at 455

Claimant argues a reduced medical expense benefit option must be affirmatively chosen in writing, not only at the inception of policy but also upon each renewal, and that respondent has failed to produce the signed coverage election form, resulting in a medical expense benefit of $250,000, rather than the $15,000 alleged by respondent to have been chosen by the insured.

In support of the position, claimant relies on *N.J.S.A.* 39:6A-4.3 which provides that the automobile insurer shall provide the following coverage options:

> e. Medical expense benefits in amounts of $150,000, $75,000, $50,000 or $15,000 per person per accident; …The coverage election form shall contain a statement, clearly readable and in 12-point bold type, in a form approved by the commissioner, that election of any of the aforesaid medical expense benefits options results in less coverage than the $250,000 medical expense benefits coverage mandated prior to the effective date of P.L. 1998, c. 21.
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> If none of the aforesaid medical expense benefits options is affirmatively chosen in writing, the policy shall provide $250,000 medical expense benefits coverage.

Claimant also relies on *N.J.S.A.* 39:6A-23 which provides:

> a. No new automobile insurance policy shall be issued on or after the 180th day following the effective date of P.L. 1985, C. 520, unless the application for the policy is accompanied by written notice identifying and containing a buyer's guide and coverage selection form… The applicant shall indicate the options elected on the coverage selection form which shall be signed and returned to the insurer.
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> c. Any notice of renewal of an automobile insurance policy with an effective date subsequent to July 1, 1984, shall be accompanied by a written notice of all policy coverage information required to be provided under subsection a. of this section.

e. A properly completed and executed coverage selection form shall be prima facie evidence of the named insured's knowing election or rejection of any option.

f. Each named insured of an automobile insurance policy shall, at least annually or as otherwise ordered by the commissioner, receive a buyer's guide and coverage selection form.

Claimant also relies on *N.J.A.C.* 11:3-15.7 which provides:

(a) For all new policies an insurer or an insurance producer shall receive a Coverage Selection Form signed by the named insured and indicating the prospective insured's coverage choices. Coverage shall not become effective until the signed Coverage Selection Form is received from the named insured, unless otherwise authorized by law.

(b) For the mid-term policy changes set forth in (b)1 through 5 below, the insurer shall receive a Coverage Selection Form signed by the named insured prior to making the change.

1. Change of policy type to Standard or Basic;
2. Change of Lawsuit Option (Standard Policy only):
3. Change of primary coverage for PIP medical expense benefits coverage (from or to Health Insurer Primary) (Standard Policy only);
4. Change in PIP Medical Expense Coverage Limit (Standard Policy only); and
5. Addition or deletion of Liability Coverage (Basic Policy only).

(c) An insurer may require that other policy changes be made by signed Coverage Selection Form.

(d) All coverage changes that are required to be made by a signed Coverage Selection Form, either by this subchapter or by the insurer, shall become effective in the following manner, except when coverage for comprehensive or collision is affected by a required inspection pursuant to *N.J.A.C.* 11:3-36.

1. For new policies, the choices on the Coverage Selection Form shall be effective on the policy effective date;

2. For mid-term policy changes, the choices on the Coverage Selection Form shall be effective the day following the date of postmark or, when personal delivery is made or if the postmark is illegible, the day following receipt of the signed Coverage Selection Form by the insurer or an insurance producer. If the change is made electronically, the change shall be effective the day following date of receipt as determined in accordance with N.J.S.A. 12A:12-15;

3. For changes upon renewal, the changes shall be effective on the date of the next policy renewal if postmarked or received by the insurer or by an insurance producer prior to the renewal date.

Claimant also argues that there is no statute or regulation that allows for a selection of lower PIP benefits to continue upon renewal and/or until the insured notifies the insurance carrier of a change, as is the case for Health Care Primary, *N.J.A.C.* 11:3-37.4 and Higher Deductible, *N.J.A.C.* 11:3-4.4(b)(3).

With respect to the electronic signature, claimant notes that an electronic signature can be valid under New Jersey law if it meets the requirements of *N.J.S.A.* 12A:12-1 et seq. In this case, the claimant argues that the respondent has not offered any evidence to support that the insured electronically signed the partially completed coverage selection form and no evidence has been submitted by the respondent that the parties agreed to conduct the transaction by electronic means, that the electronic record was capable of retention by the recipient at time of receipt, that the record was in the form as prescribed by *N.J.S.A.* 39:6A-4.3, that the sender did not inhibit the ability of a recipient to store or print an electronic record, that the electronic signature is attributable to the insured, that there was an act of the insured, that there was any showing of the efficacy of any security procedure applied to the time or the person to which the electronic record or electronic signature was attributable, or that it complied with the electronic records writing requirements. See *N.J.S.A.* 12A:12-5, 8, 9, 21. The claimant argues that there was no way of knowing whether the partially completed form was actually completed and acknowledged in an electronic writing by the insured or whether it was simply created after the fact by the respondent to mirror the limited PIP policy coverage created by the respondent.

Respondent notes that *N.J.S.A.* 12A:12-1 through 12-26, also known as the "Uniform Electronic Transactions Act" or UETA, applies to electronic records and electronic signatures relating to a transaction. See *N.J.S.A.* 12A:12-2-3(a). Only the portion related to electronic signatures is applicable to the matter at hand and the respondent notes that electronic signature means "an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record." See *N.J.S.A.* 12A:12-2. A record or signature may not be denied legal effect or enforceability solely because it is in electronic form. See *N.J.S.A.* 12A:12-7(a). Further, a contract may not be denied legal effect or enforceability solely because an electronic record was used in its formation. See *N.J.S.A.* 12A:12-7(b). If a law requires a record to be in writing, an electronic record satisfies that law. See *N.J.S.A.* 12A:12-7(c). If a law requires a signature, an electronic signature satisfies the law. See *N.J.S.A.* 12A:12-7(b).

The respondent argues that its on-line policy management system follows standard and familiar account creation and log-on procedures for insureds that choose to purchase, manage and pay for their policies electronically. Before an insured can even e-sign the coverage selection form, the insured must create an on-line account with the respondent by selecting a unique user name and password. Thereafter, the insured must agree to the terms and conditions of receiving coverage selection paperwork in an electronic form through their online account. The only way to e-sign the coverage selection form is to creating this account and agreeing to the terms and conditions.

Having considered the submissions and the arguments of counsel, and based on the unambiguous language of *N.J.S.A.* 39:6A-4.3(e), I find that a reduced medical expense benefit option must be affirmatively chosen in writing. In accordance with *Baldassano v. High Point Ins. Co.*, 396 N.J. Super. 448 (App. Div. 2007) I find that an insured is not obligated to return a signed coverage selection form upon renewal of a policy unless the insured is making a change to the coverage limits. *Id.* at 455.

Respondent bears the burden of establishing that it provided the insured with the materials required by the statute. Proof of mailing the materials establishes their receipt. To establish proof of mailing, the insurer must provide evidence of the custom of mailing combined with reliable testimony of the person charged with the duty of carrying out the custom. *Baldassano, supra*, citing *Bruce v. James P. MacLean Firm*, 238 N.J. Super. 501, 506-506 (Law Div. 1989) 505-06, aff'd o.b. 238 NJ. Super. 408 (App. Div. 1989). In this case, there is no evidence to suggest that respondent mailed the insured a Buyer's Guide, a

Coverage Selection Form and an Automobile Insurance Consumer Bill of Rights prior to issuance of the renewal policy for the period 10/19/12 through 04/19/13. The Coverage Selection Form dated 06/04/11 does not establish that the insured selected the same coverage for this period. As indicated above, on renewal of a policy, an insured is not obligated to return the completed and signed coverage form unless he elects to alter the coverage. In Bruce, supra, the court held that an insured's failure to return a properly executed selection form on renewal should be construed as the insured's intent to retain the same coverage without change. But the respondent may not conclude that its insured intended to continue the same coverage unless it has first complied with its statutory obligation to mail to its insured a Coverage Selection Form and a Buyer's Guide. The statutory mandate to mail the necessary materials to the applicant or renewing insured and the parallel regulation seek to ensure that a consumer understands the available choices. A Declaration Page showing that respondent issued a policy with a $15,000 limit without proof that the statutorily required materials were first mailed to the insured, is insufficient to establish that the insured selected $15,000 in medical expense benefits. See *Columbia Anesthesia Assoc. and Ambulatory Surgical Center a/s/o T.C. v. General Assurance/Auto One Insurance*, NJ 877563.

Therefore, I find that the policy includes a medical expense benefit of $250,000 and claimant is awarded $2,502.19, subject to any remaining deductible and/or co-payment of JC.

Attorney's Fees & Costs

I find that claimant was successful and is entitled to an award of attorney's fees and costs.

Rule 22 of the New Jersey No-Fault PIP Arbitration Rules provides that the costs of the proceedings shall be apportioned by the DRP and the Award may include attorney's fees for a successful claimant in accordance with *N.J.A.C.* 11:3-5.6.

N.J.A.C. 11:3-5.6 provides:

> (e) Pursuant to *N.J.S.A.* 39:6A-5.2(g), the costs of the proceedings shall be apportioned by the DRP and the award may include reasonable attorney's fees for a successful claimant in an amount consonant with the award. Where attorney's fees for a successful claimant are requested, the DRP shall make the following analysis consistent with the jurisprudence of this State to determine reasonable attorney's fees, and shall address each item below in the award:
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> 1. Calculate the "lodestar," which is the number of hours reasonably expended by the successful claimant's counsel in the arbitration multiplied by a reasonable hourly rate in accordance with the standards in Rule 1.5 of the Supreme Court's Rules of Professional Conduct.
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> i. The "lodestar" calculation shall exclude hours not reasonably expended;
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> ii. If the DRP determines that the hours expended exceed those that competent counsel reasonably would have expended to achieve a comparable result, in the context of the damages prospectively recoverable, the interests vindicated, and the underlying statutory objectives, then the DRP shall reduce the hours expended in the "lodestar" calculation accordingly; and
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> iii. The "lodestar" total calculation may also be reduced if the claimant has only achieved partial

or limited success and the DRP determines that the "lodestar" total calculation is therefore an excessive amount. If the same evidence adduced to support a successful claim was also offered on an unsuccessful claim, the DRP should consider whether it is nevertheless reasonable to award legal fees for the time expended on the unsuccessful claim.

2. DRPs, in cases when the amount actually recovered is less than the attorney's fee request, shall also analyze whether the attorney's fees are consonant with the amount of the award. This analysis will focus on whether the amount of the attorney's fee request is compatible and/or consistent with the amount of the arbitration award. Additionally, where a request for attorney's fees is grossly disproportionate to the amount of the award, the DRP's review must make a heightened review of the "lodestar" calculation described in (e)1 above.

Rule 1.5 of the Supreme Court's Rules of Professional Conduct provides that a lawyer's fee shall be reasonable. The factors to be considered in determining the reasonableness of a fee include the following: (1) the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly; (2) the likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer; (3) the fee customarily charged in the locality for similar legal services; (4) the amount involved and the results obtained; (5) the time limitations imposed by the client or by the circumstances; (6) the nature and length of the professional relationship with the client; (7) the experience, reputation, and ability of the lawyer or lawyers performing the services; (8) whether the fee is fixed or contingent. See also *Scullion v. State Farm Ins. Co.,* 345 N.J. Super. 431 (App. Div. 2001) *and Litton Industries, Inc. v. IMO Industries, Inc.,* 200 N.J.372 (2009).

In *Enright v. Lubow*, 215 N.J. Super. 306 (App. Div.), certif. den. 108 N.J. 193 (1987), the court set out seven basic factors to be included in the determination to award attorney's fees: (1) the insurer's good faith in refusing to pay the claim; (2) the excessiveness of plaintiff's demands; (3) the bona fides of the parties; (4) the insurer's justification in litigating the issues; (5) the insured's conduct as it contributes substantially to the need for litigation; (6) the general conduct of the parties; and (7) the totality of the circumstances. *Id* at 313.

Counsel for claimant has submitted a Certification of Services seeking a counsel fee of $2,520.00, representing 8.4 hours at $300.00 per hour and costs of $237.96. Counsel for respondent has objected to the number of hours billed and the hourly billing rate. I have reviewed the Certification of Services and find that an award of $1,000.00 is reasonable and consonant with the award, and in accordance with Rule 22 of the New Jersey No-Fault PIP Arbitration Rules, *N.J.A.C.* 11:3-5.6, Rule 1.5 of the Supreme Court's Rules of Professional Conduct and the applicable case law. I also award costs of $225.00 representing reimbursement of the arbitration filing fee.

Therefore, the DRP ORDERS:

Disposition of Claims Submitted

1. Medical Expense Benefits: Awarded:

Medical Provider	Amount Claimed	Amount Awarded	Payable To
Fort Lee Rehab, LLC	$2,502.19	$2,502.19	Fort Lee Rehab, LLC

The award is subject to any remaining deductible and/or co-payment of JC.

2. Income Continuation Benefits: Not in issue

3. Essential Services Benefits: Not in issue

4. Death or Funeral Expense Benefits: Not in issue

5. Interest: I find that the Claimant did prevail. Interest is awarded pursuant to *N.J.S.A. 39:6A-5h.*: As calculated by respondent.

Attorney's Fees and Costs

☒ I find that the Claimant prevailed and I award the following costs and fees (payable to Claimant's attorney unless otherwise indicated) pursuant to *N.J.S.A. 39:6A-5.2g:*

Costs: $ 225.00 Attorney's Fees: $ 1,000.00

THIS AWARD is rendered in full satisfaction of all claims and issues presented in the arbitration proceeding.

Entered in the State of New Jersey

Anthony M. Aloi

Anthony M. Aloi, Esq.
Dispute Resolution Professional

Date: 05/31/15