SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-2009-21

FLEMING RUVOLDT PLLC,

Plaintiff-Appellant,

v.

SENTINEL INSURANCE COMPANY, LIMITED, THE HARTFORD FINANCIAL SERVICES GROUP, and OWENS GROUP LIMITED, INC.,

Defendants-Respondents.

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Argued May 3, 2023 – Decided September 6, 2023

Before Judges Vernoia and Natali.

On appeal from the Superior Court of New Jersey, Law Division, Bergen County, Docket No. L-2938-21.

Harold J. Ruvoldt, Jr. argued the cause for appellant (Fleming Ruvoldt, PLLC, attorneys; Harold J. Ruvoldt, Jr., and Cathy Fleming, on the briefs).

Thomas F. Quinn argued the cause for respondent Owens Group Limited, Inc. (Wilson Elser Moskowitz Edelman & Dicker, LLP, attorneys; Thomas F. Quinn,

of counsel and on the brief; Susan Karlovich, on the brief).

Jonathan M. Freiman (Wiggin and Dana, LLP) of the Connecticut bar, admitted pro hac vice, argued the cause for respondents Sentinel Insurance Company, Limited and The Hartford Financial Services Group (Steptoe & Johnson, LLP, and Jonathan M. Freiman, attorneys; Sarah D. Gordon (Steptoe & Johnson, LLP) of the District of Columbia bar, admitted pro hac vice, James L. Brochin, and Jonathan M. Freiman, on the brief).

PER CURIAM

This COVID-19-related insurance coverage appeal arises from two Law Division orders dismissing plaintiff Fleming Ruvoldt PLLC's complaint against defendant insurers, Sentinel Insurance Company (Sentinel) and The Hartford Financial Services Group (Hartford), and defendant insurance broker, Owens Group Limited (Owens). The first order dismisses plaintiff's complaint with prejudice for failing to timely submit an Affidavit of Merit (AOM) supporting plaintiff's professional negligence claims asserting Owens failed to provide complete and accurate information about the pertinent insurance policies and failed to procure for plaintiff the necessary and appropriate insurance coverage to cover business interruption and other losses allegedly suffered by plaintiff's law practice during the COVID-19 pandemic. The second order dismisses with prejudice plaintiff's claims against Sentinel and Hartford for failing to state a

cognizable cause of action for coverage under the policy, common law fraud, and violations of the New Jersey Consumer Fraud Act (CFA), N.J.S.A. 56:8-1 to -227. After review of the parties' arguments and papers, the controlling legal principles, and the record on appeal, we affirm in part, reverse in part, and remand for further proceedings.

I.

Because we review orders dismissing plaintiff's complaint under Rule 4:6-2(e) for failing to state claims upon which relief may granted, our "inquiry is limited to examining the legal sufficiency of the facts alleged on the face of the complaint." Printing Mart-Morristown v. Sharp Elecs. Corp., 116 N.J. 739, 746 (1989). We also consider plaintiff's insurance policy because it is the document referred to in the complaint and "form[s] the basis of . . . claim[s]" asserted in the complaint. Banco Popular N. Am. v. Gandi, 184 N.J. 161, 183 (2005) (quoting Lum v. Bank of Am., 361 F.3d 217, 221 n.3 (3d Cir. 2004)). Based on the allegations in the complaint and the terms of the insurance policy, we summarize the pertinent facts as follows.

Plaintiff had an all-risk commercial insurance policy[1] with Sentinel, its carrier, and renewed the policy for several years. In the wake of the then-progressively worsening COVID-19 pandemic, Governors across the country, including New Jersey Governor Phil Murphy, issued stay-at-home orders implementing measures designed to curb the spread of COVID-19.

On or about April 6, 2020, plaintiff submitted a claim for coverage under its 2019-20 policy for losses allegedly suffered due to the presence of COVID-19 and Governor Murphy's Executive Orders (EOs). Plaintiff's 2019-20 policy contained a "Special Property Coverage Form" describing the basic coverage under the policy and stating Sentinel "will pay for direct physical loss of or physical damage to covered property at the premises described in the declarations (also called 'scheduled premises' in [the] policy) caused by or resulting from a covered cause of loss."

The policy further defines "covered causes of loss" as "risks of direct physical loss," except where otherwise excluded or limited. The policy defines "covered property" as the policyholder's interest in buildings, structures, and

[1] An all-risk insurance policy "covers every kind of insurable loss except what is specifically excluded." Black's Law Dictionary 954 (11th ed. 2019).

business and personal property, including fixtures and furniture extant on the premises covered by the policy.

In addition to basic coverage, the Special Property Coverage Form also provides for "additional coverage" that complements the basic coverage for direct physical loss of or damage to covered property. Among the additional coverage options is an option for coverage for lost business income. The business income coverage option applies only if the insured incurs a predicate direct physical loss of or damage to covered property caused by a covered cause of loss. It states:

> [Sentinel] will pay the actual loss of [b]usiness [i]ncome [plaintiff] sustain[s] due to the necessary suspension of [plaintiff's] "operations" during the "period of restoration." <u>The suspension must be caused by direct physical loss of or damage to property</u> at the "schedule premises," including personal property in the open (or in a vehicle) within 1,000 feet of the "scheduled premises", caused by or resulting from a covered cause of loss.
>
> [(emphasis added).]

The policy defines "period of restoration" as "the period of time" that

> a. begins with the date of direct physical loss or physical damage caused by or resulting from a covered cause of loss at the "scheduled premises", and
>
> b. ends on the date when:

> (1) [t]he property at the "schedule premises" should be repaired, rebuilt[,] or replaced with reasonable speed and similar quality; [or]
>
> (2) [t]he date when [plaintiff's] business is resumed at a new, permanent location.

The policy also provides extra expense coverage. Generally, extra expense coverage covers expenses incurred to: (1) "avoid or minimize the suspension of business and to continue 'operations'" under certain circumstances; (2) "minimize the suspension of business if [plaintiff] cannot continue 'operations'"; (3) "repair or replace any property"; or (4) "research, replace[,] or restore the lost information on damaged 'valuable papers and records.'" Like business income coverage, extra expense coverage is triggered only if there has been an underlying direct physical loss of or damage to property. The provision states:

> [Sentinel] will pay reasonable and necessary extra expense [plaintiff] incur[s] during the "period of restoration" that [plaintiff] would not have incurred if there had been no direct physical loss or physical damage to property at the "scheduled premises", including personal property in the open (or in a vehicle) within 1,000 feet, caused by or resulting from a covered cause of loss.

Also, like business income coverage, extra expense coverage is triggered only when there is a covered cause of loss during a period of restoration — that is,

while the physically lost or physically damaged property is being repaired, rebuilt, or replaced.

The policy further provides civil authority coverage, which allows the insured to recover lost business income caused by a government order issued to prohibit access to the insured premises due to a direct physical loss or damage to property nearby covered property. The civil authority coverage provision states:

> This insurance is extended to apply to the actual loss of business income [plaintiff] sustain[s] when access to [plaintiff's] "scheduled premises" is specifically prohibited by order of a civil authority as the direct result of a covered cause of loss to property in the immediate area of [plaintiff's] "scheduled premises".

As noted, the policy defines "covered cause of loss" as "risks of direct physical loss," except where otherwise excluded or limited. Civil authority coverage therefore applies only when an order issued by a civil authority specifically prohibits "access" to covered property "as the direct result of" a "direct physical loss" to "property in the immediate area" adjacent or appurtenant to covered property.

Additionally, the policy provides "limited fungi, bacteria[,] or virus coverage" under an endorsement to the policy we refer to as the virus endorsement. The virus endorsement has two relevant provisions: the exclusion

provision; and the limited coverage provision. The exclusion provision provides:

> [Sentinel] will not pay for loss or damage caused directly or indirectly by any of the following. Such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss:
>
> > (1) Presence, growth, proliferation, spread[,] or any activity of "fungi", wet rot, dry rot, bacteria[,] or virus.
> >
> > (2) But if "fungi", wet rot, dry rot, bacteria[,] or virus results in a "specified cause of loss" to [c]overed [p]roperty, [Sentinel] will pay for the loss or damage caused by that "specified cause of loss."
> >
> > . . . .
>
> This exclusion applies whether or not the loss event results in widespread damage or affects a substantial area.

The limited coverage provision excepts application of the exclusion "[w]hen . . . [the] virus results from fire or lightning" or when "additional coverage — limited coverage for 'fungi', wet rot, dry rot, bacteria, and virus" — has been triggered.[2]

[2] Plaintiff does not claim it is entitled to such additional coverage.

In its complaint, plaintiff alleges that, as set forth in its April 2020 claim for coverage, it sought to recover for losses "directly attributable to a series of various closure orders." Plaintiff also asserts that on March 18, 2020, it "was forced to suspend business operations in response to orders by state and local authorities mandating the closure of all non-essential businesses in the State of New Jersey and the State of New York in an effort to protect the public from the global pandemic caused by COVID-19 . . . ."

More particularly, plaintiff alleges the orders "forced [it] to shut down both its offices in New Jersey and New York and cut off plaintiff from access to major clients." Plaintiff contends that, as a result of the orders, it suffered losses "due to its inability to travel internationally and particularly to Asia and participate in essential meetings with clients," in addition to its alleged "inability to operate its business and meet with others in multiple locations . . . ."

Plaintiff also broadly alleges COVID-19 rendered its property "'uninhabitable' or 'unfit for use.'" Plaintiff claims its New Jersey office was unfit for use because it is housed in a building where "a number of medical facilities . . . serve, among others, a population overly disproportionately affected by COVID . . . ."

Plaintiff's complaint does not aver COVID-19 was ever actually detected on its premises, or that COVID-19, if ever actually present on its premises, physically damaged or altered its property. Based on its factual allegations, plaintiff's complaint asserts seven causes of action against Sentinel, Hartford, and Owens.

In count one, plaintiff seeks a declaratory judgment against Sentinel, Hartford, and Owens that it is entitled to coverage under the policy. In count two, plaintiff claims Sentinel and Hartford wrongfully denied coverage under the policy, and Sentinel breached the policy's terms by denying business income, extra expense, and civil authority coverage.

In count three, plaintiff asserts Sentinel and Hartford breached the implied covenant of good faith and fair dealing when Sentinel denied plaintiff's April 2020 claim for coverage "in less than one business day without any proper investigation." Plaintiff asserts Sentinel rendered an "improper denial" because it was "obligated to act in good faith towards the insured under the policy to make fair and reasonable efforts and offers to resolve plaintiff's claim."

In count four, plaintiff asserts Hartford and Sentinel violated the CFA and committed common law fraud when Sentinel "expressly promised to pay for losses of business income and extra expenses suffered by plaintiff because of

acts of civil authority" but "denied plaintiff's claim on the basis that plaintiff's loss and/or damage is not a 'covered loss under the policy," and excluded from coverage under the policy.

In count five, plaintiff asserts a professional negligence claim against Owens, alleging Owens "undertook a duty to exercise reasonable case and/or skill and knowledge normally possessed by insurance brokers, in selecting, preparing[,] and processing plaintiff's policy application." The complaint states Owens failed to exercise reasonable care by: failing to obtain for plaintiff a "Gold Standard" policy providing the comprehensive coverage plaintiff requested; failing to obtain for plaintiff a "Gold Standard" business income, extra expense, and civil authority comprehensive coverage for plaintiff covering losses due to public health emergencies arising from viruses such as COVID-19 and civil orders relating to a public health emergency such as the COVID-19 pandemic; and failing to inform plaintiff it did not have coverage for losses due to public health emergencies, including viruses and civil authority orders.

In count six, plaintiff alleges Owens "negligently supplied incorrect and incomplete information to plaintiff regarding the applicability of the business income, extra expense, and civil authority coverage under the policy."

In count seven, plaintiff alleges Owens made negligent misrepresentations concerning the coverage under the policy and negligently failed to inform plaintiff concerning the policy exclusions and that the insurers would disclaim coverage for losses — including business interruption losses and extra expenses — suffered as a result of the COVID-19 pandemic. Count seven also alleges plaintiff "justifiably relied to their detriment on defendant Owens Group's recommendations, expertise[,] and affiliations and followed their advice."

After hearing argument on defendants' dismissal motions, the motion court determined plaintiff's complaint against Sentinel and Hartford failed to state a claim upon which relief could be granted under Rule 4:6-2(e). The court found the asserted claims against the insurers failed because plaintiff did not allege facts sufficient to establish the direct physical loss of or damage to its covered property attributable to COVID-19 or the stay-at-home EOs such that there was coverage under the policy.

The motion court also determined plaintiff's professional negligence claims against Owens, as asserted in counts five, six, and seven of the complaint, should be dismissed because plaintiff did not timely file an AOM as required under N.J.S.A. 2A:53A-27 showing Owens deviated from the applicable professional standard of care. The court explained it dismissed plaintiff's claims

against Owens because plaintiff did not timely file an AOM within 120 days of the filing of Owens's answer.

By order and opinion dated January 26, 2022, the motion court granted defendant Owens's motion to dismiss the complaint with prejudice. On February 1, 2022, the motion court also entered an order granting defendants Sentinel and Hartford's motion to dismiss plaintiff's complaint with prejudice. Plaintiff appeals from the orders.

II.

In our consideration of the arguments presented by plaintiff in support of its appeal, we first address whether the motion court erred by dismissing with prejudice plaintiff's coverage claims that are dependent on whether it suffered a direct physical loss of or damage to covered property within the meaning of its 2019-20 policy. We then address whether the motion court erred by dismissing with prejudice plaintiff's claims sounding in professional negligence against Owens due to plaintiff's late filing of the AOM. We next consider whether the motion court erred by dismissing with prejudice plaintiff's CFA and common law fraud claims against Sentinel and Hartford. Last, we address plaintiff's arguments the court erred by dismissing the complaint against Hartford and the

good-faith-and-fair-dealing cause of action asserted against Sentinel and Hartford.

We conduct a de novo review of an order dismissing a complaint for failure to state a claim on which relief may be granted under Rule 4:6-2(e). Dimitrakopoulos v. Borrus, Goldin, Foley, Vignuolo, Hyman & Stahl, P.C., 237 N.J. 91, 108 (2019). Appellate courts also review decisions involving statutory interpretation de novo, including the interpretation and application of the AOM statute, N.J.S.A. 2A:53A-27. Kocanowski v. Twp. of Bridgewater, 237 N.J. 3, 9 (2019); Triarsi v. BSC Grp. Servs., LLC, 422 N.J. Super. 104, 113 (App. Div. 2011) (reviewing de novo a case involving a failure to timely file an AOM). Because this case involves two dismissal decisions, one that rests on Rule 4:6-2(e), and the other resting on an interpretation and application of the AOM statute, we conduct de novo reviews of the motion court's orders. Dimitrakopoulos, 237 N.J. at 108; Kocanowski, 237 N.J. at 9; Triarsi, 422 N.J. Super. at 113.

A.

We first address plaintiff's claim the motion court erred by failing to determine which policy was the operative policy in this case. Plainly, because plaintiff alleges it is entitled to coverage based on losses it allegedly suffered in

2020, the complaint expressly alleges Hartford and Sentinel breached the 2019-20 policy, and plaintiff submitted its claim for coverage in April 2020, we apply the terms of the 2019-20 policy to our de novo review of defendants' dismissal motions.[3]

Plaintiff argues the court erred by granting dismissal of its causes of action, asserted in counts one, two, and three, that are founded on its claim it is entitled to coverage under the policy. As we have detailed, plaintiff claimed coverage under various provisions of the policy — the Special Property Coverage Form, the business income provision, and extra expenses provision — that are dependent on the insured suffering a "direct physical loss of or damage to property" at the "scheduled premises,"[4] and under the civil authority order provision.

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[3] Our determination the 2019-20 policy governs the coverage dispute is based solely on the allegations in the complaint because we consider only defendants' dismissal motions under Rule 4:6-2(e). We do not find the 2019-20 policy governs as a matter of fact or law. As we explain, we reverse the court's order dismissing plaintiff's CFA and common law fraud claims. We also recognize discovery obtained during the litigation may support a claim the 2019-20 policy does not define the applicable coverage conditions. The parties are free to make such arguments and appropriate motions to the trial court as may be supported by the evidence as the litigation progresses.

[4] As noted, the policy includes a Special Coverage Form explaining Sentinel will "pay for direct physical loss of or damage to the [c]overed [p]roperty" at

As we explained in Mac Prop. Grp. LLC & The Cake Boutique LLC v. Selective Fire & Cas. Ins. Co., 473 N.J. Super. 1, 23 (App. Div. 2022), cert. denied sub nom. MAC Prop. Grp. LLC v. Selective Fire & Cas. Ins. Co., 252 N.J. 258 (2022), and cert. denied sub nom. MAC Prop. Grp. LLC v. Selective Fire & Cas. Ins. Co., 252 N.J. 261 (2022) [hereinafter MAC], New Jersey has "adopted a broad notion of the term 'physical[,]'" and when the term "physical" is paired with another word, such as "'physical injury,' . . . the resulting term means a "'detrimental alteration[],' or 'damage or harm to the physical condition of a thing.'" MAC, 473 N.J. Super. at 20 (second alteration in original) (quoting Phibro Animal Health Corp. v. Nat'l Union of Fire Ins. Co. of Pittsburgh, 446 N.J. Super. 419, 437-38 (App. Div. 2016)). Addressing the identical "physical-loss-of-or-damage-to-property" condition for coverage at issue here, in MAC we determined the coverage "extend[s] only to instances where the insured property has suffered a detrimental physical alteration of some kind, or there was a physical loss of the insured property." Id. at 22; see also id. at 26-27 (explaining

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plaintiff's premises. As noted, the business income provision affords coverage for actual loss of business income during suspensions on the insured's operations "caused by direct physical loss of or damage to property at the 'scheduled premises[.]'" Similarly, the extra expense provision requires coverage for certain expenses incurred by plaintiff that "would not have incurred if there had been no direct physical loss or physical damage to property at the 'scheduled premises.'"

the "overwhelming majority" of courts have "granted defendant insurers' motions to dismiss complaints seeking coverage for business losses due to government orders barring or curtailing their operations in an effort to curb the COVID-19 pandemic because the losses were not due to direct physical loss or damage to their insured premises.").

In MAC, we also considered whether a civil authority coverage provision identical in all material respects to the provision in plaintiff's policy, and we concluded there was no coverage based on Governor Murphy's EOs that plaintiff claims resulted in the closure of its operations. Id. at 27-30. We determined there was no coverage because the EOs "neither prohibited access to [the] plaintiffs' premises nor prevent plaintiff owners from being on their premises, but merely restricted their business activities," and the "plaintiffs' premises were not selectively closed by the [EOs] due to damage to nearby property." Id. at 30. We further explained that to state a cause of action for coverage under the direct physical-loss-of-or-damage-to property provision, a plaintiff must allege "damage to . . . equipment or property on or off-site that caused their premises to lose their physical capacity to operate" or otherwise caused a "physical alteration that made their premises dangerous to enter." Id. at 23. We concluded "government orders barring or curtailing [business] operations in an effort to

curb the COVID-19 pandemic" did not qualify as "losses [that] were due to physical loss or damage to . . . insured premises." Id. at 27.

We also rejected the plaintiffs' claim that "because other businesses near them were closed by the [EOs], the simultaneous closure or placement of restrictions on their own business by the same [EOs] triggered civil authority coverage." Id. at 28.

Here, the motion court correctly dismissed counts one, two, and three of the complaint because plaintiff did not allege facts claiming the direct physical-loss-of-or-damage-to-property required for coverage under the Special Property Coverage Form, the business expense provision, or the extra expense provision. See generally id. at 19-34. Plaintiff's complaint alleged only that it was forced to suspend its business operations, lost business income, and incurred additional expenses in response to, and as a result of, the EOs issued to protect the public from the pandemic caused by COVID-19. Plaintiff also alleged it suffered losses and incurred expenses because it was housed in a building where other businesses served "a population overly disproportionately affected by COVID[-19]."

Those factual allegations are of the ilk we found in MAC do not constitute a direct physical loss of or damage to property sufficient to trigger coverage

under an all-risk insurance policy. Id. at 40-41. We discern no basis to conclude a different result should apply here. Because plaintiff's Special Property Coverage, business income, and extra expenses coverage required that it first suffer direct physical loss of or damage to covered property, plaintiff's failure to allege it suffered such a qualifying loss or damage to covered property rendered its causes of action for coverage under the policy causes of action upon which relief may not be granted. Ibid.

Similarly, plaintiff's allegations supporting its claim for coverage under the civil authority provision includes only facts we determined in MAC do not require or permit coverage. Where, as here, the facts alleged in a cause of action do not support a finding of coverage as a matter of law, dismissal of the coverage claim is appropriate under Rule 4:6-2(e). See MAC, 473 N.J. Super. at 40.

Like the plaintiffs in MAC, plaintiff here alleged only "that[,] because other businesses near them were closed by the EOs, the simultaneous closure or placement of restrictions on their own businesses by the same EOs triggered civil authority coverage . . . ." Id. at 41. As we said in MAC, "[t]here is no merit" to such a claim. Ibid. Thus, because plaintiff was not entitled to coverage under the policy for its alleged COVID-19-related losses, Sentinel did not breach its obligations under the policy when it denied coverage, nor, for the same

reason, is plaintiff entitled to a declaratory judgment it is entitled to coverage.[5] The motion court therefore properly dismissed plaintiff's count one, two, and three of the complaint.

We are not persuaded by plaintiff's claim the court did not "search the complaint 'in depth and with liberality to ascertain whether the fundament of a cause of action may be gleaned even from an obscure statement of claim, opportunity being given to amend if necessary.'"[6] In our view, a close review of plaintiff's complaint does not suggest a fundament of a cause of action for coverage under the policy, and, to the contrary, plaintiff's factual allegations do not permit a finding of coverage under the principles we considered in MAC. See generally 473 N.J. Super. at 19-34.

For the same reasons, it was unnecessary for the court to dismiss the policy-based coverage claims without prejudice. Plaintiff's complaint alleged

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[5] Although unnecessary to our determination, we are also convinced that even if plaintiff was otherwise entitled to coverage under the Special Coverage Form, the business expense, extra expense, and civil authority provisions, it is not entitled to coverage under the plain language of the virus endorsement. See generally MAC, 473 N.J. Super. at 40 (holding no coverage for direct physical loss or damage to property for COVID-19 business closures under exclusions from coverage for viruses such as the COVID-19 virus).

[6] In making its argument, plaintiff cites to Banco Popular N. Am., 184 N.J. at 165 (quoting Printing Mart-Morristown, 116 N.J. at 746).

its inability to access the insured property was the result of the EOs and the restrictions on travel during the pandemic. Plaintiff alleged the COVID-19 pandemic rendered its property "'uninhabitable' or 'unfit for use,'" but plaintiff did not attribute, suggest, or allege its property's purported inhabitability or unfitness for use to any purported "direct physical loss of or physical damage to" its covered property. Instead, plaintiff claimed its losses are attributable to its office's proximity to medical providers that served "populations overly disproportionately affected by COVID[-19]."

Those allegations are wholly inconsistent with any facts supporting a finding of coverage under the policy, and, for that reason, any amendment to the complaint would have been futile. See MAC, 473 N.J. Super. at 23 (first quoting Rieder v. State, 221 N.J. Super. 547, 552 (App. Div. 1987); and then quoting Dimitrakopoulos, 237 N.J. at 107) (explaining "a dismissal of a complaint with prejudice is 'mandated where the factual allegations are palpably insufficient to support a claim upon which relief may be granted,' or if 'discovery will not give rise to such a claim'"); id. at 34 (finding no need to allow an insured to amend a complaint to assert a meritless claim for coverage); see also Notte v. Merchants Mut. Ins. Co., 185 N.J. 490, 501 (2006) (explaining under Rule 4:9-1 that a proposed amended complaint is futile if "the amended claim will nonetheless

fail, and, hence, allowing the amendment would be a useless endeavor"). The motion court did not err by dismissing with prejudice the causes of action asserted in counts one, two, and three of the complaint where, as here, dismissing those claims without prejudice to allow plaintiff to file an amended complaint would have been futile.

B.

Plaintiff also argues the motion court erred by dismissing its professional negligence causes of action because it failed to timely file an AOM in support of count five, six, and seven. Plaintiff argues its late filing of the AOM did not require dismissal of its claims against Owens because an AOM was not required under the common knowledge doctrine. See Bender v. Walgreen Eastern Co., Inc., 399 N.J. Super. 584, 590 (App. Div. 2008) ("An [AOM] is not required in a case where the 'common knowledge' doctrine applies" which is where "expert opinion is not required to establish the duty or its breach."). In the alternative, plaintiff argues its claims are not barred under N.J.S.A. 2A:53A-27 and should have been accepted by the motion court as timely due to purported extraordinary circumstances.

We "review[] de novo the statutory interpretation issue of whether a cause of action is exempt from the [AOM] requirement," without deference to the

motion court's opinion. Cowley v. Virtua Health Sys., 242 N.J. 1, 14–15 (2020) (citing Triarsi, 422 N.J. Super. at 113). We first consider plaintiff's argument the motion court erred by rejecting its claim the late-filed AOM should have been accepted because extraordinary circumstances prevented it from timely providing the AOM.

N.J.S.A. 2A:53A-27 requires a plaintiff alleging an "act of malpractice or negligence by a licensed person in his profession or occupation" must provide an AOM to each defendant within the timeframe set forth in the statute. The statute further requires the provision of an AOM "within 60 days following the date of filing of the answer to the complaint by the defendant," which time limit may be extended by the court for "no more than one additional period, not to exceed 60 days." N.J.S.A. 2A:53A-27. An insurance producer, such as Owens, is a "licensed person[]" under the statute. N.J.S.A. 2A:53A-26(o).

"[T]he lack of a timely AOM" under N.J.S.A. 2A:53A-27, "may be excused in narrow situations in which a plaintiff demonstrates 'extraordinary circumstances' for the untimeliness" Yagnik v. Premium Outlet Partners, LP, 467 N.J. Super. 91, 114 (App. Div. 2021) (citation omitted). Plaintiff failed to carry its burden of establishing extraordinary circumstances here.

Owens filed its answer on July 7, 2021. As a result, plaintiff's AOM was due sixty days later, on September 10, 2021. Plaintiff did not provide its AOM within the sixty-day period, request the additional sixty-day period permitted by the statute, or make any showing of good cause permitting the additional sixty-days the statute allows. If such an application had been made, and plaintiff had satisfied the motion court that there was good cause for the statutory extension, plaintiff would have been required to provide its AOM by November 5, 2021. Plaintiff took no action prior to that deadline to obtain the statutory extension. It was not until January 21, 2022, following the filing of Owens's motion to dismiss the complaint, and just prior to the oral argument on the motion, that plaintiff provided an AOM.

Plaintiff argued before the motion court there were extraordinary circumstances excusing its failure to comply with the timeliness requirements of N.J.S.A. 2A:53A-27. In support of its contention, plaintiff — a law firm represented by its two members — relied solely on a certification of one of those lawyers.

The certification avers that one member of the firm — the attorney who had handled this matter from its inception — suffered from ongoing medical issues requiring "significant medical tests and several procedures" commencing

in July 2021, when Owens filed its answer, and continuing through January 2022, when the matter was transferred to the second member of the firm who then provided an AOM supporting the claims against Owens. The certification also explained the attorney who had the initial responsibility for the matter had been "hospitalized in September 2021," and then hospitalized again from December 14, 2021, through January 4, 2022, when he was released to a rehabilitation center. According to the certification, it was not until ailing counsel's release on January 4, 2022, that the matter was transferred within the plaintiff law firm to the firm's other member, who then subsequently provided the required AOM supporting plaintiff's claims against Owens.

Missing from the certification is any explanation as to the manner in which counsel's medical issues prevented plaintiff from providing an AOM during the initial sixty-day period required under N.J.S.A. 2A:53A-27 or from demonstrating good cause for its failure to file within the initial sixty days such that it would have been entitled to the additional sixty-day period under the statute. For example, the certification does not include an averment that counsel's medical issues interfered with his or his colleague's ability to obtain or provide the AOM. And, presumably, if the attorney's medical issues were such that he was unable to obtain the AOM during the statutory period, there is

no explanation as to why other lawyers in the firm did not undertake responsibility for the ailing counsel's matters, including this one, during the times the medical issues prevented him from doing so.

We do not question the accuracy of counsel's representations concerning her colleague's medical issues, but the scant information provided in the certification is simply too general and too vague to sustain the burden of establishing the "narrowly prescribed" extraordinary circumstances necessary to allow the filing of an AOM beyond the statutory period. Ferreira v. Rancocas Orthopedic Assocs., 178 N.J. 144, 156 (2003) (Long, J., concurring in part); cf. Tischler v. Watts, 177 N.J. 243, 245-47 (2003) (finding "compelling circumstances exist" to excuse out-of-time cure to deficiency in AOM where attorney suffered from "immediate and debilitating effects of her aggressive radiation and chemotherapy treatments" for "advanced lung cancer"). It is simply not enough to generally allege counsel representing a plaintiff suffered from medical issues during the period within which an AOM should have been filed without detailing the manner in which the medical issues interfered with the ability of the counsel or counsel's law firm to timely file an AOM during the statutory period.

The certification does not address such issues or offer any facts supporting a determination there are extraordinary circumstances excusing plaintiff's failure to timely provide the AOM within the statutory period. Instead, the certification appears to request a finding that because the initial counsel experienced medical issues, extraordinary circumstances existed a fortiori excusing the failure to provide the AOM as required under N.J.S.A. 2A:53A-27. Plaintiff cites no legal authority supporting such a conclusion, and we have independently not found any.

The lack of sufficient facts and competent evidence establishing extraordinary circumstances required, and requires, a rejection of plaintiff's claim the motion court erred by determining the AOM was untimely provided. "An attorney's 'carelessness, lack of circumspection, lack of diligence, or ignorance of the law' does not constitute 'extraordinary circumstances'" warranting excusal of a failure to timely file an AOM. Stoecker v. Echevarria, 408 N.J. Super. 597, 612 (App. Div. 2009) (quoting Balthazar v. Atl. City Med. Ctr., 358 N.J. Super. 13, 26 (App. Div. 2003)).

In Stoecker, the plaintiff's attorney served the AOM "more than 120 days after [the defendant] had filed her amended answer to the complaint." Id. at 613. The plaintiff offered "no explanation for failing to serve the affidavit within the

time required by N.J.S.A. 2A:53A-27." Ibid. Under those circumstances, we determined, as we must here, the plaintiff failed to establish extraordinary circumstances permitting the late filing of the AOM. See ibid. (citation omitted) (holding the plaintiff's "attorney provided no explanation for failing to serve [an AOM] within the time required by N.J.S.A. 2A:53A-27" and "therefore did not show that the failure to serve a timely [AOM] was due to 'extraordinary circumstances.'"); see also Ferreira, 178 N.J. at 154 ("If defense counsel files a motion to dismiss after the 120-day deadline and before plaintiff forwarded the [AOM], the plaintiff should expect that the complaint shall will be dismissed with prejudice" in the absence of a demonstration of extraordinary circumstances).

Plaintiff also attributes the failure to timely file an AOM on "the fact of holidays in December, as well as Covid-related issues." The argument finds no support in competent evidence presented to the motion court and is untethered to any explanation as to the manner in which holidays in December or COVID-19 prevented plaintiff from obtaining an AOM during the 120-day time period available under N.J.S.A. 2A:53A-27, and which expired on November 5, 2021.

We therefore reject plaintiff's argument its failure to timely file an AOM to support its counts five, six, and seven claims against Owens should be

excused due to extraordinary circumstances. We therefore affirm the motion court's dismissal of plaintiff's count five, six, and seven causes of action.

We also consider plaintiff's argument the motion court erred by rejecting its claim an AOM is not required based on the common knowledge exception to N.J.S.A. 2A:53A-27. The exception applies only in the "rare case" where "the carelessness of the defendant is readily apparent to anyone of average intelligence[,]" Rosenberg v. Cahill, 99 N.J. 318, 325 (1985), and when expert testimony "is not required to prove a professional defendant's negligence[,]" Cowley, 242 N.J. at 8. It applies "where 'jurors' common knowledge as lay persons is sufficient to enable them, using ordinary understanding and experience, to determine a defendant's negligence without the benefit of the specialized knowledge of experts.'" Bender, 399 N.J. Super. at 590 (citation omitted). For example, the common knowledge exception has been applied where a plaintiff claimed a dentist extracted the wrong tooth. Hubbard ex rel. Hubbard v. Reed, 168 N.J. 387, 396-97 (2001).

Plaintiff claims an AOM is unnecessary because lay persons "of reasonable intelligence can use common knowledge to determine that there was a deviation from" an insurance broker's professional standard of care, such that

"an expert is no more qualified to attest to the merit" of plaintiff's negligence claim against Owens. We disagree.

The relationship between an insurance broker and a client gives rise to a professional duty owed by the broker to the client to exercise good faith and reasonable skill in advising insureds. Triarsi, 422 N.J. Super. at 115. "Insurance intermediaries . . . must act in a fiduciary capacity to the client '[b]ecause of the increasing complexity of the insurance industry and the specialized knowledge required to understand all of its intricacies.'" Ibid. (quoting Walker v. Atl. Chrysler Plymouth, Inc., 216 N.J. Super. 255, 260 (App. Div. 2011)).

In Triarsi, we concluded "expert testimony would be required to establish that a broker and its agent have a duty with respect to the payment of renewal premiums, avoidance of cancellation, and reinstatement in the event of cancellation." Id. at 116. We "d[id] not agree with [the plaintiff's] assertion that the existence of that duty is within the common knowledge of lay people." Ibid. We explained, however, that our conclusion may have been different if "the existence of the duty might be considered self-evident." Id. at 116 n.4. That is not the case here.

Plaintiff's argument its causes of action fall within the common knowledge of lay people and are dependent on a standard of care that is self-

evident is misplaced. We reject the argument in part because plaintiff's causes of action asserted against Owens turn on the existence of a professional duty of care in the context of insurance brokering, a highly complex area of professional practice that we have held is not obvious or self-evident. Triarsi, 422 N.J. Super. at 115-16, 116 n.4.

Moreover, in determining whether an AOM is required, we "must look to the underlying factual allegations, and not how the claim is captioned in the complaint." Id. at 112. "[I]t is the nature of the proof required that controls." Ibid.

Plaintiff's negligence claim in count five of its complaint asserts Owens "undertook a duty to exercise reasonable care and/or skill and knowledge normally possessed by insurance brokers in selecting, preparing[,] and processing [p]laintiff's policy application and in obtaining an insurance policy . . . ." (emphasis added). Plaintiff alleges Owens "breached its duties of care to [p]laintiff by its negligent acts and omissions" including, but not limited to:

> a. Failing to exercise reasonable care in obtaining "Gold Standard" policies to provide requested comprehensive coverage for plaintiff[;]
>
> b. Failing to exercise reasonable care in obtaining insurance policies to provide "Gold Standard" business

> income, extra expense[,] and civil authority comprehensive coverages for plaintiff that would cover losses due to a public health emergency arising from a virus such as COVID-19[;]
>
> c. Failing to exercise reasonable care in obtaining insurance policies to provide "Gold Standard" business income and extra expense comprehensive coverage to plaintiff that would cover losses due to order of a civil authority relating to a public health emergency arising from a virus such as COVID-19[;]
>
> d. Failing to inform plaintiff that the [p]olicy obtained did not have comprehensive coverage which would provide "Gold Standard" business expense and extra income coverage applicable to plaintiff's business operations in the event of a public health emergency arising from a virus such as COVID-19[; and]
>
> e. Failing to inform plaintiff that the policy obtained did not have coverage which would provide as broad as possible business expense and extra income coverage applicable to [p]laintiff's business operations due to order of a civil authority relating to a public health emergency arising from a virus such as COVID-19.

Plaintiff similarly alleges in count six that Owens "negligently supplied incorrect and incomplete information to plaintiff regarding the applicability of business income, extra expense, and civil authority coverage under the policy." In count seven, plaintiff alleges Owens "mispresented and/or failed to present material facts to plaintiff including, but not limited to, that defendant Hartford

would disclaim the coverage plaintiff purchased for civil authority coverage, business interruption, and virus coverage."

"[I]t is true that specialized knowledge is part of the rationale for imposing a duty on insurance brokers," due to "the increasing complexity of the insurance industry" but also because of "the specialized knowledge required to understand all of its intricacies." Triarsi, 422 N.J. Super. at 115, 116. Indeed, in count five, plaintiff alleges Owens failed to procure for plaintiff a "Gold Standard" policy covering all the different coverages plaintiff avers it relied on Owens to obtain on its behalf. Defining the "Gold Standard" for such coverages is not a matter of common knowledge and requires expert testimony defining that standard and explaining whether Owens satisfied it.

Similarly, in count six plaintiff alleged it relied on Owens's "expertise" in accepting Owens's coverage recommendations, and, in count seven, plaintiff alleged it relied on Owens's expertise and followed Owens's professional advice. Resolution of those claims require a determination as to whether Owens's advice and recommendations met the standard of care of professional insurance brokers. Again, that standard is not a matter of common knowledge, and it therefore requires expert testimony and timely service of an AOM under N.J.S.A. 2A:53A-27. See Couri v. Gardner, 173 N.J. 328, 341 (2002)

(explaining an AOM in claims in contract or tort where "the underlying factual allegations . . . require proof of a deviation from the professional standard of care" for that particular profession). We reject plaintiff's claims to the contrary.

C.

We next address plaintiff's argument the motion court erred by dismissing with prejudice plaintiff's count four CFA and common law fraud claims against Hartford and Sentinel. The motion court found plaintiff did not sufficiently allege a fraud claim under the CFA or the common law, finding "[p]laintiff's allegations stem from its disagreement with the basis for denying [its] claim," as opposed to any "unlawful conduct on the part of Sentinel or Hartford." The judge also found "[t]here is no allegation that Sentinel or Hartford made any material misrepresentation to [p]laintiff on which plaintiff relied[,]" and, on that basis, the motion court order dismissed the claims with prejudice.

To prove common law fraud, the party alleging fraud must show: (1) a material misrepresentation of a presently existing or past fact; (2) knowledge or belief by the defendant of its falsity; (3) an intention that the other person rely on it; (4) reasonable reliance thereon by the other person; and (5) resulting damage." Gennari v. Weichert Co. Realtors, 148 N.J. 582, 610 (1997). Equitable fraud similarly requires a showing of a misrepresentation or omission

of material fact, an intent the misrepresentation or omission be relied upon resulting in the injured party's reasonable reliance, and damages, except proof of scienter is not required. Jewish Ctr. of Sussex Cnty. v. Whale, 86 N.J. 619, 625 (1981). In either case, "plaintiff must prove each element by 'clear and convincing evidence.'" DepoLink Ct. Reporting & Litig. Support Servs. v. Rochman, 430 N.J. Super. 325, 336 (App. Div. 2013) (quoting Enright v. Lubow, 202 N.J. Super. 58, 72 (App. Div. 1985)). Our Rules of Court further require allegations of fraud or misrepresentation to show "particulars of the wrong, with dates and times if necessary[.]" R. 4:5-8.

"The CFA provides a remedy for any consumer who has suffered an ascertainable loss of moneys or property as a result of an unlawful commercial practice and allows him or her to recover treble damages, costs, and attorneys [sic] fees." Heyert v. Taddese, 431 N.J. Super. 388, 411 (App. Div. 2013). To sustain a private CFA cause of action, a consumer must "show that the merchant engaged in an 'unlawful practice,' . . . and that [the consumer] 'suffer[ed] [an] ascertainable loss . . . as a result of the use or employment' of the unlawful practice." Lee v. Carter-Reed Co., 203 N.J. 496, 521 (2010) (quoting N.J.S.A. 56:8-2, 8-19). "An 'unlawful practice' contravening the CFA may arise from (1) an affirmative act; (2) a knowing omission; or (3) a violation of an

administrative regulation." Dugan v. TGI Fridays, Inc., 231 N.J. 24, 51 (2017). An unlawful practice under the CFA may occur "in connection with the sale or advertisement of any merchandise or real estate, or with the subsequent performance of" an individual involved in such a transaction. N.J.S.A. 56:8-2.

Here, plaintiff claims it alleged "a repeated and factually specific course of fraudulent conduct consisting of false statements made by [defendants] directly and through their broad reaching advertising campaigns, which false statements were designed to and did induce [plaintiff] . . . to rely on [defendants'] materially false statements and misleading and unlawful conduct." However, the allegations in count four more specifically assert only that Hartford and Sentinel "expressly promised to pay losses of business income and extra expense suffered by [p]laintiff because of acts of [c]ivil [a]uthority" and then failed to do so by subsequently denying coverage under the policy, including under the policy exclusions.

More broadly, however, plaintiff's complaint makes repeated allegations Hartford and Sentinel made other fraudulent misrepresentations related to the policy. For example, the complaint includes claims plaintiff purchased the predecessor policies to the 2019-20 policy based on representations by Hartford and Sentinel that "[t]he coverage was to apply whenever [plaintiff's] business

was interrupted from external causes and not caused by the conduct of [p]laintiff."

Plaintiff further alleges the insurers thereafter modified the successive annual policies without providing any notice of a change in the coverage it was promised, and plaintiff relied on the representation in purchasing the annual polices, including the 2019-20 policy, to its detriment because the insurers denied coverage for business losses plaintiff sustained as the result of the interruption of its business due to the EOs and COVID-19 pandemic, which are causes not the result of plaintiff's conduct. Plaintiff also alleges the insurers committed fraud by modifying its insurance coverages through the annual successive policies issued to plaintiff while changing coverage to plaintiff's detriment without properly, fully, or accurately advising plaintiff of changes in coverage. These allegations are not specifically referred to in count four, but they are incorporated by reference in that count of the complaint.

We agree with the motion court count four of the complaint lacks the specificity required to adequately plead fraud against Hartford and Sentinel. However, the express incorporation of all the complaint's factual allegations in the complaint, including those we have described, support plaintiff's assertion of CFA and fraud claims against Hartford and Sentinel. For those reasons, the

motion court should have afforded plaintiff an opportunity to amend the complaint to more specifically allege its CFA and common law fraud claims against Hartford and Sentinel in count four. See, e.g., Rebish v. Great Gorge, 224 N.J. Super. 619, 628 (App. Div. 1988) (granting the plaintiff "60 days from the date of this opinion to move to amend her pleadings on those counts [dismissed for lack of specificity by the motion court] so as to comply with [Rule] 4:5-8."); In re Est. of Santolino, 384 N.J. Super. 567, 583 (Ch. Div. 2005) (citing Rebish, 224 N.J. Super. at 541) ("Where a fraud pleading does not include the required specificity, the pleader should ordinarily be afforded the opportunity of amending the pleading in lieu of dismissal.").

We therefore vacate the dismissal with prejudice of plaintiff's fraud-based claims in count four against Hartford and Sentinel and remand with instructions that the motion court permit plaintiff an opportunity to amend its complaint to adequately plead its count four fraud claims against Hartford and Sentinel.[7]

D.

Next, we address plaintiff's breach of breach of the covenant of good faith and fair dealing claim, as well as its contention the motion court erred by

[7] By remanding for that purpose, we offer no opinion on the merits of plaintiff's putative CFA and common law fraud claims.

dismissing its claims against Hartford. Plaintiff argues defendants breached the implied covenant of good faith and fair dealing in connection with Sentinel's denial of coverage. We are not persuaded.

In New Jersey, every party to a contract is bound by an implied covenant of good faith and fair dealing. Wilson v. Amerada Hess Corp., 168 N.J. 236, 244 (2001). The covenant requires that parties to a contract "refrain from doing 'anything which will have the effect of destroying or injuring the right of the other party to receive' the benefits of the contract." Brunswick Hills Racquet Club, Inc. v. Route 18 Shopping Ctr. Assocs., 182 N.J. 210, 224-25 (2005) (quoting Palisades Props., Inc. v. Brunetti, 44 N.J. 117, 130 (1965)).

"A party breaches the implied covenant when it exercises its contractual functions 'arbitrarily, unreasonably, or capriciously' and with an 'improper motive.'" Wilmington Sav. Fund Soc'y, FSB for Pretium Mortg. Acquisition Tr. v. Daw, 469 N.J. Super. 437, 452 (App. Div. 2021). A party claiming a breach of the covenant must therefore prove "bad motive or intention." Brunswick Hills Racquet Club, Inc., 182 N.J. at 225. To do so, the party claiming a breach 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." Ibid. (citing 23 Williston on Contracts § 63:22 at 513-14 (Lord ed. 2002)).

Plaintiff's claim Sentinel breached the covenant of good faith and fair dealing fails by denying coverage under the policy. However, even accepting the allegations in plaintiff's complaint as true, they are insufficient to support the cause of action because, based on the allegations in the complaint, plaintiff is not entitled to coverage under the policy in the first instance. See, e.g., Badiali v. N.J. Mfrs. Ins. Grp., 220 N.J. 544, 555 (2015) (quoting Pickett v. Lloyd's, 131 N.J. 457, 473 (1997)) (explaining "a claimant who could not have established as a matter of law a right to . . . the substantive claim would not be entitled to assert a claim for an insurer's bad faith refusal to pay the claim."). We therefore affirm the dismissal of plaintiff's count three breach of good faith and fair dealing claim.

Plaintiff also argues the motion court erred by dismissing its claims against Hartford. The motion court found "that the [p]olicy references [to] 'The Hartford' and its logo are not enough to maintain [plaintiff's] claim" against Hartford. Under the express terms of the policy, Sentinel is plaintiff's insurance carrier. According to the complaint, plaintiff submitted its claim to Sentinel, and it is Sentinel's denial of the claim plaintiff challenges in its complaint. The

complaint further alleges Hartford is not plaintiff's insurance carrier, but rather is Sentinel's parent.

Generally, contract obligations are limited to the parties making them, and only parties to contracts are liable for their breach. See Comly v. First Camden Nat'l Bank & Tr. Co., 22 N.J. Misc. 123, 127 (Sup. Ct. 1944) ("[A]n action on a contract cannot be maintained against a person who is not a party to it"). Moreover, contract language indicating a party to the contract undertakes an obligation "on behalf of" a non-party does not in itself bind the non-party in the absence of explicit language otherwise establishing an agency relationship. Cf. Carte Blanche (Sing.) PTE., Ltd. v. Diners Club Int'l., Inc., 758 F. Supp. 908, 920 (S.D.N.Y. 1991).

Here, the policy expressly states Sentinel is the "Writing Company" for the policy. The "Special Property Coverage Form" of the policy provides that "[t]he words 'we,' 'us' and 'our' refer to the Company providing this insurance." Since defendant Sentinel is the writing company for the policy, the use of the words 'we', 'us', and 'our' throughout the policy refer to Sentinel, not Hartford. Thus, the policy does not bind Hartford because the policy explicitly refers to Sentinel as the company that holds the policy and is liable to plaintiffs in the event legal action is taken pursuant to the policy. Hartford is not a party to the

policy, and plaintiff does not allege it is. We therefore affirm the motion court's dismissal of plaintiff's claims against Hartford arising under the policy, including any claim Hartford breached the covenant of good faith and fair dealing.[8] Cf. Brunswick Hills Racquet Club, Inc., 182 N.J. at 224 (explaining the covenant of good faith and fair dealing binds "[e]very party to a contract").

Any arguments we have not expressly addressed we find are without sufficient merit to warrant discussion in a written opinion. R. 2:11-3(e)(1)(E).

We reverse the dismissal of plaintiff's count-four CFA and common law fraud claims. We affirm the court's dismissal of all other claims asserted in the complaint. We remand for further proceedings consistent with this opinion. We do not retain jurisdiction.

[8] Our affirmance of the dismissal of plaintiff's claims against Hartford arising under the policy does not affect our determination that plaintiff shall be permitted to amend its CFA and common law fraud claims under count four against Hartford. The fraud claims are based on Hartford's alleged conduct — including, for example, alleged fraudulent misrepresentations concerning policy coverage and fraud in modifying coverage under the policies — that are not dependent on whether Hartford has a contractual obligation to provide coverage for plaintiff's claimed losses under the 2019-20 policy.