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LEGAL NOTES

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MISREPRESENTATION—INTENT TO DECEIVE: *Metropolitan Life Insurance Company v. Fugate* (C.A. 5, January 23, 1963) 313 F.2d 788. Fugate applied to Metropolitan for a life policy in 1959, which was issued in due course, and he died some months thereafter. In his application for this policy he denied that he ever used alcoholic beverages to excess, that he had been a patient or visited a hospital, clinic, dispensary or sanatorium, or that he had consulted any physician within the past five years. The fact was that in 1958 on two occasions he had been confined for periods of about ten days each to two different hospitals, one of which specialized in the treatment of alcoholism. He had suffered from delirium tremens. On both of these occasions he had been treated by physicians and he admitted that he had been drinking over a period of years and that he consumed as much as two bottles of whiskey a day.

After Fugate's death the misrepresentations were disclosed and Metropolitan denied liability for any amount in excess of the premiums paid with interest. The beneficiary refused this tender and brought suit in a Florida court. This suit was removed by Metropolitan to the United States District Court and there tried to a jury. The jury found for the beneficiary and the motion of Metropolitan for a judgment in its favor was denied. After judgment was entered for the beneficiary Metropolitan appealed.

The Court of Appeals for the Fifth Circuit, applying Florida law, concluded that under applicable decisions the jury verdict could not be disturbed unless "the evidence admits of no other conclusion than that there was an intent to deceive." On the question of whether the use of liquor was excessive, the Court concluded that it was bound by the jury's verdict that the use was not excessive. However, as to the insured's denial that he had consulted a physician or had been in a hospital, the Court held that as a matter of law the insured was guilty of fraud and concealment and that for this reason the judgment in favor of the beneficiary must be reversed and judgment rendered for Metropolitan.

One of the three judges dissented in a lengthy opinion contending in effect that the jury verdict was binding and should not be disturbed. His claim was that the alleged misrepresentation as to the hospital stays and the visits to physicians was tied up with the alleged misrepresentation as to excessive drinking and the jury's verdict in favor of the beneficiary was binding. There had been evidence, which he stressed, that the insured had suffered from a

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ruptured disc and was operated on three years before he applied for the policy, that he had joined the church a year before and that he drank only to relieve the pain from the back condition. A number of friends and business associates had testified that they did not know of his drinking.

The Florida law was changed by the Legislature shortly after the policy was applied for so that if the misrepresentation was either fraudulent or material to the acceptance of the risk or the hazard assumed or if the company would not have issued the policy applied for if the true facts had been stated, the company was not liable. It was agreed that this statute had no application to the particular case because the effective date was shortly after the policy was applied for.

CUBAN LIFE POLICY—SUIT IN FLORIDA FEDERAL COURT: *Rodriguez v. Pan American Life Insurance Company* (C.A. 5, October 17, 1962) 311 F.2d 429. Rodriguez purchased from Pan American in Cuba a $20,000 life policy. Premiums were by the terms of the policy payable in legal money of the United States and the policy provided that it was "exempt from any restrictions as to residence, travel, or occupation."

Premiums were paid in United States money from January 1945 until January 1952. About that time the Cuban Government decreed that all obligations due citizens of Cuba be paid in Cuban pesos and that all obligations incurred by Cubans were likewise to be paid in Cuban pesos. Thereafter, Rodriguez paid and Pan American accepted Cuban pesos without any formal modification in the contract, which contained the usual provision that it could be modified only by specified officers.

Rodriguez fled to Florida when Castro came into power. In October 1959 he tendered to Pan American United States funds to apply against automatic premium loans, which money Pan American refused on the basis that premium payments should be made in Cuban pesos in Cuba. He applied for the cash value and this was refused.

Rodriguez brought this action for the cash value of the policy in a Florida State Court and Pan American removed the action to the United States District Court because of diversity of citizenship. Pan American then moved to dismiss the action on the basis that the application for insurance was executed in Cuba, the policy was delivered in Cuba, all premiums were paid in Cuba and all rights which plaintiff claimed were governed by the laws of Cuba. The District Court dismissed the suit stating:

> The plaintiffs are citizens of Cuba, defendant is a United States corporation incorporated in Louisiana, and doing business in Florida; all the transactions took place in Cuba, and are, therefore, governed by Cuban law; the claim did not accrue within the jurisdiction of the court; the docket is crowded, and it would be a burden on the court to litigate the difficult legal questions which arise; for the convenience of the witnesses, and parties, and in the interest of justice; and for other reasons (not mentioned) the action was dismissed on the grounds of *forum non conveniens.*

On appeal to the Court of Appeals for the Fifth Circuit, that Court held that the District Court was in error in refusing to hear the case. In reversing the District Court, the Court of Appeals did not pass on the merits of Rodriguez' claim. The Court (Carswell, D.J.) stated:

It is for the District Court to determine upon development of all the facts, by summary judgment or otherwise, whether the Cuban decrees are confiscatory or whether the particular decrees are otherwise violative of fundamental concepts of justice and, therefore, without status, in these particular cases.

If such decrees are found wanting by these standards it follows that they will not be given force and effect in our courts. The attempted enforcement of such decrees by the Cuban agent against American citizens was denied in Banco, and it matters not whether the thrust of those decrees be directed against Cuban nationals or American citizens. The American appellee corporation here is certainly no more subject to such decrees than others, and, as in Banco, is fully protected from confiscatory effect within the limit of the power of our courts. The action of the Cuban agent was dismissed in the Banco case, and for the same reasons we reverse the dismissal of the complaints here.

It is noted that, unlike the Second Circuit in the Banco case, we do not have in the records before us an expression of any kind from the State Department. None has been requested. With the fullest cognizance of the responsibility of the executive branch in the field of foreign relationships, we do not perceive any necessity for formal comment by the State Department about these cases.

Consistently, repeatedly and currently, the State Department has expressed its conclusion that our courts are not restrained from adjudicating the effect of the decrees of the Castro government in Cuba. This has now been made so clear we feel full reliance by the courts upon such expressions may be made without the necessity of a formal enunciation in each and every such case. Indeed, the wisdom of requesting another, and yet another, statement on the identical subject seems quite doubtful. It is specifically noted that there was judicial response to the executive branch's change in approach in Bernstein v. Van Heyghen Freres, S.A., supra.

This is one of a series of suits pending in Florida and elsewhere and involving the efforts of Cuban nationals to receive payment in the United States and in United States funds. The Cuban assets of the United States insurance companies have been taken over by the Cuban Government and the position of the insurance companies is that they should not be required to pay Cuban nationals who fled to the United States in United States funds. Some of these Cuban cases will undoubtedly reach the United States Supreme Court and there be decided.

GROUP LIFE INSURANCE—CONVERSION PRIVILEGE: *Caine v. John Hancock Mutual Life Insurance Company* (C.A. 6, February 16, 1963) 313 F.2d 297. Caine was an employee of James Heddon's Sons at the time of his death and as such was insured under a group policy issued by John Hancock. James Heddon's Sons was controlled by Murchison Brothers of Dallas and the group policy was written through Mississippi Lamar Insurance Trust, covering employees of several Murchison enterprises.

Caine was a member of what was called the "Executive Council," entrance into and departure from which was within the discretion of the Murchisons. The only direct emolument flowing from membership was a larger life insurance benefit.

Caine, as a member of the Executive Council, was insured for $100,000. Shortly before his death, by an office memorandum, instructions were given to strike his name from the list of members of the Executive Council, which would serve to reduce his coverage to $40,000. Caine was never notified of this action because of his early death.

The group policy provided for a conversion privilege within 31 days after the earlier of termination of employment or "the date of termination of his membership in the class or classes of employees insured hereunder," and provided coverage during the conversion period.

After the insured's death John Hancock took the position that Caine was not a member of the Executive Council at the time of his death, that there was no conversion privilege under the circumstances and hence no coverage during the conversion period, and that Caine belonged to a class of employees entitling him to $40,000 of coverage.

The beneficiary sued, claiming that there was coverage for the $100,000 at the time of Caine's death either because he still belonged to the Executive Council or, if he did not, he was entitled to convert the $60,000 of insurance and hence was, in effect, covered for the full $100,000 when he died. The District Court, and on appeal the Court of Appeals for the Sixth Circuit, agreed with the beneficiary that there was $100,000 of insurance in effect when Caine died. The Courts were of the opinion that, although Caine had not been so notified, he was not a member of the Executive Council when he died. However, the Courts regarded the contract as ambiguous and held that the provision, quoted above, regarding the conversion privilege on termination of membership in the class or classes of employees insured under the policy gave to Caine the right to convert the amount by which his coverage was reduced and hence he had this coverage during this conversion period.

AVIATION COVERAGE—SCHEDULED AIR CARRIER—TICKET MACHINE: *Steven v. Fidelity and Casualty Company* (California Supreme Court, December 18, 1962) 27 Cal. Rptr. 172, 377 P.2d 284. Steven purchased at Los Angeles from a vending machine a $62,500 aviation insurance policy for a premium of $2.50. At the same time he purchased a round trip airplane ticket to Dayton, Ohio, which included a flight from Terre Haute, Indiana, to Chicago, Illinois.

The insurance policy covered travel by air on "scheduled air carriers," and it also provided coverage in or on a land conveyance provided by such scheduled air carrier where there was an interruption or temporary suspension of such scheduled air carrier's service.

Steven reached Terre Haute, but his scheduled flight to Chicago was cancelled. The ticket agent for the scheduled air carrier arranged for the charter

by Steven and three others of an air taxi flight to Chicago, and Steven was killed by the crash of the plane as it arrived in Chicago.

The insurance company took the position that it was not liable because the insured did not die as a result of a scheduled airline flight. The beneficiary brought suit and in the trial court the position of the insurance company was upheld. On appeal to the California Supreme Court, that Court reversed the judgment by a four-to-three vote and held the insurance company liable. The majority opinion held that there was coverage during this substitute flight even though the policy provided coverage for substitute flights only for land transportation provided by a scheduled air carrier. The Court here adopts a very strange interpretation of the policy, which is applied with special force to policies such as this sold in machines.

In its majority opinion the Court states:

> The special circumstances of this case establish a second reason for our conclusion that the insurer cannot successfully claim that the policy did not cover the substituted transportation. In this type of standardized contract, sold by a vending machine, the insured may reasonably expect coverage for the whole trip which he inserted in the policy, including reasonable substituted transportation necessitated by emergency. If the insurer did not propose such coverage, it should have plainly and clearly brought to the attention of the purchaser such limitation of liability.
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> We turn to the first point. We must determine whether, when Mr. Steven faced the necessity of arranging substituted transportation at Terre Haute, the policy afforded him clear notice of non-coverage of such substituted transportation. We examine the question in the light of the purpose and intent of the parties in entering into the contract, Mr. Steven's knowledge and understanding as a reasonable layman, his normal expectation of the extent of coverage of the policy and the effect, if any, of the substitution of the transportation upon the risk undertaken by the insurer.
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> The purpose and intent of the insured in taking out the insurance was to obtain insurance protection for the trip. The insured could fairly believe that the policy would cover a reasonable emergency substitution necessitated by the exigencies of the situation. Since weather conditions and mechanical failure upon not infrequent occasions require such substitution, the insured would not ordinarily expect that his insurance would fail in the event of these foreseeable contingencies. Since his contract covered the *trip*, he would not contemplate a hiatus in coverage; he bargained for protection for the whole, not part of, the trip.
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> A reasonable person, having bought his ticket for a fixed itinerary, and thus having at the moment of purchase of the policy gained insurance protection for the whole trip, would normally expect that if a flight were interrupted by breakdown or other causes, his coverage would apply to substitute transportation for the same flight. If, for instance, the scheduled plane crash-landed, he would certainly assume that the policy covered the emergency relief plane whether or not it were a scheduled air liner. The same normal expectation would apply to the substitution of an alternate plane because the scheduled one had been grounded by mechanical failure.
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> The risk of injury on the substitute conveyance in many cases will be no greater than the risk on the scheduled flight; in all cases it will be less than if the scheduled air line attempts to fly the scheduled flight despite bad weather or mechanical difficulty. Thus,

both in the terms of occurrence and magnitude of risk, substitute emergency transportation falls well within the obligation undertaken by the insurer.

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We must view the instant claim in the composite of its special and unique circumstances. To equate the bargaining table, where each clause is the subject of debate, to an automatic vending machine, which issues a policy before it can even be read, is to ignore basic distinctions. The proposition that the precedents must be viewed in the light of the imperatives of the age of the machine has become almost axiomatic. Here the age of the machine is no mere abstraction; it presents itself in the shape of an instrument for the mass distribution of standard contracts. The exclusionary clause of that contract, upon which the insurance company relies, is an unexpected one. Its application in some circumstances would be unconscionable. It is placed in an inconspicuous position of the document. In view of all these characteristics its rigid application would cast an unexpected burden upon the traveling public and would prefer formality of phrase to the reality of the transaction.

This case is an extreme case, difficult to justify. The Court may well be accused of making a new contract for the parties instead of interpreting the contract which the parties themselves have made.

CREDIT INSURANCE—WITHDRAWAL OF APPROVAL—WILFUL VIOLATION OF STATUTE: *Old Republic Life Insurance Company v. Thacher* (New York Court of Appeals, November 1, 1962) 12 N.Y. 2d 48, 186 N.E. 2d 554, 234 N.Y.S. 2d 702. Early in 1958 the New York Legislature passed a statute regulating credit insurance and particularly premium rates to be charged. Immediately prior to the October 1, 1958 effective date of this law, Old Republic and another company commenced an action to annul the regulation issued by the Superintendent under this law. The court immediately enjoined the execution and enforcement of this regulation, which was amended a few weeks thereafter to cure the defects alleged by Old Republic.

The Supreme Court on February 26, 1960 annulled the regulation as amended, holding that the Superintendent did not have the power and jurisdiction to fix maximum premium rates. However, early the next year the Appellate Division reversed this judgment and dismissed the petition, and this judgment was affirmed by the New York Court of Appeals.

In March 1959, while the "Wikler" litigation was pending, Old Republic issued and delivered in New York 13 policies of group credit life insurance on forms approved by the Superintendent prior to the enactment of the 1958 legislation. Approval of these forms had not been withdrawn by the Superintendent and the forms, as approved, were filled in to include premium rates such as were used by Old Republic in connection with these policies.

Prior to the issuance of the 13 policies in question the Superintendent had warned Old Republic that, quite apart from the regulation, Old Republic had a duty to comply with the statute, the validity of which was not brought into question by the pending litigation.

The Superintendent imposed a civil fine of $13,000 on Old Republic, claiming

that it had wilfully violated Sections 154 and 204 of the New York Insurance Law requiring approval of policy forms prior to use. Old Republic thereupon brought this action in the Appellate Division of the Supreme Court seeking to annul the determination of the Superintendent by which he levied the fine. The Appellate Division sustained the position of Old Republic and the Superintendent then appealed.

The Court of Appeals upheld the position of the Superintendent and, accordingly, reversed the judgment below. That Court took the position that Section 141 of the New York Insurance Law, relating to withdrawal of approval of policy forms, had no application to credit life insurance policies issued after October 1, 1958, that a new procedure for approving credit life rates was provided, and the Superintendent was granted new power over such rates. The Court further held that the action of Old Republic was "wilful" within the meaning of the New York Law. In its opinion the Court (Froessel, J.) stated:

> In our opinion, the section 141 procedure was wholly inapplicable to *the credit life policies issued in this case after October 1, 1958*. Without reference to existing policy forms, the new statutes created an entirely new procedure for approving credit life insurance *rates*, granting to the Superintendent a new power over them. The Superintendent was mandated not to approve forms or rates if the latter were "unreasonable in relation to the benefits provided," a standard not theretofore applicable to credit life insurance. Moreover, subdivision 7 of section 154 clearly speaks of "policies of credit insurance to be issued," i.e., after its effective date, which was nearly six months after its enactment, and the policies here were issued during a period commencing more than 10½ months following its enactment.
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> In light of the foregoing, it is our opinion that the word "wilful" as used in section 225 of the Insurance Law means no more than intentional and deliberate. Upon this view, there can be no doubt that the Superintendent was fully warranted in finding that respondent had "wilfully" violated the new statutes. Respondent was fully apprised of appellant's proper position that delivery of the policies constituted a violation of the amended statutes themselves, which in clear terms provided for approval of rates as well as forms in policies "to be issued," and the stay with respect to the *regulation* did not operate to stay the enforcement of the *statutes*. Fully aware of the risk involved, and after having been duly cautioned by the Superintendent, respondent nonetheless accepted the risk and disobeyed the statutes, thereby securing a decided advantage over the other insurance companies who complied with the law, and must now pay the penalties, the amounts of which are not challenged.

SIMILARITY OF NAMES: *Prudential Insurance Company of America v. Prudential Life and Casualty Insurance Company* (Oklahoma Supreme Court, July 17, 1962, Second Petition for Rehearing Denied January 22, 1963) 377 P.2d 556. Mutual Life and Accident Insurance Company proposed on July 31, 1957 to change its name to "Prudential Life and Casualty Insurance Company" and to convert into a stock legal reserve life insurance company. The next day the Commissioner of Insurance of Oklahoma issued a certificate of authority to the company to do business under that name. The following month

Prudential Insurance Company of America filed with the Commissioner a request that he direct the Oklahoma company to cease using any name including the word "Prudential." The claim of the New Jersey company was that the new name caused uncertainty and confusion. The Insurance Commissioner, after a hearing, entered an order refusing to take any action, and the New Jersey company appealed to the District Court of Oklahoma where the case was tried anew.

At this trial the New Jersey company proved that it was the second largest life insurance company in the United States, that it spent large sums in advertising and that in fact there had been confusion by reason of the adoption by the Oklahoma company of the name "Prudential." The New Jersey company proved that several persons purchased insurance from the Oklahoma company thinking that they had purchased it from the New Jersey company, that claims by policyholders of the Oklahoma company had been submitted to the New Jersey company, that mail had likewise been misdirected, that complaints against the Oklahoma company had been sent by the Insurance Commissioner's office to the New Jersey company and that a public recognition survey indicated that a great majority of those interviewed who associated the word "Prudential" with insurance connected that name with the New Jersey company.

After the hearing the District Court affirmed the order of the Oklahoma Insurance Commissioner, and the New Jersey company thereupon appealed to the Oklahoma Supreme Court. The Oklahoma Supreme Court reversed the judgment of the District Court by a five-to-four vote, holding that the names were confusing in violation of Oklahoma Statutes and that the Oklahoma company should change its name.

In its opinion the Court (Williams, C. J.) stated:

> We think that the evidence demonstrates that the similarity of respondent's name to that of petitioner had a deceptive effect in the mind of the public and that confusion resulted therefrom.
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> Respondent contends that it and petitioner are not in competition and that this is a defense to the action. Respondent argues that its business is largely accident and health, while petitioner concentrates on life insurance; that it sells to a different class of people than does petitioner, and issues a different type policy.
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> We do not agree. Both companies sell life insurance, and accident and health insurance to the public. Neither will refuse to sell a policy to a desirable risk. Admitting for the moment that respondent and petitioner are not now in competition, nevertheless we cannot agree with the argument. There would be nothing to prevent respondent in the future from emphasizing life insurance, contacting the same prospects as petitioner and selling almost duplicate policies. There is no assurance that active competition would not develop at a later date.
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> The question arises as to the reason for respondent's adoption of its latest name. Petitioner and respondent do not agree on the answer. For whatever reason it was done, it is clear to us that the result has been to create a deceptive and confusing situation in the public mind.

It is so easy for one who wishes to sell goods upon their merit, to select from all the names available one which by no possibility can cause confusion between his goods and those of a highly successful competitor that the courts look with suspicion upon one who, in choosing a name, approaches so near to his successful rival that the public may fail to distinguish between them. Florence Mfg. Co. v. Dowd Co., 2 Cir., 178 F. 73.

This cause is remanded to the District Court of Oklahoma County with directions that it in turn remand the same to the Insurance Commissioner of the State of Oklahoma and he be directed and ordered to cause respondent immediately to cease doing any advertising or the conducting of any new business under its present corporate name.

In the event that respondent in changing, qualifying and/or modifying its present corporate name continues therein the word "Prudential" said word is never to be used by respondent with greater emphasis thereon than any other word or words, and shall not be the first word nor the dominant word in such corporate name. Nor shall respondent use in advertising or business relations the word "Prudential" in such fashion or manner as would confuse or tend to mislead the insurance buying public.

These cases involving similarity in names of insurance companies cause the courts a great deal of difficulty, as is well illustrated here. There are now almost 1,500 legal reserve life insurance companies in the country and the number of desirable names is reduced with the organization of each new company. There is the natural tendency to select a name which is assuring to the buying public and at times there appears to be a distinct tendency to take advantage of a name similar to that of an established company.