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LEGAL NOTES

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MISREPRESENTATION—CHOICE OF LAW: *Fleet Messenger Service v. Life Insurance Company of North America* (C.A. 2, April 4, 1963) 315 F.2d 593. The Fleet Messenger Service applied for a "key-man" policy on the life of its president. Life Insurance Company of North America thereafter issued its $100,000 policy, and the insured died seven months later from "advanced occlusive coronary atherosclerosis with myocardial fibrosis." The company refused to pay. The policy was applied for and the first premium paid in New Jersey, the company not being licensed in New York. The company's home office was in Pennsylvania, and the insured lived at all times in New York.

The district court submitted the case to the jury on the question of misrepresentation, which the company alleged as the reason for nonpayment, and the jury found for the plaintiff. Thereafter, the court set the jury verdict aside and entered judgment for the company.

On appeal to the court of appeals, that court affirmed the judgment below. It held that under the circumstances the New York law should be applied, that there had been material misrepresentation, and that under New York law there could be no recovery. In its opinion the court (Lumbard, C.J.) stated:

> In conformity with a pre-trial order, consented to by the parties, Judge Levet made a pre-trial determination that New York law controlled. We agree. A federal district court sitting in New York must use the choice-of-law rules of New York to determine the law which is applicable in an action grounded on state law. Klaxon Co. v. Stentor Electric Manufacturing Co., 313 U.S. 487, 61 S.Ct. 1020, 85 L.Ed. 1477 (1941). In Auten v. Auten, 308 N.Y. 155, 124 N.E.2d 99, 50 A.L.R.2d 246 (1954), New York adopted the "center of gravity" or "grouping of contacts" approach for choice-of-law problems in contract situations having elements connected with more than one jurisdiction. Under that approach, the governing law is that of the jurisdiction "which has the most significant contacts with the matter in dispute." Id. at 160, 124 N.E.2d at 102; Rubin v. Irving Trust Co., 305 N.Y. 288, 305, 113 N.E.2d 424 (1953). The plaintiff questions the applicability of Auten to insurance contracts, relying on New Amsterdam Casualty Co. v. Stecker, 3 N.Y. 2d 1, 163 N.Y.S.2d 626, 143 N.E.2d 357 (1957), in which ambiguous language of the New York Court of Appeals might be construed to indicate a withdrawal from the Auten rationale. But Auten is cited as authority for the decision in New Amsterdam, 3 N.Y.2d at 5, 163 N.Y.S.2d at 628, 143 N.E.2d at 358, and as we have stated in another case, Zogg v. Penn Mutual Life Ins. Co., 276 F.2d 861, 864 n. 6 (2 Cir., 1960), we do not understand New Amsterdam to be a departure from the rule laid down in Auten.
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> Applying the "center of gravity" test, we believe that New York is the state having

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the most significant contacts with this controversy. Both the beneficiary and the insured were New York residents. Opposed to this are the facts that the insurer is a Pennsylvania corporation, not licensed to do business in New York; that the policy was issued, thereby becoming effective, at the insurer's home office in Pennsylvania; and that the policy's provisions for notice to the insurer by the insured required that notice be given at the Pennsylvania home office. There were also some contacts with New Jersey; the application for the policy was executed in that state, and the first premium was tendered to one of the defendant's representatives there. The New Jersey contacts are fortuitous, and no one contends that the law of that state should control. But for the fact that the defendant was not licensed to do business in New York, the events occurring in New Jersey would almost certainly have taken place in New York.

The situation, then, is that the beneficiary's and insured's sides of the transaction are connected with New York, and the insurer's side with Pennsylvania. We think a New York court would apply New York law. Compare Strubbe v. Sonnenschein, 299 F.2d 185 (2 Cir., 1962). If we can presume that in a case where the contacts are so nearly evenly balanced in number and 'nature,' a New York court would look also to the substantive impact of the contending laws, such a test further supports the application of New York law. The issues to be resolved in this case concern the effect of an insured's misrepresentations on the beneficiary's right to recover. New York law is harder on beneficiaries in this respect than the law of Pennsylvania, and it is the out-of-state insurer who relies on New York law. There is no problem of local law being applied to the disadvantage of the party from out of state. New York having fashioned a 'hard' rule regarding the effect of an insured's misrepresentations on the beneficiary's right to recover, it is difficult to see why, in a controversy with an out-of-state insurer over a policy issued on the life of a New York insured, the New York beneficiary should not be held to the same law which would apply if the insurer were not from out of state.

Under New York Insurance Law, McKinney's Consol. Laws, c. 28, § 149(2) a material misrepresentation avoids an insurance contract. Section 149(4) provides that, for purposes of determining materiality, a misrepresentation that an applicant for life insurance 'has not had previous medical treatment, consultation or observation' shall be deemed a misrepresentation that applicant 'has not had the disease, ailment or other medical impairment for which such treatment or care was given or which was discovered by any licensed medical practitioner as a result of such consultation or observation.' There is no dispute that, if by § 149(4) the insured is deemed to have had the disease for which he was treated, that fact is material under the standard of materiality contained in § 149(2). Chase's misrepresentations are unquestionably covered by § 149(4); unless waived, therefore, they constitute a defense in an action to recover on the policy.

LIABILITY FOR NEGLIGENT DELAY—CONFLICT OF LAWS: *Lowe's North Wilkesboro Hardware v. Fidelity Mutual Life Insurance Company* (C.A. 4, June 13, 1963) 319 F.2d 469. The hardware company applied for a $200,000 life policy on its president, Buchan. The insured lived in North Carolina, and the agent of Fidelity Mutual was located in Washington, D.C. The last of the three parts of the application for the policy was received in Philadelphia on October 6, and the retail credit report was received October 14. On October 19 a $50,000 policy was prepared and was sent to Washington. Some slight delay was accounted for by the absence of Fidelity Mutual's chief underwriting officer, who

was on a trip. The $50,000 policy was accepted by Buchan, and a request was made that an attempt be made to increase the amount. The insured died on October 22.

This action, brought by the proposed beneficiary, was based on alleged negligent delay in acting on the original application and on the request for reconsideration. The district court held that, if the North Carolina law applied, an action of this type might lie if there was delay. However, if the Pennsylvania law governed, there was no liability under the law of that state for negligent delay. The court held that Pennsylvania law did govern and dismissed the suit, and from that action this appeal was taken.

The court of appeals held that the important events on which the negligence claim was based occurred in Pennsylvania and not in North Carolina. Accordingly, the decision of the district court in favor of Fidelity Mutual was affirmed on this appeal. In affirming the judgment, the court (Sobeloff, C.J.) stated:

> In failing to formulate the reasons for applying the law of a foreign forum, the North Carolina court has not differed from other jurisdictions; and even in multi-state torts courts have with few exceptions merely chosen whatever rule seemed reasonable for the particular case under adjudication, without attempting to formulate the reasons for selecting that rule. Scholars and commentators have had little more success in providing guidelines for choosing the proper and just rule. Against every rule applied and every proposal made great clouds of criticisms have been raised, and each commentator appears to have a different "best" solution for the difficulty. The applicable rules for a conflicts law of torts have constantly changed in the ceaseless search for a just and fair resolution of the problem.
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> Thus, favored with few guides and observing that even the validity of these is obscured by substantial criticism, we find it most reasonable, in these circumstances, to avoid a rigid rule and to pursue instead a more flexible approach which would allow the court in each case to inquire which state has the most significant relationships with the events constituting the alleged tort and with the parties. The relative weight due particular factors will vary from case to case, and the court must judge the totality of contacts of the states concerned with the parties and the subject matter. Having thus determined which state has the most significant relationships, the court then will apply the law of that jurisdiction.
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> It cannot be said that there existed between the present parties an established relationship having a particular location; there were only preliminaries looking to the creation of a relationship. But if these preliminaries themselves should be viewed as a relationship of a kind, the question is, where did it center?
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> Plaintiff stresses that Buchan's residence in life and the place of his death were in North Carolina, that there the plaintiff was engaged in business, and that plaintiff sustained there the loss caused by the alleged tort. It is of course true that, in addition to the defendant's conduct complained of, an injury must be shown to have resulted before tort liability can arise. It does not follow, however, that because plaintiff was domiciled in North Carolina and Buchan lived and died there, the tort complained of happened in that state. It would seem to make no difference in this case if Buchan had died elsewhere. Scarcely can the mere fact that the proposed insured lived in North Carolina be highly significant. This circumstance is reduced almost to the point of irrelevancy in comparison with the events which occurred in Pennsylvania. And while

the domicile of the plaintiff corporation merits consideration, it cannot be accorded dominant importance in fixing the location of the tort.

The important events upon which liability, if any, would rest occurred in Pennsylvania. It is to the home office of defendant in Pennsylvania that the application was sent; all information relative to the policy was obtained through or sent to the Pennsylvania office. Only there could an application for a policy of the size desired be acted upon; and in that place the application was rejected and an offer of a $50,000 policy made. In sum, it was in Pennsylvania that the alleged delay, the foundation of the cause of action, took place. The fact that the application form was completed in North Carolina before its transmission to Pennsylvania does not loom large against the events in Pennsylvania so intimately related to the alleged delay. For these reasons we conclude that Pennsylvania, rather than North Carolina, has the more significant relationships, and the law of Pennsylvania should be applied.

Pennsylvania does not recognize a cause of action for negligent delay in acting upon an insurance policy. The District Court was correct in granting defendant's motion for summary judgment.

Affirmed.

In insurance cases most courts, unlike this court, seem to be prone to apply the law of the state in which the insured lives when he applies for the policy, especially where the insurance company is doing business in that state, as was the case here. The result reached was no doubt correct in any event in this case because on the basis of the facts it would not appear that there was any negligent delay chargeable to Fidelity Mutual.

MISREPRESENTATION—SUBSTANDARD POLICY: *Turner v. Manhattan Life Insurance Company* (C.A. 9, July 10, 1963) 320 F.2d 553. The insured, Andre, had been rated up substantially by one company and had been rejected by another in 1956 on account of a heart condition. Manhattan's general agent, Fixa, submitted an application to the company in 1958, and Manhattan offered $20,000 Class F, plus $50 per thousand, and this offer was refused. The general agent continued his efforts to insure Mr. Andre, and subsequently, in 1959, the medical director, Dr. LaPointe, approved a $25,000 policy rated Class D, plus $15 per thousand extra for three years. This policy was promptly accepted and paid for. The insured was stricken with a heart attack four days after the policy was delivered and died about a year thereafter.

The Manhattan Life refused to pay on the basis of alleged misrepresentation. Its claim was that the insured answered falsely the question, "Have you even been an inmate of, or received treatment or cure at an asylum, hospital or sanitarium?" and a further question regarding ailment or disease of the brain or nervous system. Some months prior to the date the policy in question was issued, the insured had spent two days in a hospital for what was thought to be a slight stroke, or "cerebral vascular accident." The tests, however, were negative.

The United States District Court held that there was material misrepresentation and that there could be no recovery. On this appeal the court of appeals reversed and by a two-to-one vote held the Manhattan to be liable. That court

held that was no misrepresentation under the circumstances. The court was no doubt influenced by the fact that Manhattan knew at all times that the insured had a heart condition and was being treated constantly by his doctor and also by the fact that the policy was quite severely rated. The court indicated that the premium was "350 per cent of normal" plus the $15 extra, when presumably the fact was that the rating was 350 per cent and not the premium. The court, in the majority opinion, was highly critical of Manhattan. Hamlin, circuit judge, dissented on the basis that there was ample evidence to support the finding of the district judge that there was material misrepresentation. He thought there was merit in the Manhattan claim of fraud, misrepresentation, and nondisclosure.

This case illustrates the fact that the court will scrutinize with care a misrepresentation claim involving a substandard policy in which the company was aware at the time it went on the risk of the impairment which resulted in the death of the insured. The harsh criticism of the company in this case is difficult to explain or justify.

AVIATION RESTRICTION—DEATH BY DROWNING AFTER CRASH: *Rauch v. Underwriters at Lloyd's of London* (C.A. 9, July 8, 1963) 320 F.2d 525. The accident policy excluded death "while the Assured is operating . . . or serving as a member of a crew of an aircraft." The assured died after the plane which he was piloting had crashed in a lake shortly after take-off. His body was found three days later in the water near the plane. He could not swim.

The beneficiary sued, claiming that the death was the result of drowning, which was not an excluded risk and which did not occur while the assured was operating the aircraft. The trial court and, on appeal, the Ninth Circuit Court of Appeals agreed, one judge dissenting, that as a matter of law the assured did die while operating the plane and hence there could be no recovery. The court, in its opinion, stated:

> We hold that the aeronautic activities of decedent Rauch did not end with the actual flight initiated by him, but included his voluntary or involuntary presence and movements in the lake water near the plane following its crash, as disclosed by the evidence. We agree with the Trial Court in holding that decedent Rauch's death occurred *while* operating and serving as a member of the crew of the airplane which crashed into Fish Lake and that appellant beneficiary's recovery on the policy is barred by its aviation exclusion clause.

The dissenting judge was of the opinion that the exclusion clause was sufficiently ambiguous to permit recovery. He took the position that the death did not necessarily occur "while" the assured was piloting the plane.

LIFE INSURANCE FEDERAL INCOME TAX—TAX-EXEMPT INTEREST: *Atlas Life Insurance Company v. United States of America* (D.C. Oklahoma, May 1, 1963) 216 Fed. Supp. 457. Atlas Life brought this action to recover taxes which it claimed were imposed on the receipt by it of tax-exempt interest. Atlas Life claimed that the basic formula of the Life Insurance Company Income Tax Act

of 1959 in fact served to tax interest from state and municipal bonds owned by Atlas Life; and the Internal Revenue Service refused to recompute the tax in accordance with Sections 804(a)(2) and 809(b)(1) of the Code so as to avoid this result.

It appeared to be conceded that Atlas Life was required to pay a larger tax on account of the receipt of this tax-exempt income than it would have been required to pay had the money been left idle without income. The question at issue was whether the effect of this formula written into the law did in fact serve to tax the income which should not have been taxed. This formula divided the income between what the law refers to as the "life insurance company's share" and the "policyholder's share." The policyholder's share is not taxed under the law, but the company's share is taxed.

The receipt of the tax-exempt interest operates under the formula written into the law to reduce the amount of the policyholder's share, which is not subject to tax, and hence to increase the tax which is payable. Atlas was required to pay an added tax of about 29 per cent on account of the receipt of the tax-exempt interest as compared with the tax which would have been payable had the money been left idle.

The district court held that the formula written into the law should be applied and that the exception language had no application under the circumstances. Accordingly, Atlas Life's claim for refund was denied, except for an overpayment which had been conceded.

The position of the district court is thus stated:

> Atlas contends that the formula for determining its income tax is unconstitutional in that a tax is laid upon its tax-exempt interest income. I do not agree. The Act simply classifies income for purposes of taxation and no tax is laid upon tax-exempt interest received by Atlas. The Power of Congress to lay and collect taxes is plenary subject only to certain constitutional restrictions not here present. The Congress may classify incomes for the purpose of taxation. The formula provided by Congress is for all similar life insurance companies and does not discriminate against any, including Atlas.
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> To adopt the formula urged by Atlas would amount to a striking down of the formula adopted by Congress, which this Court will not approve, and at the same time set up a formula not provided by Congress. In the Atlas formula it gives no consideration to interest from tax-exempt securities as income. This is certainly unrealistic. For the power of Congress to classify income and lay a tax thereon see Denman v. Slayton, 282 U.S. 514, 51 S.Ct. 269, 75 L.Ed. 500.
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> Atlas relies heavily on National Life Insurance Company v. United States, 277 U.S. 508, 48 S.Ct. 591, 72 L.Ed. 968, and State of Missouri, ex rel. Missouri Insurance Company v. Gehner, 281 U.S. 313, 50 S.Ct. 326, 74 L.Ed. 870. These cases do not support the Taxpayer's position. In National Life the Court held as unconstitutional Section 245(a) of the Revenue Act of 1921, 42 Stat. 227, which provided that a reserve deduction allowed to all insurance companies should be reduced by the amount of tax-exempt interest received. The Court in essence held that by pro tanto denying a deduction solely by reason of receipt of tax-exempt interest, the Congress had imposed a tax on that interest which was constitutionally exempt. In Missouri v. Gehner, the

Court held unconstitutional a state property tax on net worth of insurance companies which, in computing net worth, allowed a deduction for federal bonds, but required a pro rata deduction in the deduction that was otherwise allowable for insurance reserves. No comparable denial of deductions is made by the Act here in question. These cases cannot be so narrowly construed as urged by Atlas. See Denman v. Slayton, supra.

Having reached the conclusion that by the application of the Act, tax-exempt interest received by Atlas is not in fact taxed, judgment will be entered denying the claimed refund, except to the extent of $1,440.74 resulting from adjustments agreed upon by the parties.

This case is extremely important to the life insurance companies and to the government. The Atlas Life appealed to the United States Court of Appeals for the Tenth Circuit. Regardless of the decision by that court, it is highly probable that the United States Supreme Court will be asked to and will pass on this issue.

The portions of the law in question were drafted after the bill reached the Senate. The exception language was added to show that the intent of the Congress was not to tax state and municipal interest. The formula, however, increased the tax if such interest was received. The question is whether the fact that the tax was so increased necessarily means that a tax is levied on interest which should be tax-exempt. A constitutional issue seems to have been avoided by the exception language, one purpose of which was to avoid the chance that the courts might hold, contrary to prior holdings, that the federal government could, consistent with the federal Constitution, tax state and municipal bonds.

DIVIDEND LESS THAN ANNUAL PREMIUM—DUTY OF INSURER TO APPLY DIVIDEND: *Simmons v. Cambridge Savings Bank* (Massachusetts Supreme Judicial Court, July 2, 1963) 191 N.E.2d 681. The insured elected to pay premiums annually on his term policy and to have dividends "used to reduce premiums due on anniversary." He failed after due notice to pay an annual premium of $16.63. He then had a dividend credit of $6.36, which was more than sufficient to pay the quarterly premium of $4.32. The insured died shortly thereafter.

The beneficiary claimed that the bank had the duty to apply the dividend credit to the payment of a quarterly premium in order to prevent a lapse, and brought this suit. The trial court found for the beneficiary on this question, but the Appellate Division reversed. On further appeal to the Supreme Judicial Court of Massachusetts, that court affirmed the judgment of the Appellate Division in favor of the bank. In affirming the judgment, the court (Wilkins, C.J.) stated:

In Lamar v. Aetna Life Ins. Co., 85 F.2d 141, 142 (10th Cir.), two principles were stated, "[1] It is the general rule of law that where an insurer has in its possession sufficient unapplied dividends presently due the insured to pay the stipulated premium, it should apply them in extinguishment of the premium and thus avoid lapse of the policy unless the insured directs otherwise. And the law will make the application if the insurer fails to act, the consent of the insured thereto being presumed. . . . [2] But it is equally well settled that such dividends must be sufficient in amount to discharge the premium in full, otherwise the doctrine has no application and lapse is not pre-

vented." In all the cases cited for the latter principle the dividends were insufficient to pay even the smallest premium instalment provided for in the policy, but the reference appears to be to the full stipulated premium. As to the first principle, the stipulated premium in the case at bar is an annual one.

The issue is to be decided with reference to all policyholders whose policies may be treated as lapsed by the insurer, the living as well as those who die. The rights of the insurer are to be fairly considered. The proposition which we consider, but not as advocated by the plaintiff, may be stated in this form: Whenever at the expiration of a grace period there is a declared dividend to the credit of the insured who has elected to have dividends applied to reduce premiums, and that dividend is sufficient to pay a premium on a quarterly basis, but not on the stipulated annual basis, the insured, who had the right to change the basis of payment but had not done so, unless he notifies the insurer that he intends to let the policy lapse, is to be taken by his silence to authorize payment on a quarterly basis.

As to the insured and the plaintiff, the beneficiary, it is obvious that they would have preferred that the quarterly premium be paid than that the policy lapse. In this case assent could retroactively be presumed. But in order to reach this result, it would be necessary to hold that every policyholder living at the expiration of the grace period should prospectively be taken to assent to a change in the method of payment where no notice of an intention to let the policy lapse is given to the insurer. This would involve a revision of the policy which we feel unable to make under sound principles of construction of contracts.

ACCIDENTAL MEANS—HEART ATTACK CAUSED BY EXERTION: *Linden Motor Freight Company v. Travelers Insurance Company* (New Jersey Supreme Court, July 5, 1963) 193 A.2d 217. The double-indemnity provision of the life insurance policy covered death resulting from "bodily injuries effected directly and independently of all other causes through external, violent and accidental means." The insured died from a coronary thrombosis shortly after moving some heavy packages in a warehouse. There was no suggestion of an unexpected event or that physically something unforeseen or involuntary occurred in connection with the insured's efforts.

The trial court found that the death did not occur in a manner to be covered by the insuring clause of the double-indemnity provision and entered judgment for the Travelers. The case was then appealed to an intermediate appellate court, and before a decision could be reached there the New Jersey Supreme Court assumed jurisdiction and proceeded to decide the case.

The New Jersey Supreme Court examined these difficult cases from many jurisdictions, including a very old and a more recent case decided by the Supreme Court of the United States. The court held that double-indemnity benefits were not payable, rejecting the reasoning in contrary decisions from other states. In commenting on these decisions, the court states:

Taken as a whole, they represent pretty much the same kind of melange in reasoning and result which we have noticed in other states in voluntary act cases. This is not said critically, but rather to emphasize that, as elsewhere, the decisions may be reconciled perhaps only on the basis that the actual rationale in each case is, in the final analysis, the particular court's conception of a fair and reasonable result on the specific facts,

even though that thought may not be so candidly expressed in the language of the opinion, which ordinarily instead speaks of either the Barry or Landress dissent approach. And, there is, of course, plenty of room for difference of opinion with respect to the result in many cases or in a class of cases, as shown by differing conclusions among the states in analogous factual situations.

This case, by a highly respected court, is opposed to many recent cases holding the company liable in these exertion deaths whether the insurance clause was "death by accidental means" or "accidental death." The decision is significant because the court considered and rejected contrary holdings by a large number of courts.