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LEGAL NOTES

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NATIONAL SERVICE LIFE INSURANCE—RIGHT OF ESTATE TO PAYMENT: *United States v. Henning*, (United States Supreme Court, Nov. 17, 1952) 344 U.S. 66. The insured died in service July 4, 1945 and his father, the named beneficiary, died five months later without having received any part of the policy proceeds. Then surviving were the insured's stepmother and his mother. The stepmother died shortly thereafter, leaving only the insured's mother. The Government claimed that the stepmother had last borne the parental relationship to the insured, that the mother could not under the circumstances come within the statutory class of devolutionary takers, that no estate was entitled to the proceeds and hence the proceeds should escheat to the National Service Life Insurance Fund.

The District Court held that the father's estate was entitled to the proceeds accruing during his life but unpaid, the stepmother's estate was entitled to the installments accruing during her life after the death of the father, and that installments thereafter accruing were payable to the mother. On appeal, this decision was affirmed by the Court of Appeals, but on further appeal, the United States Supreme Court reversed, holding that under the National Service Life Insurance Act as it existed prior to a 1946 amendment an estate of a deceased beneficiary could not take even installments accruing during her lifetime but unpaid. The United States Supreme Court held that the insured's mother was a surviving beneficiary entitled to take the entire proceeds.

Mr. Justice Burton agreed that an estate was not entitled, under the Act as it existed at the time, to the proceeds but disagreed with the Court's conclusion that the mother qualified as the person entitled to take after the death of the stepmother, who admittedly up to that time was entitled to receive the proceeds. Mr. Justice Jackson and Mr. Justice Frankfurter also dissented on the basis that the Act should be construed as entitling the estate of a deceased beneficiary to installments accruing during the lifetime of such beneficiary.

REINSTATEMENT—EVIDENCE OF INSURABILITY: *Hogan v. John Hancock Mutual Life Insurance Company*, (C.A. 3, April 11, 1952) 195 F.2d 834. The policy on the life of Savage was made payable to Hogan, his business partner. The policy lapsed for nonpayment of the second quarterly premium and the insured shortly thereafter applied for reinstatement. The policy provided that it might be reinstated "upon production of evidence of insurability satisfactory to the

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Company." The John Hancock's reinstatement application, which Savage signed, provided that reinstatement should not be effective unless the insured was in sound health on the date the application was approved and unless he had not consulted or been treated by a physician except as stated.

The insured consulted a physician on November 3, 1945, which was either just before or just after he signed the application for reinstatement, and he was told that he was suffering from tuberculosis. The insured died 16 months thereafter from that disease.

John Hancock refused to pay the face amount of the policy and the named beneficiary, Hogan, commenced this action. The company set up the facts that the insured was not in sound health as required by the reinstatement application when the application was approved and also that he had been treated by physicians between the signing of the application and its approval by the company. The District Court held that because of these facts the reinstatement was not effective and the beneficiary appealed.

On appeal, the beneficiary claimed that the policy was irrevocably reinstated because the insured had complied with the reinstatement provision of the policy, which merely required the production of evidence of insurability and the payment of back premiums, and that the further provisions of the policy as to sound health and treatment by physicians were contrary to the reinstatement provision of the policy and therefore void. The Court of Appeals held that the John Hancock was entitled to impose the condition as to sound health and as to treatment by physicians and that these provisions merely represented a "spelling-out by the insurer of what it will require as 'evidence of insurability satisfactory to the Company.'" The Court held that since the insured clearly was not in good health when the company approved the application and since in the interval he had in fact been treated by a physician, there could be no recovery. The Court also rejected the contention that since the application for reinstatement and back premiums were held for more than six weeks before action, this was evidence of the insurer's intent to revive the policy. The Court pointed out that the application for reinstatement expressly gave the company 60 days within which to act and it did act within that period.

PREMIUM NOTICE STATUTE—MONTHLY PREMIUMS: *Mutual Life Insurance Company v. Weigel*, (C.A. 10, June 9, 1952) 197 F.2d 656. The life policy, as issued, provided for annual premiums, and one annual premium was paid. At the end of the first year the insured, unable to pay the second annual premium, sent in a monthly premium together with his policy, requesting a change in method of premium payments. The company returned his policy, stating that it was not needed, and sent out for his signature a request to change the method of payment to "monthly annual premiums." This was signed by the insured. The company stated that he could go back to annual premiums when he so desired.

The insured paid six monthly premiums but no more. He died after the expiration of the grace period for the payment of the next monthly premium and the company claimed that his policy had lapsed for nonpayment of this premi-

um. The beneficiary claimed that the policy did not lapse because the company admittedly did not give the notice of premium due, which notice is required by a Kansas statute except where the premium is to be paid weekly, biweekly or monthly.

The District Court and, on appeal, the Court of Appeals for the 10th Circuit held that the company was required by the Kansas statute in question to send the statutory notice and since this notice was not sent, the company could not forfeit the policy for nonpayment of premiums for six months after default and the insured had died within this six-month period. The basis of the decision was that the policy remained an annual-premium-payment policy and that the arrangement entered into merely gave to the insured the privilege of paying this annual premium in monthly installments. The Court stressed the fact that the company had not felt it necessary to endorse any change on the policy. The Court pointed out that another Kansas statute provided that where an insurance company entered into a subsequent agreement extending the time for payment of a life premium it need not attach such an agreement to the policy and could provide therein for lapse without notice, but this statute did not have any application because no such agreement was entered into.

One judge dissented from this extremely technical construction of the Kansas notice statute.

GROUP ANNUITY CONTRACT—PERPETUAL OBLIGATION: *Freeport Sulphur Company v. Aetna Life Insurance Company*, (D.C. Louisiana, Sept. 10, 1952) 107 F. Supp. 508. The Aetna Life issued its group annuity contract in 1934 covering employees of Freeport. The contract did not provide for termination by Aetna but did provide, after the initial five-year period, for some slight increase in rate each five years as to new employees.

In November 1949, Aetna, after a series of unsuccessful attempts to adjust the rate base materially as to new employees, advised Freeport that after January 1, 1950, employees not then covered could not be covered. Freeport claimed that this constituted a breach of its contract and commenced this action to determine whether the attempted cancellation as to new employees was lawful. Aetna's claim was that the contract was not a perpetual obligation to provide coverage for new employees and that since no termination provision was incorporated in the contract, the contract was terminable by it at will as to new employees.

The United States District Court held that the Aetna did not assume by its contract a perpetual obligation as to new employees but that since the contract provided no termination date it was not terminable at will, as contended by the Aetna, but was terminable only after reasonable time. The Court further held that 25 years from the date of the contract was under the circumstances a reasonable time, thereby obligating Aetna to continue to insure new employees for the balance of the 25-year period.

The Court denied Aetna's claim that the contract, in so far as wholly executory, was discriminatory and illegal under controlling New York law. The Court ordered specific performance of the contract as construed, and from this judgment both parties have appealed.

DIVORCE—PROPERTY SETTLEMENT AS AFFECTING BENEFICIARY'S INTEREST: *Mabbitt v. Wilkerson*, (Arkansas Supreme Court, March 24, 1952) 247 S.W.2d 201. The insured was divorced from the beneficiary and the property settlement provided that she should remain as beneficiary under the policy so long as she lived and did not remarry, but that in the event of her death or remarriage the policy should become the absolute property of the insured. The beneficiary did remarry and the insured died without effecting a change in benefit in accordance with his reserved power under the policy terms.

Upon the insured's death the named beneficiary, the former wife, claimed the policy proceeds and the insured's second wife and widow claimed that the proceeds belonged to the insured's estate. The insurance company interpleaded the rival claimants and the trial court awarded the proceeds to the named beneficiary. On appeal, the Supreme Court of Arkansas reversed this judgment, holding that the insured's estate was entitled to the proceeds. It likened the case to a situation where the insured attempted to change his beneficiary by means of a will, which procedure the Supreme Court of Arkansas had previously held (contrary to the majority view) was proper even though the policy procedures for effecting a change in beneficiary were not carried out.

INCONTESTABLE CLAUSE—AVIATION EXCLUSION: *Mutual Life Ins. Co. v. Daniels*, (Colorado Supreme Court, May 5, 1952) 244 P.2d 1064. The insured took out his policy in 1940 and died in 1945 while piloting a military plane as an officer in the United States Air Force. The policy contained a provision for the payment of only the policy reserve in the event the insured died "as a result of operating or riding in any kind of aircraft" except under certain conditions as a fare-paying passenger. The policy contained no military or war restrictions but did contain, as required by the Colorado statute, a two-year incontestable clause.

The beneficiary claimed that the aviation exclusion was valid only while the policy was incontestable and claimed that in any event the aviation exclusion was limited to civilian aviation and did not cover a military aviation accident such as resulted in the death of the insured. The trial court agreed with the contention of the beneficiary and granted judgment for the face amount of the policy and not merely for the limited benefit.

The Supreme Court of Colorado reversed the judgment of the lower court, holding that the incontestable statute of Colorado did not serve to limit the exclusion to the two-year period as contended and also that the aviation exclusion was not intended to restrict only in the event of a civilian aviation death. The Court stated:

> We are of the opinion that the aviation rider contained in the policy is not limited to civilian aviation. There is no specific provision that it is so limited, and the fact that there is no reference to military or naval aviation does not, in our judgment, mean that that is not excluded in the forbidden character of aviation flight when the aviation rider excepts death as a result of operating or riding in any kind of aircraft, whether as a passenger or otherwise, except as a fare-paying passenger on regularly scheduled routes, etc. Nor does the fact that the policy did not have a war-risk clause give support to any implication that military flights were not excluded.

AGENT'S LICENSE—AUTOMOBILE DEALERS: *Motors Insurance Corporation v. Robinson*, (Ohio Court of Common Pleas, March 22, 1951) 106 N.E.2d 572; Appeal dismissed, (Ohio Court of Appeals, Oct. 23, 1951) 106 N.E.2d 581; Appeal dismissed, (Ohio Supreme Court, March 19, 1952) 157 Ohio St. 354, 105 N.E.2d 61; Appeal dismissed, (United States Supreme Court, Oct. 13, 1952) 344 U.S. 803. Ohio amended its agent's license law in 1949 to deny a license to an appointee of an insurance company where it was his purpose or intention "principally to solicit or place insurance on appointee's own property or that of relatives, employers or employees or that for which they or the appointee is agent, custodian, vendor, bailee, trustee or payee." Motors Insurance Corporation, a subsidiary of General Motors Corporation, had been duly licensed by Ohio and had been engaged in the business of insuring against physical damage to and theft of motor vehicles. Robinson, the Superintendent of Insurance of Ohio, had licensed almost 1,000 persons and corporations as agents of Motors Insurance Corporation, all of the individuals being automobile dealers or officers or employees of such dealers.

Superintendent of Insurance Robinson, acting in accordance with the law as amended in 1949, threatened not to issue new or renewal licenses to appointees of Motors Insurance Corporation. That corporation, along with several of its agents, brought this action to enjoin Superintendent of Insurance Robinson from refusing to grant the licenses. The trial court stated that the purpose of the restriction was "to prevent an unfair advantage in the placing of insurance and the licensing of persons who were not intending to do a general insurance business, but simply to supplement their primary business of selling automobiles." The court denied that any of the plaintiffs had been deprived of their rights under the Federal or the Ohio Constitutions, stating that "The statute under consideration does not deprive any class, group or individual from securing an insurance license if he has the necessary qualifications and intends to use his license to conduct a general insurance business. . . ."

The trial court dismissed the petition and this action was upheld on further appeals by the Ohio Court of Appeals, the Ohio Supreme Court and the Supreme Court of the United States.

MURDER OF INSURED BY BENEFICIARY—RIGHTS OF CONTINGENT BENEFICIARY: *Neff v. Massachusetts Mutual Life Insurance Company*, (Ohio Supreme Court, June 18, 1952) 107 N.E.2d 100. The named primary beneficiary killed his wife, the insured, and he was convicted of murder and sentenced to the penitentiary for life. The settlement agreement in force at the insured's death provided for the retention of the proceeds by the company with interest payable to the husband with the right granted to the husband to withdraw the whole or any part of the proceeds at any time after the insured's death. The agreement further provided that on the death of the survivor of the insured and the designated primary beneficiary any amount then remaining should be paid to the insured's stepchildren or to the survivor of them.

The administrator of the insured's estate commenced an action against the

Massachusetts Mutual, claiming he was entitled to the proceeds. The company interpleaded the guardian for the two minor stepchildren and paid the proceeds into court. The trial court held that since the primary beneficiary was debarred on public policy grounds, the proceeds should be awarded to the guardian of the contingent beneficiaries, the two stepchildren. On appeal, the Court of Appeals of Ohio reversed this judgment, awarding the proceeds to the administrator of the insured's estate. On further appeal, however, the Supreme Court of Ohio reversed the judgment of the Court of Appeals and affirmed the judgment of the trial court. The Supreme Court of Ohio held that under the beneficiary clause any distribution of the policy proceeds would have to await the actual death of the primary beneficiary, which apparently had occurred prior to the oral hearing in the Ohio Supreme Court.

The Supreme Court of Ohio distinguished other apparently contradictory cases on the basis of difference in beneficiary language.

See *TSA* IV, 183.

POLICY LOAN—REPAYMENT FROM INSURED'S ESTATE: *In Re Schwartz' Estate*, (Pennsylvania Supreme Court, March 24, 1952) 369 Pa. 574, 87 A.2d 270. The two life policies, issued in 1913, named the beneficiaries irrevocably but obligated the company to make policy loans to the insured to the extent of the cash value. Policy indebtedness was outstanding when the policies matured by the insured's death and the named beneficiaries claimed that such policy loans should be repaid out of the insured's estate, particularly since his will provided for the payment of "my just debts."

The lower court held that the policy loans did constitute debts and directed the repayment of such loans out of the insured's estate. On appeal, the Supreme Court of Pennsylvania reversed this judgment, holding in accordance with decisions from other jurisdictions that a policy loan was not in fact a loan at all but rather an advance, that no obligation to repay the policy loan existed and that the policy loan should be deducted from the proceeds and the net amount paid to the beneficiary. The Court distinguished a prior Pennsylvania case in which it had held, in effect, that where a life policy had been assigned as security for indebtedness, such indebtedness should be deducted in computing the Pennsylvania inheritance tax.

The Pennsylvania Court in this case follows what appears to be the unanimous view. The courts are also agreed that where the policy is assigned to a creditor as security for a debt, the beneficiary is entitled to reimbursement out of the insured's estate where her policy proceeds have been depleted by the insured's debt. The exception to this doctrine of subrogation is that the beneficiary will not be entitled to subrogation or reimbursement where it appears that such was not the intent of the insured.

See *TSA* II, 136–37; *TSA* III, 149.

WAR EXCLUSION—UNDECLARED WAR: *Harding v. Pennsylvania Mutual Life Insurance Company*, (Pennsylvania Superior Court, July 17, 1952) 171 Pa.

Super. 236, 90 A.2d 589. The Pennsylvania Mutual issued its policy to Harding one month after hostilities commenced in Korea. The double indemnity provision of the policy excluded from the risks assumed accidental death resulting from "Military, air or naval service in time of war" and the double indemnity portion of the policy also provided for the termination of such accidental death benefit "if the Insured shall at any time, voluntarily or involuntarily, engage in military, air or naval service in time of war."

The insured, then a member of the Pennsylvania National Guard, was inducted into the federal service with his unit on September 5, 1950 and he was killed in a railroad accident on his way to camp about a week later. The Pennsylvania Mutual claimed that the double indemnity provision had terminated because the insured had engaged in the military service in time of war, and refused to pay the double indemnity benefit. The designated beneficiary commenced this action and the trial court agreed with the insurance company, granting judgment only for the face amount after adjustments.

On appeal to the Pennsylvania Superior Court, that Court held that the undeclared war then and now going on in Korea did not constitute "war" within the meaning of the double indemnity termination provision and hence the insurance company was liable for double indemnity. The Court pointed out that other companies in their exclusion clauses use the expression "declared or undeclared war" and that the mere use of the word "war" by the Pennsylvania Mutual created an ambiguity which should be construed in favor of the insured and his beneficiary. The Court in its opinion stated:

> The contract presumably was prepared by competent insurance company attorneys, who, no doubt, were familiar with the most recent decisions relating to war risk provisions in insurance contracts; and if the appellee did not intend to assume risks growing out of hostilities short of war it could have so provided by extending the phrase "in time of war" to include undeclared war.
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> Since "war" is a word which has been held to import various meanings, it is incumbent upon the insurer to make clear that it applies to undeclared war, as well as to declared war, for even if the action in Korea should be held to be war, it is at most an undeclared war. In our opinion the insurer has failed to meet the burden cast upon it. The attempt of the appellee to evade liability of double indemnity should not receive judicial condonation. The phraseology of the policy was chosen by the insurer and tendered in fixed form to the prospective policyholder, and since its language is reasonably open to two constructions, we will adopt that construction which is more favorable to the insured.

In an opinion issued the same day and involving identical policy language and the same insurer the same Court held the insurer liable for double indemnity as well as single indemnity where the insured was killed in action in Korea. The case is *Beley v. Pennsylvania Mutual Life Insurance Company*, 171 Pa. Super. 253, 90 A.2d 597.

AVIATION EXCLUSION—AERONAUTIC FLIGHT: *Aetna Life Insurance Company v. Reed*, (Texas Supreme Court, July 2, 1952) 251 S.W.2d 150. The insured, Reed, was killed in 1948 while riding as a passenger in a private plane. The double indemnity rider of his life policy issued in 1922 excluded death "from an aeronautic flight." Aetna paid the face amount but refused to pay the double indemnity benefit. The beneficiary contended that the aviation exception applied only if the insured were in control of and operating the plane when it crashed.

The Aetna commenced this action for a declaratory judgment construing the language of the double indemnity rider. The trial court and, on appeal, the Court of Civil Appeals held that the exclusion language did not apply to the circumstances of Reed's death and that the beneficiary was entitled to the double indemnity benefit. (The opinion of the Court of Civil Appeals is digested at *TSA* IV, 189–90.)

On further appeal to the Supreme Court of Texas, the judgments below were reversed and judgment entered for the Aetna on the basis that the insured's death did in fact result "from an aeronautic flight" within the meaning of the double indemnity rider. The Court considered but refused to follow the decision of the Court of Appeals of the District of Columbia in the *Clapper* case involving quite similar policy language (see *TASA* XLVII, 421–22). The Court also considered the fact that when the Reed policy was issued two cases had been decided which held that the double indemnity was not payable under exception language admittedly somewhat different; but the Court stated that the principles announced in these two cases were persuasive.

The Reed case is one of the few recent aviation exclusion cases involving policies issued many years ago where the court has been willing to consider and to construe the policy in the light of the case law then existing. In most of such recent cases the courts have given the exception language a meaning which certainly the insurer did not intend.

SETTLEMENT OPTION—TESTAMENTARY DISPOSITION: *Toulouse v. New York Life Insurance Company*, (Washington Supreme Court, May 29, 1952) 245 P.2d 205. On the maturity of his 20-year endowment policy the insured elected to leave the proceeds with the New York Life under the terms of an agreement by which interest was accumulated and on his death the proceeds were payable to designated nieces and a nephew. He reserved the right to make withdrawals at any time without the consent of the nieces and nephew. On the death of the insured his executor claimed the proceeds on the ground that the arrangement was testamentary in nature and, not having been executed with the formality required of wills, was invalid. The nieces and nephew claimed that the arrangement constituted a valid third-party donee-beneficiary contract and not a testamentary disposition.

The trial court and, on appeal, the Supreme Court of Washington (in a 5 to 4 decision) held that the contract was valid, as claimed by the nieces and nephew. The Court based its decision in part on the enactment of a Washington statute

permitting life insurers to hold proceeds under settlement options, stating that this statute implied that contracts such as the one under consideration need not comply with the statute of wills.

The four dissenting justices were of the opinion that the insurance contract ended with its maturity and they likened the arrangement to one where a person deposits money with another, reserving the right to withdraw the money and providing for the balance to be paid to designated parties. Such an arrangement, not involving insurance, clearly would be invalid under Washington law.

The New York Supreme Court (the trial court) held invalid a somewhat similar agreement on the ground that it was testamentary. See *TSA* IV, 188–89. This case is now on appeal. The 1952 New York Legislature passed an act authorizing agreements of this type although not executed with the formalities required of wills.