TRANSACTIONS OF SOCIETY OF ACTUARIES
1951 VOL. 3 NO. 7

LEGAL NOTES

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STATUTORY REGULATION OF INSURANCE—REQUIREMENT THAT CASUALTY INSURER ACCEPT ASSIGNED RISKS: *California State Auto. Ass'n Inter-Insurance Bureau v. Maloney*, (United States Supreme Court, April 23, 1951) 71 S. Ct. 601. The California statute, as amended, provided for a compulsory assigned risk plan, to which the Bureau, an unincorporated insurer, refused to subscribe. Under this plan insurers doing an automobile liability business in California were required to take their share of risks by assignment where the driver could not procure insurance voluntarily. After the Insurance Commissioner revoked the license of the Bureau because of its refusal to subscribe to the assigned risk plan, it commenced an action in the California courts, claiming that the act was unconstitutional in that it violated the Due Process Clause of the Fourteenth Amendment by forcing the insurers into contracts against their will and to assume contracts involving abnormal risks and required the particular company to accept a different class of risk from the accustomed class. The law was upheld against these attacks in the California courts and, on appeal to the United States Supreme Court, the case was affirmed.

In the opinion, Mr. Justice Douglas outlined the wide variety of circumstances under which state regulation of insurance had been upheld against the claim of violation of the Due Process Clause of the Fourteenth Amendment. In its opinion the Court stated:

> Here, as in the banking field, the power of the state is broad enough to take over the whole business, leaving no part for private enterprise. . . .
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> Clearing the highways of irresponsible drivers, devising ways and means for making sure that compensation is awarded the innocent victims, and yet managing a scheme which leaves the highways open for the livelihood of the deserving are problems that have taxed the ingenuity of law makers and administrators. . . .
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> We cannot say California went beyond permissible limits when it made the liability insurance business accept insurable risks which circumstances barred from insurance and hence from the highways. Appellant's business may of course be less prosperous as a result of the regulation. That diminution in value, however, has never mounted to the dignity of a taking in the constitutional sense.

The United States Supreme Court will go far in upholding the power of states to regulate insurance.

ASSIGNMENT TO CREDITOR—EFFECT ON BENEFICIARY'S RIGHT: *Phoenix Mutual Life Insurance Company v. Connelly*, (C.A. 3, April 6, 1951) 188 F. 2d 462.

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The insured reserved the right to effect a change in beneficiary without the consent of the beneficiary. The life policy provided that:

> Rights of Insured. If the right to change the beneficiary has been reserved to the insured, an assignment, release or surrender of this policy or any interest therein by the insured, if of legal age, shall operate to the extent thereof to assign, release or surrender the interest of any and all beneficiaries hereunder.

The insured executed an assignment of the policy as collateral for a loan. The insured's daughter, then named as beneficiary, did not join in this assignment. The insured later substituted his wife as beneficiary.

On the insured's death the loan was unpaid and the assignee-creditor claimed the proceeds. The widow also claimed that she was entitled to the proceeds and the Phoenix Mutual interpleaded the two claimants in the Federal District Court.

The District Court concluded that under the controlling New Jersey law the written assignment executed by the insured alone did not affect the rights of the beneficiary, vested under New Jersey law, but that the assignee acquired nothing more than the interest of the insured in the policy of insurance, which interest terminated on the death of the insured with a beneficiary surviving. On appeal to the Court of Appeals for the Third Circuit, that Court reversed, holding that these New Jersey decisions relative to the effect of an assignment by an insured alone on the rights of the beneficiary would not be applied by the New Jersey courts where there was this clear contract language as to the effect of an assignment. The Court stated:

> The district court was in error, therefore, when it concluded, as a matter of law, that the written assignment upon which the claim of the assignee was based did not affect the vested right of the beneficiary and that by the assignment the assignee acquired nothing more than the interest of the insured in the policy of insurance which was contingent upon his survival of the beneficiary. The assignment did more than pass the interest of the insured. The act of assignment was the exercise of a power reserved to the insured by the terms of the contract to affect both his rights and those of the beneficiary. Both were subordinated to the rights of the assignee.

The Court further held that the New Jersey exemption statute did not prevent the insured from making the policy payable to the creditor, particularly against the claim of a beneficiary who was not such at the time of assignment.

The decision of the District Court did not give effect to the terms of the policy. The decision of the Court of Appeals is sound. The New Jersey view that a revocable beneficiary nevertheless has a "vested" interest is distinctly the minority view.

WAR EXCLUSION—STATUS CLAUSE: *New York Life Insurance Company v. White*, (C.A. 5, July 13, 1951) 190 F. 2d 424. The insured applied for the life policy a few days before she entered the Army Nurse Corps and the policy was issued with a war and aviation rider of the type generally prevailing in World War II, which excluded among other things death of the insured "outside the

Home Areas while the Insured is in the military or naval forces of any country engaged in war." At the time the policy was issued the company was aware of the fact that she intended to enter the Army Nurse Corps shortly thereafter.

The insured met her death on Saipan one year after the policy was issued as a result of an attack by American sailors. The company admitted liability for the reduced amount provided under the war clause in the event of death outside the Home Areas in the military or naval forces but denied that it was liable for the face amount. The beneficiary sued and in the District Court a judgment in favor of the beneficiary was entered for the full amount of the policy on the basis (*a*) that the Army Nurse Corps was not a part of the military forces, (*b*) that the war clause was intended to relate only to risks incidental to military action and that it does not exclude full coverage of death by murder unconnected with military action, and (*c*) that the company by issuing the policy and collecting the premiums with knowledge that the insured was entering the service and was going and did go outside the Home Areas waived the limitation.

The Court of Appeals reversed the District Court, holding that the Army Nurse Corps was part of the military forces, that the clause was a "status" clause, and that the company by its action in continuing to collect premiums had not waived the clause. The Court in its opinion stated:

> Paragraph (1) above quoted is a "status" clause which limits liability by reason of insured's military status and geographical location alone, without reference to the cause of death, or to the activities from which it resulted. In this respect it differs from paragraphs (2), (3), and (4), which are "result" clauses applying to death caused by or resulting from war or aviation activities. If the Army Nurse Corps is a part of the military forces of the United States, the "status" clause (paragraph (1) above quoted), unless waived, would preclude recovery, as the insured at the time of her death was admittedly serving in the Army Nurse Corps outside the Home Areas as defined in the rider. . . .
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> An insurer may be willing to insure the life of a person in the military forces so long as the insured remains in areas distant from actual hostilities, but may be unwilling to assume such risk when the person enters or approaches an actual or potential combat zone. Both the company and the applicant for insurance are free to contract as they please in that respect. In this case, the parties contemplated that the insured would soon enter the military service. The company was willing to insure her for the full amount of the policy so long as she remained in the Home Areas, but not when she left those areas. That was the protection agreed upon.

When it accepted the premium of March 27, 1945, the company knew the insured had departed the Home Areas. But her departure did not *ipso facto* terminate the policy, nor authorize the company to cancel it, as in the *Golden* and *Harmon* cases hereinafter mentioned. Acceptance of the premium continued the policy in effect in accordance with its terms, subject to the limitations of the war clause. This clause does not purport to terminate *all* coverage because of insured's departure from the Home Areas. Notwithstanding such departure, the policy still carries substantial and beneficial coverage which the insured was entitled to retain, and which, so long as the premiums were paid, the company could not cancel. Even while serving in the military forces in time of war *within* the Home Areas, the insured was fully covered, whether death resulted from natural causes or from injuries received in military service within the Home

Areas. Had the insured permanently or intermittently returned to the Home Areas, even though she returned in an uninsurable condition as to new insurance, the policy would have automatically afforded her full coverage while in the Home Areas, except for death resulting from service outside those areas. Meanwhile, other rights created by the policy were unimpaired. The insured accepted the policy with full knowledge of the limitations in the war clause.

This is the usual and the reasonable construction of a "status" clause.

SURRENDER OF CONTRACT—EFFECTIVE DATE: *Fennell v. John Hancock Mutual Life Insurance Company*, (Alabama Supreme Court, June 14, 1951) 53 So. 2d 556. The life policy, issued under date of January 25, 1935, provided that after two full annual premiums had been paid the holder "within thirty-one days after default in the payment of a subsequent premium" might elect in writing to surrender the policy for its cash value. On January 17, 1948, prior to any default, the insured signed an election to surrender the policy for its cash value, which election document stated that the election should not be effective until the instrument was received at the Boston home office but when so received the company's liability under the policy except for the cash value should cease and determine.

The policy and the release were forwarded to Boston on January 17, 1948 and received there January 19. On January 22 the check for the cash value was issued and the policy endorsed as surrendered as of that day. The check was sent through the Birmingham office, where it was received and remailed to the insured, as directed, on January 23. The insured died two days later, apparently without having received the check.

The John Hancock admitted liability for the amount of the cash value but claimed that it was not liable for the face amount because it claimed the policy was effectively surrendered prior to the insured's death. The beneficiary claimed that because the policy was not in default in the payment of premiums the surrender of the policy for cash was not an exercise of the option provided by the terms of the policy but at most was merely an offer for a settlement by mutual agreement, which offer was not accepted by the company prior to the insured's death.

The trial court denied the contention of the plaintiff, granting judgment for the John Hancock. On appeal to the Supreme Court of Alabama, that Court affirmed. The Supreme Court held that the policy provision should be construed as giving to the insured a contract right to surrender the policy even before default. The view of that Court was that the provision quoted above served merely as a limitation within which time the insured must make an election after default in the payment of premiums. The Alabama Supreme Court further held that even if the insured had not had the contract right to surrender the policy, the surrender would have been effective because the company had actually accepted the surrender of the policy and mailed its check in payment in accordance with the insured's instructions prior to his death.

The decisions in other jurisdictions on this point are somewhat in conflict.

DUE DATE OF RENEWAL PREMIUMS: *American National Insurance Company v. Gregg*, (Colorado Supreme Court, April 30, 1951) 231 P. 2d 467. Gregg, the insured, applied for the policy in June 1946. The policy was dated August 9, 1946 and delivered and the first semiannual premium paid September 10, 1946. The policy provided that the policy should not take effect until the first premium was paid. The insured died March 30, 1947, which was within the period covered by the semiannual premium plus the grace period if dated from September 10, 1946 but not from August 9, 1946. The second semiannual premium was not paid.

The beneficiary claimed that she was entitled to six months plus the grace period of coverage from September 10, 1946 because the policy admittedly did not take effect until that date. The insurance company claimed that the policy had lapsed prior to the date of the insured's death and also that even though it had received the net amount due from the agent, the premium had not been paid because the insured only gave his note, which was not paid when due.

The Colorado Supreme Court, relying on prior Colorado cases, held that the period covered by the first semiannual premium commenced September 10, 1946 and not August 9, 1946 and that the policy was in force when the insured died. The court held also that since the company had received the net amount due it, the company could not complain although its agent had not been paid.

Colorado is one of the few states which still adhere to the view that the policy provisions as to the due date of premiums subsequent to the first will not be respected where the result is to give the insured less coverage than he has paid for. Most courts respect the policy provisions as to the effective date of the coverage.

MISREPRESENTATION—INSURER'S DUTY TO INVESTIGATE: *Johnson v. Life Insurance Company of Georgia*, (Florida Supreme Court, May 25, 1951) 52 So. 2d 813. The insured applied for a life insurance policy on the nonmedical basis July 20, 1949 and the policy was issued and delivered shortly thereafter. He died of tuberculosis on March 25, 1950. The insured had been examined by his own physician on the day he applied for the policy. X-rays taken five days later, the day the policy was issued, established that the insured then was suffering from pulmonary tuberculosis. About two months after the policy was issued the company, through its agent, learned that the insured had gone to a tuberculosis sanitarium, but the agent continued to collect premiums from time to time.

On the insured's death the company claimed that the policy was void because of misrepresentations in the application as to the health of the insured at the time of the application, because of breach of the good health clause, and because of a policy provision limiting liability of the company to a return of the premiums in the event the insured had received medical or surgical treatment or attention, not disclosed, within two years from the date of issue of the policy. The beneficiary contended that the company had waived its right to declare the policy void by reason of its action in continuing to collect premiums after knowledge that the insured had gone to a tuberculosis sanitarium shortly after the is-

suance of the policy. The trial court held for the company on the basis of misrepresentation and breach of the policy conditions. However, on appeal, the Supreme Court of Florida reversed, stating that:

> In the instant case, the defendant had knowledge of the fact that the insured was suffering from tuberculosis only two months after the date of the issuance of the policy; and, from the very nature of this disease, the only reasonable inference is that the insured was suffering therefrom on the date of the issuance of the policy. Instead, however, of making the further inquiry dictated by reasonable prudence, the defendant deliberately disregarded this information, and we think it must now be held to be charged with knowledge of the facts which such an inquiry would have disclosed, and upon which defendant now relies as a defense to the payment of the full amount due under the policy.

This case goes quite far in holding that the insurer is under a duty to make inquiry and may not rely on the truth of the statements made to it by the insured in his application.

AVIATION EXCLUSION—PARTICIPATING IN AVIATION OR AERONAUTICS: *Pafford v. Standard Life Insurance Company of Indiana*, (Florida Supreme Court, June 8, 1951) 52 So. 2d 910. The double indemnity provision of the life policy excluded death resulting "from bodily injuries sustained while participating in aviation or aeronautics." The insured, Pafford, was killed in an accidental crash of a regularly scheduled commercial airline carrier. The company admitted liability for and paid the regular death benefit, but refused to pay the double indemnity benefit. The beneficiary sued for double indemnity and the trial court, on the basis of prior Florida cases, held that such benefit was not under the circumstances payable.

The beneficiary appealed to the Florida Supreme Court, claiming that the Florida cases denying recovery should be overruled because of advance and new developments in aviation and because other jurisdictions have held that fare-paying passengers on commercial airlines are not participants in aviation or aeronautics. The Florida Supreme Court affirmed the judgment for the insurance company, stating that when the meaning of a contract is well settled the court is not at liberty to modify it by interpretation though it may modify judge-made rules for better conformity with justice.

The Florida cases which the Court refused to disturb were relatively old cases. The recent trend has undoubtedly been towards holding the company liable where the insured dies in a commercial airline crash while riding as a passenger and the exclusion language is "death resulting from engaging or participating in aeronautics." The courts also have been inclined to disavow an earlier distinction between "engaging" and "participating." Under this earlier view "participating" was regarded as somewhat more restrictive than "engaging."

PREMIUM TAXES—DISCOUNT FOR DIRECT PAYMENT: *Commissioner of Corporations & Taxation v. Metropolitan Life Insurance Company*, (Massachusetts Su-

preme Judicial Court, July 3, 1951) 99 N.E. 2d 866. The Massachusetts tax statute applicable to the Metropolitan imposed a two percent premium tax but provided for the deduction of "all premiums returned to policyholders" and "dividends which during said year have been paid or credited to policyholders or applied to purchase additional insurance or to shorten the premium paying period." The Metropolitan issued industrial weekly premium policies providing for a 10 percent refund for direct payment of such premiums to a company office.

The Massachusetts Commissioner of Corporations and Taxation claimed that Metropolitan was not entitled to deduct such refunds made by it and accordingly assessed Metropolitan for the additional tax. Metropolitan, claiming that the refunds represented "premiums returned to policyholders" within the meaning of the statute, appealed to the Appellate Tax Board. The Board abated the tax and, on further appeal, the Massachusetts Supreme Judicial Court affirmed the decision in favor of Metropolitan, stating:

> We think that the sums repaid to policyholders under the provision in the policies for "Refund on Direct Payment of Premiums" were "Premiums returned" within the meaning of those words in the deduction provisions of G.L. (Ter. Ed.) c. 63, § 20, as appearing in St. 1943, c. 531, § 1. We must assume that the policies were issued in accordance with the elaborate precautions contained in G.L. (Ter. Ed.) c. 175, designed to secure sound policies as well as good faith and fair dealing with the policyholders. It is evident that the policies must have been calculated on the theory that the full premium would be required, and in fact the policyholders did pay the full premium. After the actual experience of a year demonstrated that no expense had been incurred for collectors, and that ten per cent of the premiums had not been needed to carry the policies and could safely be released, that proportion of the premiums paid was actually returned to the policyholders. A statute that permits a deduction for dividends ought consistently to permit a deduction for payments returned in this manner.
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> The commissioner's theory that the policyholder has simply been paid a sum of money for helping out the company by reducing its expenses is not an adequate analysis of the situation. The facts are that the policyholder has paid a premium for a policy and under the terms of the policy has got part of the premium back again, because of a reduction in the cost of carrying the policy. It seems to us that on principle this is just as truly a premium returned as is the repayment of part or all of a premium after the cost of carrying the policy has been reduced by cessation or reduction of the risk through cancellation, or by any of the other more conventional means resulting in what is commonly called a return premium. In either event the policyholder properly gets the benefit of a lessening of the burden which the company originally assumed and for which the policyholder originally paid.

INSURABLE INTEREST—ASSIGNMENT TO ONE WITHOUT SUCH INTEREST: *Butterworth v. Mississippi Valley Trust Company*, (Missouri Supreme Court, June 11, 1951) 240 S.W. 2d 676. The insured, Butterworth, assigned his $100,000 life policy absolutely to his creditor and business associate, Tarlton, who thereafter paid all premiums and later assigned the policy to the Tarlton Trust. After Tarlton's death Butterworth assigned his interest in the policy to the Butter-

worth Trust. On the insured's death the trustees of the Butterworth Trust commenced an action for an accounting, claiming that the entire interest in the policy was not legally conveyed to the Tarlton Trust. The principal basis of the contention was that the Tarlton Trust, the assignee of Tarlton, had no insurable interest in the life of Butterworth and that in the accounting the Trust should not even be credited with the $57,955 paid as premiums by Tarlton and by the Trust.

The trial court dismissed the action, holding that the Tarlton Trust was entitled to the proceeds and, on appeal, this judgment was affirmed. The Missouri Supreme Court examined the Missouri cases, in some of which it appeared that an assignment to one without an insurable interest, even though in good faith and not a cloak for a wager, was invalid. The Supreme Court of Missouri held that such an assignment was valid, that Court stating:

> The contract of insurance is before us. It is not a contract of indemnity for actual loss. It is but a definite promise to pay a certain definite sum on the happening of a future event. Here Butterworth alone and in good faith negotiated the contract with the insurer. It was his personal property. He had a right to have Tarlton made the beneficiary, as creditor. He had a right to assign, sell or give it to Tarlton as he could any other personal property. Butterworth had good reasons for desiring to dispose of it. The policy was at least a portion of the consideration whereby he discharged his indebtedness to Tarlton. Butterworth had a right to so use it. He could do what he pleased with his own and, too, Tarlton had an insurable interest in Butterworth. Could Tarlton lawfully assign the policy to Tarlton Trust? It is our conclusion that he could.

There are now few states which require that the assignee of a life policy have an insurable interest where the transaction is not a cloak for a wager.

GROUP INSURANCE—ISSUANCE OF INDIVIDUAL POLICIES UNDER BLANKET ARRANGEMENT: *Board of Insurance Commissioners v. Great Southern Life Insurance Company*, (Texas Supreme Court, May 2, 1951) 239 S.W. 2d 803. The Great Southern Life Insurance Company entered into an arrangement with Houston Bank & Trust Company, Trustee for Texas Bankers Association, which arrangement was designed to provide insurance coverage for member banks of the Association. The arrangement contemplated the issuance of individual policies without medical or other selection up to certain limits with certain underwriting safeguards, including the requirement that there be at least 500 lives or $1,000,000 of insurance coverage by December 31, 1948 and that there be at least 80 percent of the employees of each bank covered. A retirement plan had been set up in conjunction with this arrangement for insurance.

The Life Insurance Commissioner of Texas claimed that the policies were issued in violation of the group insurance law. Thereafter the Great Southern declined to write policies covering new employees. The Trustee then instituted this action against Great Southern and the Board of Insurance Commissioners, seeking a declaratory judgment as to its powers, responsibilities, duties and liability in connection with the insurance.

The trial court held that the policies issued to employees of banks having less than 25 employees were issued in violation of the Texas group life law, but that where the employer had more than 25 employees the insurance was valid. On appeal by both parties, the Court of Civil Appeals held that there was no violation of Texas law in connection with issuance of the policies.

On further appeal, the Texas Supreme Court reversed, holding that the arrangement violated the provision of the Texas group life statute, which stated that "except as may be provided in this Act, it shall be unlawful to make a contract of life insurance covering a group in this State." The Court held that the letter of the insurance company setting out the arrangement was part of the contract, that the effect was to issue group insurance contrary to the statute, and that the group statute was valid and constitutional.