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LEGAL NOTES

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DOING BUSINESS BY MAIL—SERVICE OF PROCESS: *Travelers Health Association v. Virginia*, (United States Supreme Court, June 5, 1950) 339 U.S. 643. The Travelers Health Association, a Nebraska nonprofit membership association with its only office in Omaha, conducted a mail-order health insurance business. New members paid an initiation fee and assessments as levied. The funds so collected were used for operating expenses and for the payment of sick benefits to members. The Association had no paid agents, its new members being obtained through the unpaid activities of old members who were encouraged to recommend the Association to friends and submit their names to the home office.

The Travelers Health Association had about 800 Virginia members, all solicited by mail. The Association caused claims for losses to be investigated in Virginia and the Virginia courts admittedly were available to the Association.

The Virginia Corporation Commission commenced an action against the Association to force it to cease and desist from the further solicitation or sale of certificates to Virginia residents. Service was had on the Association by registered letter addressed to Omaha, Nebraska. The Association made a special appearance, claiming that Virginia had no jurisdiction over it. The Commission held that it did have jurisdiction and ordered the Association to cease and desist from further sales of certificates to Virginia residents until it had complied with the Virginia "Blue Sky Law," which required the Association to obtain a permit from the State Corporation Commission and in connection with this permit to file detailed information concerning solvency and to agree that suits against the Association might be brought in Virginia. The order of the State Corporation Commission was affirmed on appeal by the Virginia Court of Appeals and a further appeal was taken to the United States Supreme Court on the contention that the Virginia law as construed violated Constitutional requirements of due process of law.

The United States Supreme Court affirmed the Virginia decision by a 5 to 4 vote. The Court in the majority opinion reviewed prior Supreme Court decisions, stating:

> Measured by the principles of the *Osborn*, *Hoopeston* and *International Shoe* cases, the contacts and ties of appellants with Virginia residents, together with that state's interest in faithful observance of the certificate obligations, justify subjecting appellants to cease-and-desist proceedings under § 6. The Association did not engage in mere isolated or short-lived transactions. Its insurance certificates, systematically and widely

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delivered in Virginia following solicitation based on recommendations of Virginians, create continuing obligations between the Association and each of the many certificate holders in the state. Appellants have caused claims for losses to be investigated and the Virginia courts were available to them in seeking to enforce obligations created by the group of certificates. See *International Shoe Co.* v. *Washington, supra,* at 320.

Moreover, if Virginia is without power to require this Association to accept service of process on the Secretary of the Commonwealth, the only forum for injured certificate holders might be Nebraska. Health benefit claims are seldom so large that Virginia policyholders could afford the expense and trouble of a Nebraska law suit. In addition, suits on alleged losses can be more conveniently tried in Virginia where witnesses would most likely live and where claims for losses would presumably be investigated.

Mr. Justice Douglas concurred in the majority opinion but wrote a separate opinion predicated largely on the basis that the Association was in fact doing business in Virginia. Mr. Justice Douglas stated:

A state is helpless when the out-of-state company operates beyond the borders, establishes no office in the state, and has no agents, salesmen, or solicitors to obtain business for it within the state. Then it is beyond the reach of process. In the present case, however, that is only the formal arrangement. The actual arrangement shows a method of soliciting business within Virginia as active, continuous, and methodical as it would be if regular agents or solicitors were employed. Cf. *Hoopeston Co.* v. *Cullen,* 318 U.S. 313.

Practically all of appellant's business in Virginia originates with and is the result of the activities of its Virginia members. The recommendation of a member relieves an applicant of the duty of furnishing any reference. Though the old members are not designated as "agents," it "clearly appears," as stated by the Supreme Court of Appeals, "that the association relies almost exclusively on these activities of its Virginia members to bring about an expansion of its Virginia business." *Travelers Health Assn.* v. *Virginia,* 188 Va. 877, 887; 51 S.E. 2d 263, 267. This device for soliciting business in Virginia may be unconventional and unorthodox; but it operates functionally precisely as though appellant had formally designated the Virginia members as its agents. Through these people appellant has realistically entered the state, looking for and obtaining business. Whether such solicitation is isolated or continuous, it is activity which Virginia can regulate.

The four dissenting Justices were of the opinion that Virginia did not have the authority under applicable United States Supreme Court decisions construing the Constitutional provision to thus proceed against the Association.

This decision, if adhered to, is of extreme importance to companies which operate largely on a mail-order basis. It would appear from this decision that the United States Supreme Court will uphold the Unauthorized Insurers Service of Process Act drafted by the All-Industry Committee and already enacted in many states.

AVIATION EXCLUSION—FAILURE OF INSURED TO SIGN RESTRICTIVE RIDER: *McDaniel v. California-Western States Life Insurance Company,* (C.A. 5, May 2, 1950) 181 F. 2d 606. Smith, an Aviation Machinist Mate in the Navy, applied in 1947 for a life policy with Family Income Rider attached. Because of the

aviation hazard to which he was subject, the insurance company placed in the policy a rider excluding death "as a result of travel or flight in or upon any kind of aircraft, or from falling or otherwise descending therefrom or therewith during said travel or flight." The insured signed one copy of this rider, which was returned to the insurance company, but failed to sign the copy of the rider included in the policy.

While riding in a Navy plane along with other Navy personnel the plane crashed at sea and disintegrated. There were no eyewitnesses and no survivors.

The insurance company admitted liability for the limited benefit provided under the aviation rider but denied that it was liable for the full amount. The beneficiary sued for the full amount, her principal contention being that the aviation rider was not legally a part of the policy because it was not signed. She also contended that there was no clear evidence that the insured died as a result of travel or flight in an aircraft and therefore the exclusion, even if valid, did not apply. The United States District Court and, on appeal, the United States Court of Appeals held that the aviation exclusion rider was a valid part of the policy contract even though the insured did not sign it and that the insured clearly met his death within its terms.

The United States Supreme Court refused to review this decision, denying certiorari October 9, 1950. 71 S.Ct. 56.

WAR RIDER—WAIVER BY ACCEPTANCE OF PREMIUMS: *White v. New York Life Insurance Company*, (D.C. Georgia, Feb. 14, 1950) 91 F. Supp. 125. In April 1944 New York Life issued its $5,000 policy to the insured who was entering the Army Nurse Corps. The policy contained a war and aviation rider of the "status" type which provided for the return of premiums with interest if the insured died from any cause outside the Home Area while in the military or naval service. The New York Life, with knowledge that the insured was outside the Home Area as defined, continued to collect premiums until the insured's death.

In April 1945 the insured was killed while on Saipan Island and the beneficiary contended that by continuing to collect premiums after the insured left the Home Area as defined and with knowledge of this fact, the New York Life had waived the policy restriction. The United States District Court in this case agreed with this contention and granted judgment to the beneficiary for the face amount of the policy plus interest, but denied the beneficiary's claim to attorney's fees in addition on the ground that "the question of liability is a close one as the case presents complex questions of law not heretofore passed on so far as the Court is advised."

This decision clearly is unsound and should be reversed on appeal. The doctrine of waiver or estoppel has no proper application to a situation such as this where the policy does provide some coverage while the insured is without the Home Area, even though this coverage be rather limited. This case illustrates the point that courts are prone to find some way to avoid the effects of war restrictions if they can do so without doing too much violence to established law.

MISREPRESENTATION IN APPLICATION—MINORS—BINDING EFFECT: *Modern Woodmen of America v. Stevens*, (Arizona Supreme Court, June 19, 1950) 219 P. 2d 322. The insured had been issued a certificate by the Modern Woodmen of America, in the amount of $500, when he was about one year of age. The society's regulations required minors to transfer to the adult age group upon reaching 16. The insured upon reaching that age applied for the transfer and in his application for an increased amount of coverage misrepresented the state of his health. The society, relying on his answers, issued a certificate in the amount of $2,000. Upon the insured's death the claim was presented and the society, having discovered the misrepresentation, tendered the amount of the junior certificate plus premiums paid since the transfer.

In this suit brought on the senior certificate the beneficiary contended that the insured's misrepresentations and warranties of good health, being those of a minor, were not binding upon him or his beneficiary. In rejecting this argument and finding for defendant society, the court said:

> We have considered the cases cited by plaintiff in support of her position. . . . We are not impressed with the soundness of these decisions and refuse to follow them. It appears to us that if a minor makes express warranties in a contract upon which the other contracting party relies and which materially affect the acceptance of the risk or the hazard assumed by it if the minor attempts to enforce the contract he must stand upon it in its entirety and is in no better position than an adult would be under similar circumstances. The law relating to the enforceability of contracts with minors has been evolved for his protection and not as an instrument through which he may defraud others.

Rhode Island still adheres to the view that a life policy may not be avoided for misrepresentation, fraud or breach of warranty where the applicant is a minor.

DISABILITY BENEFITS—INSANITY AS EXCUSING NOTICE: *Chagnon v. Metropolitan Life Insurance Company*, (New Hampshire Supreme Court, July 6, 1950) 75 A. 2d 167. The two life policies contained disability provisions which provided for waiver of premium and monthly income in the event the insured became disabled as defined. The contracts further provided that waiver of premium and payment of monthly income should not begin "more than six months prior to the date of receipt of the required proof." Proof of claim was filed June 10, 1948, it being alleged that the disability commenced October 9, 1938.

The Metropolitan claimed that by the terms of its contract it was not liable for benefits prior to December 10, 1947, which was six months before the date the proofs of claim were filed. The conservator of the insured claimed that since the basis of the disability was mental incompetence, the Metropolitan should be required to pay benefits just as if proper notice and proofs had been submitted and to return the premiums which had been paid during the period when benefits would have been allowed had due notice and proofs been given.

The conservator brought an action against the Metropolitan for the back

disability payments and the premiums paid during disability. The jury found that the insured did become disabled on October 9, 1938 and not in 1945, as contended by the Metropolitan. The trial court, however, allowed benefits only from the date of filing the proof of claim.

On appeal, the New Hampshire Supreme Court affirmed the judgment below, stating that it would follow that line of cases which held that insanity or mental incompetence of the insured would excuse the lack of or delay in notice or proof of disability. The New Hampshire Supreme Court also denied the claim of the Metropolitan that the action should have been brought by the named beneficiary rather than by the conservator. The Metropolitan's contention was that since the policy provided that income payments would be paid to the beneficiary in lieu of the insured in the event of insanity, the beneficiary was the proper party to sue. The Court's view was that since the company had not made the payment to the beneficiary on record, the conservator could sue, drawing an analogy to the facility of payment clause of an industrial policy.

There is, as the Court indicated, a sharp split in the authorities as to whether insanity excuses notice and proof which is required by the terms of the policy.

AGENTS' COMPENSATION—AMOUNT NOT AGREED TO IN ADVANCE: *Metropolitan Life Insurance Company v. Durkin*, (New York Court of Appeals, July 11, 1950) 93 N.E. 2d 897. A union was certified as collective bargaining agent for Metropolitan industrial agents in New York City and nearby communities. A dispute arose as to compensation and in October 1942 the dispute was certified to the National War Labor Board. In September 1943 the Regional War Labor Board ordered an increase in compensation of $2.85 per week, retroactive to October 24, 1942, the date the dispute was certified to the Board. On appeal to the National War Labor Board, the Regional Board's determination, including the retroactivity question, was affirmed.

The Metropolitan contended that the retroactive feature of the award was contrary to Section 213-a, which prohibits the payment of compensation to an industrial agent "greater than that which has been determined by agreement made in advance of the rendering of such service." After depositing the amount in dispute less withholding taxes in escrow, Metropolitan commenced this action for a declaratory judgment as to whether the order requiring the retroactive pay increase was consistent with the New York statute in question. The trial court and, on appeal, the Appellate Division held that the order requiring the retroactive pay increase did not violate the New York statute. On further appeal, the New York Court of Appeals affirmed the judgments below, stating that the Legislature did not intend the statute in question to apply to a situation such as was presented. The Court in its majority opinion stated that the plain purpose of the statute was to put an end to excessive and ex post facto rewards and that it had no objective in any way relevant to the situation presented.

Judge Conway, an ex-Superintendent of Insurance of New York, wrote a

long dissenting opinion which was joined in by Judge Lewis. This dissenting opinion reviewed in much detail the Armstrong Committee testimony concerning the acquisition cost of life insurance and the history of the enactment of Section 213 in 1906 and of 213-a in 1940. The dissenting Judges were of the opinion that the award was improper and contrary to the statute.

GOVERNMENT ALLOTMENT—PAYMENT OF PREMIUMS IN ERROR: *Atlas Life Insurance Company v. Davis*, (Oklahoma Supreme Court, Oct. 3, 1950) —— P. 2d ——. The insured arranged for the Government to pay his insurance premium by deduction from sums due him. However, in September 1941 the insured notified the military authorities of his election to withdraw his allotment. The Government continued to pay the premiums on the policy after the cancellation of the allotment and after the insured terminated his military service.

Upon the insured's death in January 1947 the company contended that although all premiums had been paid they were paid by the Government in error and that the policy was not in force.

The trial court and, on appeal, the Supreme Court of Oklahoma held that from the insurer's point of view it is immaterial who pays the premiums and that payment by a third party—in this instance the Government—was sufficient to continue the policy in full force and effect. The Oklahoma Supreme Court held that a provision in the federal statutes permitting the Government to recover erroneous payments and to enforce a lien on the policy did not alter the situation.

EFFECTIVE DATE—SUBSTANDARD INSURANCE: *Republic National Life Insurance Company v. Hall* (Supreme Court of Texas, June 28, 1950) 232 S.W. 2d 697. Hall applied for a $20,000 20-payment life policy in the latter part of March 1949. He was a private pilot and in addition was somewhat overweight, so it was understood that there would be an extra premium in some amount for the full coverage policy applied for. At the time he applied for the policy he signed in blank a salary deduction order authorizing the deduction from his pay of the necessary monthly premium. The application form provided that the acceptance of any policy issued should constitute a ratification of any correction or addition to the application made by the company.

The Republic National determined that the premium on account of the special aviation hazard should be $100 per year and that the policy should be issued on the basis of rated age 44 instead of true age 36, which produced in total an increase of about $140 a year above the normal premium. This premium was endorsed by the company on the application.

The policy was issued in due course and sent to the agent who received it on Saturday, April 9th. Hall was killed in an airplane accident the next day in Wyoming without having seen the policy.

Republic National insisted that it was not liable under the contract because there had been no agreement as to the premium rate, which was an essential term. The beneficiary contended that the policy was in force in view of the un-

derstanding on the part of all concerned that the premium would be higher than normal because of the aviation hazard and also because of the overweight. The trial court agreed with the beneficiary and granted judgment for the face amount, which judgment was affirmed on appeal by the Texas Court of Civil Appeals except as to an allowance for statutory attorney's fees.

On further appeal to the Supreme Court of Texas, that court held that the policy was not in force at the time of the insured's death because there had been no agreement as to the rate of premium, which is an essential element in a life insurance contract. The court distinguished between contracts of life insurance where rates are not fixed by the state and where the contract does not contemplate insurance for emergency or temporary purposes. The Supreme Court of Texas, in reversing the decisions below, stated:

> Viewing the instant controversy in a somewhat different way, Mr. Hall's application amounted to no more than an invitation for an offer, not only by its mere failure to state a premium, but also by its express language aforementioned to the effect that any "Home Office Corrections or Additions," for which the application provided a space, would not be binding upon Mr. Hall unless he accepted the policy. Similar provisions have been applied so that, where the insurer proceeds to issue a policy with a premium higher than that applied for, and the policy is accepted, the premium obligation of the insured dates only from the acceptance, and the accrual of later premiums is postponed accordingly, regardless of the date of the policy. See *Haynes* v. *Midland Nat. Life Ins. Co.*, 60 S.D. 212, 244 N.W. 110. Here Mr. Hall, omitting to give a premium figure in his application, necessarily contemplated that a figure would be tendered by the home office by way of an "addition," which would become binding upon him when, but only when, he accepted the policy. He never accepted the policy because he did not live to know it had been issued.