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LEGAL NOTES

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BANKRUPTCY—POLICY LOANS MADE AFTER APPOINTMENT OF TRUSTEE: *Lake v. New York Life Insurance Company* (C.A. 4, January 5, 1955) 218 F.2d 394. The insured was declared bankrupt and thereafter the New York Life and four other insurance companies, without knowledge of his bankruptcy or the fact that a trustee had taken possession of his known assets, made policy loans to him substantial in amount. He denied that any bankruptcy proceedings were pending against him in several of his policy loan applications. The trustee, thereafter learning of the policy loans, sued to recover the surrender value of the policies as of the date of the filing of the bankruptcy petition without any credit to the companies on account of the loans thereafter made.

The United States District Court held in favor of the companies on the basis that a 1938 amendment to the Bankruptcy Act had not withdrawn the protection which a person acting in good faith and without knowledge of the bankruptcy had up to that date. For a digest of the District Court's opinion see *TSA* VI, 609–610.

On further appeal, the United States Court of Appeals for the Fourth Circuit reversed, holding that the 1938 amendment had in fact withdrawn the protection afforded an innocent person and that the loans fell outside the class of protected transactions. The Court held that the 1938 amendment did apply to life insurance and did in effect overrule a United States Supreme Court decision favorable to the position of the companies, stating:

> The present case falls outside the class of protected transactions because the loans on the security of the policies were made after August 6th, when the petition in bankruptcy was filed, and after August 9th, when the receiver took possession of all the known assets of the bankrupt. Therefore by the express terms of the introductory words of subsection d and by the language of paragraph (4) thereof, the transactions were not covered; but they were within the terms of paragraph (5) which invalidates transfers by or to the bankrupt after the date of bankruptcy.
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> We cannot accept the argument advanced by the companies that subsection d has no application to life insurance because the decision in the Frederick case was not specifically overruled by Congress. That decision belongs to the period when the courts in the absence of a clear mandate of Congress were endeavoring to work out a guiding rule under the facts of the cases as they arose; but that mandate has now been laid down and the Frederick case may no longer be accepted as a governing authority.

The effect of this decision is serious because there appears to be no practical way for a life insurance company to check the bankruptcy records in every case

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where an application for a loan or for the surrender of a nonexempt policy is made. The United States Supreme Court refused to disturb this decision and remedial legislation is now pending in Congress.

SETTLEMENT OPTION—TESTAMENTARY DISPOSITION: *Wilhoit v. Peoples Life Insurance Company* (C.A. 7, February 2, 1955) 218 F.2d 887. On the insured's death his widow, the named beneficiary, received the proceeds. About three weeks thereafter she entered into a deposit agreement with the company which was somewhat different in its terms from any settlement option in the policy. Under the terms of the deposit agreement the money was left at interest with the right of full withdrawal and with the proviso that any sums remaining at her death should be paid to her brother.

In her will the beneficiary bequeathed the insurance proceeds, still on deposit, to a son of her stepson. The brother named in the deposit agreement had predeceased her. On the death of the widow the proceeds were claimed by the person designated in the will and by the estate of the deceased brother.

The District Court, and on appeal the Court of Appeals for the Seventh Circuit, held that the agreement was invalid as testamentary in character and that the person named in the will was entitled to the proceeds, the Court, Major, C.J., stating:

> Irrespective of whether the agreement in the instant case be characterized as an assignment, a contract for the benefit of a third party or an attempted gift *causa mortis*, no reason is discernible why any different rule of law should be applied. Mrs. Wilhoit deposited her money with the company, which obligated itself to pay interest and return the principal to her on demand. Only "in the event of her death" was the deposit, if it still remained, payable to Robert G. Owens. If Mrs. Wilhoit had deposited her money with a bank rather than with the insurance company under the same form of agreement, we think that it would have constituted an ineffectual disposition because of failure to comply with the Indiana statute of wills.

REPRESENTATIONS OF INSURED—BINDING EFFECT ON PARTNER-BENEFICIARY: *Byrnes v. Mutual Life Insurance Company* (C.A. 9, December 6, 1954) 217 F.2d 497. On July 1, 1947, the insured applied for two $50,000 life policies, one payable to his wife and one payable to his business partner, who paid the premium on this second policy. The insured failed to disclose certain serious ailments requiring hospitalization, and on his death shortly after the policies were issued the Mutual Life claimed that its policies were voidable and tendered the refund of the premiums.

The widow sued under her policy and received a jury's verdict and judgment in her favor below, which the Court of Appeals reversed on the basis that the trial judge should have set aside the verdict in the widow's favor.

In this action by the partner, Byrnes, he claimed that since he paid the premium he was not bound by the representations of the insured. The Mutual Life asked for a summary judgment without a trial, and the District Court in this

case did grant the summary judgment. The partner, Byrnes, appealed from this judgment and, on appeal, the Court of Appeals affirmed, stating:

> We cannot see how the payment of the premium on a life insurance policy by a person who is beneficiary can, in the absence of a specific contract, different from the policy entered into by the insured, give rise to any right superior to those of the insured who applies for the policy. We cannot see how the beneficiary who chooses to pay the premiums and does not enter into a special contract has greater rights than the wife, who in addition to her community property rights, has a greater interest in the life of the husband than a business partner.
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> Human life is whole and indivisible and to hold that a third person, by merely paying the premium acquires a right to have the insurance company deal with him on a separate, independent basis under penalty of not being bound by the misrepresentations of the insured is to introduce an uncertain and speculative element into the field of life insurance, which would be dangerous indeed. For the insured, by connivance with the person who pays his premium, could secure unbreakable policies in the face of the most palpable fraud. We do not think that the law of Arizona would sanction a plan fraught with such danger.

BINDING PREMIUM—EFFECTIVE DATE OF COVERAGE: *Ransom v. Penn Mutual Life Insurance Company* (California Supreme Court, October 8, 1954) 274 P.2d 633. The applicant, Ransom, applied for a life policy and was examined by the company's doctor. He paid the full first premium. The application under such circumstances provided that the insurance should take effect from the date of the medical examination "provided the Company shall be satisfied that the Proposed Insured was at that time acceptable under the Company's rules for insurance upon the plan at the rate of premium and for the amount applied for,..."

The application disclosed a visit to the family physician. The physician on inquiry said that Ransom had complained of a heavy feeling in the chest and that laboratory studies, including an electrocardiogram, were essentially normal. The company requested Ransom to submit to further medical examination, but he was killed in an automobile accident before this could be done. The Penn Mutual then tendered a return of the binding premium, claiming there was no coverage.

The beneficiary sued and the trial court, the Court of Appeals and the California Supreme Court all found in her favor. The beneficiary's contention was that a contract of insurance arose immediately on receipt by the company of a completed application and the premium payment, subject to the right of the company to terminate the agreement if it subsequently concluded that Ransom was not acceptable. The Penn Mutual contended that its satisfaction as to Ransom's acceptability for insurance was a condition precedent to the existence of any coverage, and that it was not so satisfied. The company also argued without success that because of the high blood pressure readings Ransom was unacceptable, that the receipt form attached to the application was not used as re-

quired and that there was misrepresentation about high blood pressure and about the fact that the electrocardiogram was taken.

The California Supreme Court in its opinion, Gibson, C. J., stated:

We are of the view that a contract of insurance arose upon defendant's receipt of the completed application and the first premium payment. The clause quoted above is subject to the interpretation that the applicant is offered a choice of either paying his first premium when he signs the application, in which event "the insurance shall be in force . . . from the date . . . of the application," or of paying upon receipt of the policy, in which event "no insurance shall be in force until . . . the policy is delivered." The understanding of an ordinary person is the standard which must be used in construing the contract, and such a person upon reading the application would believe that he would secure the benefit of immediate coverage by paying the premium in advance of delivery of the policy. There is an obvious advantage to the company in obtaining payment of the premium when the application is made, and it would be unconscionable to permit the company, after using language to induce payment of the premium at that time, to escape the obligation which an ordinary applicant would reasonably believe had been undertaken by the insurer. Moreover, defendant drafted the clause, and had it wished to make clear that its satisfaction was a condition precedent to a contract, it could easily have done so by using unequivocal terms. While some of the language tends to support the company's position, it does not more than produce an ambiguity, and the ambiguity must be resolved against defendant.

This decision seems to be subject to fair criticism that the court is not enforcing the contract which the parties have entered into but is, rather, making a new contract for them.

GOOD HEALTH—CONDITION PRECEDENT—APPLICANT'S GOOD FAITH AND LACK OF KNOWLEDGE OF BAD HEALTH: *Brubaker v. Beneficial Standard Life Insurance Company* (California District Court of Appeal, Jan. 24, 1955) 278 P.2d 966.The applicant, Brubaker, admittedly was suffering from cancer when he signed Part I of his application for a life policy on March 14, when he signed Part II on March 25 and when the policy was delivered to him April 11. He died November 4. The application for the policy provided "that any policy issued shall not take effect unless and until the first premium has been paid and the policy delivered to me during my good health. . . ."

After the insured's death the company tendered to the beneficiary the premiums paid, denying that it was liable otherwise under the policy. The beneficiary brought this action for the $7,000 face amount and the trial court rendered judgment in her favor. On appeal to this intermediate California state court, the Court affirmed this judgment in favor of the beneficiary after reviewing cases from other jurisdictions and finding a difference of opinion as to whether the actual good health controls or whether the condition precedent as to good health should be construed as relating primarily to change in health between the date of the application and the date the policy is stated to become effective by its delivery and the payment of the first premium.

In its opinion adopting the second view, the Court stated:

It seems to this Court that to follow the harsh Massachusetts rule would leave a gap in time in every life insurance policy, in which the beneficiaries would not be protected with insurance. For even though the premiums for the policies had been paid, even though the insured had complied with every covenant binding upon him in the insurance contract, the policies would be void because lurking undetected within his body was some disease which would kill him sometime.

It seems to this Court that it would be wrong to allow this difficult and sometimes perplexing question of fact to be at large in the contract of life insurance, and to subject beneficiaries to the delay, expense, and uncertainties of determining that fact in legal proceedings. It seems to this Court that in the interest of justice a time should be fixed and certain beyond which that fact shall not be at large, unless fraud or misrepresentation, or some other lawful defense, be present.

POLICY LOAN—EFFECTIVE DATE OF TRANSACTION: *Langley v. New York Life Insurance Company* (Kentucky Court of Appeals, December 10, 1954) 273 S.W.2d 567. The beneficiary paid the premium for the single premium life contract and by endorsement the contract provided that she should have the right without the insured's consent to exercise every option, enjoy every privilege and receive every benefit conferred by the policy. The insured later was confined to a state hospital on account of mental illness and the beneficiary, then seriously ill, desired to retrieve her investment in the policy for her own estate. She attempted to surrender the policy for its cash value, but was told she could not do so because of a policy requirement that a surrender must be made within 30 days of the anniversary date. Thereafter, she applied for a loan and after some delay due to the loss of her application a check representing the loan value was issued payable to her order. She died just before it was delivered. Her executor thereafter with the consent of the company cashed the check and distributed the proceeds as part of the beneficiary's estate.

Three years later the insured brought this action for the cancellation of the encumbrance on the policy represented by the policy loan, claiming that the transaction was not complete prior to the beneficiary's death and that on her death all of her rights under the policy ceased and reverted to him. The lower court and, on appeal, the Kentucky Court of Appeals held that all essentials of the loan agreement were completed before the beneficiary's death and that all that remained to be done was the physical placing of the check in her hands. The Court stated that the beneficiary had accepted the policy loan option prior to her death and a binding loan contract then came into existence.

EXTENDED INSURANCE—DATE OF COMMENCEMENT: *Myles v. National Life and Accident Insurance Company* (Mississippi Supreme Court, February 14, 1955) 77 So.2d 815. The industrial life policy, consistent with Mississippi law, provided specifically that the term of extended insurance should commence "on" the due date of the first premium in default. The insured defaulted in the payment of a weekly premium under his policy and died about three years later. If the extended insurance were considered as commencing with the due date of the first premium in default, such coverage expired the day before his death. If, on

the other hand, the due date of such premium were eliminated and the extended insurance commenced as of the following day, there was coverage.

The trial court, and on appeal the Mississippi Supreme Court, held that the policy provision was not ambiguous and was valid and that the insurance expired the day before the insured died. The Court considered also and rejected the contention that the extended insurance should not commence until the end of the grace period for the payment of premiums.

JUDICIAL REVIEW OF INSURANCE SUPERINTENDENT'S DECISION—LOCATION OF HOME OFFICE: *Guardian Life Insurance Company v. Bohlinger* (New York Court of Appeals, December 31, 1954) 124 N.E.2d 110. The Guardian Life purchased property in Westchester County as an investment and under a section of the New York Insurance Law not requiring the Superintendent's approval of the purchase. Thereafter the company decided it would like to use this property for home office purposes. The New York Insurance Law requires the approval of the Superintendent to the purchase of property to be used for home office purposes. Superintendent of Insurance Bohlinger, after a hearing, disapproved the company's petition to use the property for home office purposes, stating that the property was not "requisite for its convenient accommodation in the transaction of its business."

The Guardian appealed to the court from this decision of the Superintendent of Insurance. On this appeal, the trial court upheld the Superintendent on the basis that his decision was adequately supported by the record. That court refused to decide whether his action was subject to judicial review. (The trial court's opinion is digested at *TSA* V, 369–370.) On further appeal to the Appellate Division, that Court affirmed, two of the five justices dissenting. On further appeal to the highest New York court, the Court of Appeals, that Court affirmed the decisions below. In affirming the decisions, the Court held that the action of the Superintendent was not subject to judicial review so long as he acted within the grant of authority of the statute. The Court, in reaching its decision, examined the history of this and other sections of the Insurance Law, finding that the legislature provided for review of certain actions of the Superintendent but deliberately failed to provide for review of other actions, including his action with reference to the purchase of property for home office use. The Court stated, in answer to the claim that absence of judicial review may encourage abuse of administrative power by the Superintendent, that this is something which should be addressed to the legislature.

In its opinion the Court, Field, J., stated:

> We deem it clear, as already noted, that, in expressly providing for review in some sections of the Insurance Law and making no provision for such review in other sections, the legislature followed a consistent and purposeful pattern. Provisions for licensing and revocation of licenses, as well as for consolidation and conversion of insurers, carry authorizations for review (e.g., Insurance Law, § 40, subd. 7; § 51, subd. 5; § 117, subd. 2; §§ 486, 487), while, on the other hand, provisions to protect policy-

holders against unwise, improvident or illegal expenditures of company moneys generally do not provide for judicial re-examination (e.g., Insurance Law, §§ 70–75, 81, 85, 101–103, 195). The legislature thus reflected its design that decisions of the Superintendent involving investments and finances—in which field flagrant abuses had been uncovered in the investigation by the Armstrong Committee—should be final and that he should not be subjected to judicial review to justify the action taken by him.

That is not to say, however, that there is to be no judicial scrutiny whatsoever. Even where judicial review is proscribed by statute, the courts have the power and the duty to make certain that the administrative official has not acted in excess of the grant of authority given him by statute or in disregard of the standard prescribed by the legislature. Cf. *Barry v. O'Connell*, 303 N.Y. 46, 52, 100 N.E. 2d 127, 130; *People ex rel. Metropolitan Life Ins. Co. v. Hotchkiss*, 136 App. Div. 150, 120 N.Y.S. 649. So, here, for instance, the courts will decide whether or not the Superintendent, in reaching his conclusion, employed the standard fixed by the statute, namely, whether the property purchased by Guardian was or was not "requisite for its convenient accommodation in the transaction of its business." There can be no doubt here that the Superintendent did make his determination solely with that standard in mind. Not only did he explicitly state that Guardian's present New York City quarters "are [not] inadequate for the convenient transaction of its business," but he made findings necessarily leading to the conclusion that the purchase was not required for the convenient accommodation of the company's business.

GROUP ACCIDENT AND HEALTH INSURANCE—CERTIFICATE INCONSISTENT WITH POLICY: *Riske v. National Casualty Company* (Wisconsin Supreme Court, December 7, 1954) 67 N.W.2d 385. The group accident and health policy issued to a labor union was thereafter amended so as to provide benefits for a "wife" of a member rather than for a "spouse." However, the certificate as reissued still defined a dependent entitled to benefits as including a spouse. The Wisconsin group statute in question provided that "the application of the employer, or executive officer or trustee of any association, and the individual applications, if any, of the employees or members insured shall constitute the entire contract between the parties. . . ." The Wisconsin statute contained also the usual provision requiring the issuance of an individual certificate setting forth a statement as to the insurance protection to which the individual is entitled and to whom payable.

The insured member's husband became disabled and, if a dependent as defined, the insured was entitled to benefits on account of the disability of her husband. The company refused to pay on the basis that the group policy had been amended so that benefits were not payable in case of the disability of a spouse but were payable only in the case the spouse was the wife. The trial court upheld the action of the company in its contention that the master policy controlled, but, on appeal, the Wisconsin Supreme Court reversed, stating:

Under the circumstances before us we must hold that the learned trial court was in error in ignoring the certificate relied upon by the appellant. We need not hold that it has become a part of the insurance contract contrary to the declarations of both policy and certificate, but we have no doubt that the certificate, issued under the representa-

tions of the policy itself to an insured who has contributed to the premium, effectively estops the respondent from showing that the coverage, conditions and limitations of the policy are different from those stated in the certificate and which the policy proclaims will be found there. We hold, therefore, that, for the purposes of this action, appellant's spouse is her dependent and she is entitled to the benefits which the policy provides for the disability of one.