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LEGAL NOTES

B. M. ANDERSON*

GROUP ANNUITY CONTRACT—PERPETUAL OBLIGATION: *Freeport Sulphur Company v. Aetna Life Insurance Company*, (C.A. 5, July 24, 1953) 206 F. 2d 5. The Aetna Life group annuity contract issued to Freeport in 1934 did not provide a termination date but did provide for premium rate increases on a gradual basis as to employees covered after the initial 5-year period. 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 then instituted this declaratory judgment action to determine the rights and liabilities under the contract. The District Court held that the contract was not a perpetual one but that Aetna was obligated to insure new employees for a reasonable time, which the court fixed as 25 years from the date the contract was issued. Both parties appealed from this judgment.

The Court of Appeals agreed that the contract was not a perpetual contract and that new entrants need not be accepted after a reasonable time. However, the Court of Appeals fixed 20 years rather than 25 years as a reasonable time, basing its decision in part on the fact that the contract specifically provided for increases in rates through March 31, 1954, indicating that Aetna itself contemplated that the contract would remain in force at least to that date. The Court also denied the claim that the contract was illegally discriminatory under controlling New York law, as did the District Court. In fixing 20 years as a reasonable period during which Aetna was obligated to accept new entrants, the Court stated:

> We differ with the district judge only as to what is a "reasonable time" for the operation of the contract. We think 25 years is too long. Since April 1, 1934, economic conditions have radically changed, interest rates have sharply declined, and life expectancy has substantially lengthened. All these things enter into the rates to be charged for such a policy as this.

The District Court's opinion is digested at *TSA* IV, 827.

SERVICE OF PROCESS—UNAUTHORIZED INSURER: *Parmalee v. Iowa State Traveling Men's Association*, (C.A. 5, Aug. 6, 1953) 206 F. 2d 518. The Association, through correspondence between its office in Iowa and the insured in Florida, solicited and issued its policy and collected premiums until the insured's death. The Association was not qualified to do business in Florida but handled the entire transactions through the mail. Suit was instituted in Florida

* B. M. Anderson, not a member of the Society, is a member of the Alabama, Connecticut, and United States Supreme Court Bars and is the author of the Third Edition of *Vance on Insurance*.

and service had on the Florida Insurance Commissioner in accordance with the Florida Unauthorized Insurers Process Act, which provided for such service if an unauthorized insurer effected by mail or otherwise the issuance or delivery of an insurance contract, the solicitation of an application for such contract, or the collection of premiums, membership fees, assessments or other considerations for such contract.

The Association asked that the suit be dismissed on the ground that it was not "doing business" in Florida and had not appointed an agent upon whom service of process in that state might be had and that the service on the Insurance Commissioner was not proper service. The Florida statute in question was attacked on the basis that it denied due process of law and equal protection of law to the Association contrary to the Fourteenth Amendment to the Federal Constitution.

The United States District Court dismissed the action on the ground that the Association was not doing business in the state and not subject to service of process there. On appeal, the Court of Appeals reversed, holding that it was within the power of the Florida legislature and consistent with the Federal Constitution to provide for service of process under such circumstances.

In upholding the validity of the statute, the Court said:

> The statute evidences a plan which the Legislature could, and did, find was necessary for the protection of its residents who became insured in the manner referred to in the statute. It is a declaration of the state's public policy that its residents should not be faced with "the often insuperable obstacle of resorting to distant forums for the purpose of asserting legal rights under such policies." The means adopted reasonably removes such obstacle and protects those for whom government has a legitimate concern. Subjection to process and jurisdiction directly relates to the accomplishment of the permissible legislative aim and is necessary to accomplish it. The statute evidences a valid exercise of a power of government and has a direct relation to that power. It in no wise offends "traditional notions of fair play and substantial justice." "An unauthorized foreign . . . insurer" is put on notice by the statute of the consequences of its acts. Such an insurer has no unlimited right to effect and maintain insurance contracts with Florida residents as it alone desires and without regard to a declared public policy which is reasonable in purpose and effect. The subject matter being the enforcement of insurance contracts received and paid for by its residents, the State Legislature was not bound by the incidents and extent of activities which in a different business might be necessary to constitute "doing business" within the state. As to contracts in which the state is so intimately concerned, it was within the legislative power to provide and establish its own definition of "doing business" by which the issuer of such contracts would be subjected to Forida jurisdiction in suits for enforcement of them. This is not to say, of course, that the Florida Legislature can set up an arbitrary or fanciful test of "doing business." It is to say that the "minimum contacts" which the Legislature recognized, from which result the creation and continuance in existence of an insurance contract until it becomes a potential claim, are sufficient to authorize subjection to suit upon such contract.

The Association sought a review of this decision by the United States Supreme Court but the Court on November 9, 1953 denied certiorari. For a digest of

the United States Supreme Court's opinion in a somewhat similar case, see *TSA* II, 485–86.

ORAL PLEDGE OR ASSIGNMENT—CREDITOR'S RIGHT: *Commercial National Bank v. Chapman*, (C.A. 5, Aug. 18, 1953) 206 F. 2d 349. The insured overdrew his company's account at the bank and the bank loaned his company $1,000.74 by honoring its outstanding checks. To secure this loan the insured "deposited" his life policies with the bank as collateral security and a short time thereafter he made a policy loan from the insurance company and repaid the bank the amount loaned to cover the overdraft.

The policies remained with the bank and on the insured's death the bank claimed the policy proceeds to cover sums thereafter borrowed from the bank and owing at the date of the insured's death. The beneficiaries claimed that since there was no valid pledge of these policies the bank was not entitled to the proceeds. The United States District Court and, on appeal, the Court of Appeals for the Fifth Circuit agreed with the named beneficiaries and held that under Georgia law the insurance policies could not be validly pledged by mere delivery.

DOUBLE INDEMNITY—MILITARY EXCLUSION: *Weissman v. Metropolitan Life Insurance Company*, (D.C. California, May 20, 1953) 112 F. Supp. 420. The life policy issued in 1943 provided for additional indemnity benefits in the event of the insured's death by accidental means but excluded as to such benefits death while the insured was "in the military, naval or air forces of any country at war." The insured was killed in action in Korea in 1951. The Metropolitan admitted liability for and paid the single indemnity benefits but denied that it was liable for the additional indemnity benefits, claiming that the insured was in the military forces of a country "at war" when he met with death.

The beneficiary commenced this action against Metropolitan for the double indemnity benefits and the court, after reviewing many other cases in point, held that the United States was in fact at war in Korea at the time the insured died and judgment accordingly was rendered in favor of the Metropolitan. The court in its opinion stated:

> From the authorities cited above we must come to the conclusion that there may be war (within the meaning of that term employed in an insurance policy) without an official declaration thereof, and that unless it is indicated in the contract that the term "war" is to be used in its strict, legal sense the parties have a right to assume it is to be given its common understanding or meaning.
>
> We doubt very much if there is any question in the minds of the majority of the people of this country that the conflict now raging in Korea can be anything but war. Certainly those who have been called upon to suffer injury and maiming, or to sacrifice their lives, would be unanimous in their opinion that this is war—war in all of its horrible aspects. And the families deprived of the love and companionship of their sons, brothers, husbands and fathers—who meet each day with hope and fear for their boys and men in Korea—and the widows and orphans of the men who died there—certainly they are aware of the stark reality that the Korea conflict is war.

The decisions are in conflict as to whether the action in Korea constitutes "war" within the meaning of a life insurance policy. On October 12, 1953, the United States Supreme Court refused to review the *Beley* and *Harding* cases, wherein the Pennsylvania Supreme Court had held that the Korean action did not constitute war. (See digests of these cases, *TSA* V, 94–95.) This refusal by the United States Supreme Court to review these two cases does not necessarily mean that the United States Supreme Court agrees with the conclusion, and in some later case that Court may decide that the Korean action does constitute war within the meaning of a life insurance policy.

LIQUIDATION OF MUTUAL COMPANY—JURISDICTION OF INSURANCE COMMISSIONER: *Allyn v. Hull*, (Connecticut Supreme Court of Errors, July 28, 1953) 140 Conn. 222, 99 A. 2d 128. Certain directors of a mutual fire insurance company decided that they would liquidate the company, sell its charter and divide up the assets among themselves. Accordingly, they refused to renew expiring policies for others, issued policies to themselves, reinsured outstanding risks except their own policies with another company and distributed to themselves the company's net assets amounting to $19,240.

Insurance Commissioner Allyn brought this declaratory judgment action against the five directors in order to obtain a decision concerning the proper disposition of the company's assets. The trial court held that he had no standing to bring the action against the directors, and on appeal to the Connecticut Supreme Court of Errors this judgment was affirmed. The Court in its opinion said:

The plaintiff is a state official whose office was created by the General Assembly. General Statutes § 6025. Like other comparable public officials, he has only such power and authority as are clearly conferred or necessarily implied. *State* v. *Hartford Accident & Indemnity Co.*, 138 Conn. 334, 339, 84 A. 2d 579; Mechem, Public Officers, § 511; 43 Am. Jur. 68, § 249. Section 6029 prescribes his powers and duties. It requires him, among other things, to "see that all laws respecting insurance companies are faithfully executed." Undoubtedly, this vests him with a wide range of discretion. *American Casualty Ins. & Security Co.* v. *Fyler*, 60 Conn. 448, 460, 22 A. 494. That discretion, however, cannot be exercised on everything bearing directly or indirectly upon the subject of insurance. See *Noyes* v. *Byxbee*, 45 Conn. 382, 385. The legislative mandate which we have quoted does not endow him with limitless authority to do whatever he thinks he ought to do. The statute does not speak of laws relating to insurance. It refers to laws respecting "insurance companies." The authority granted by it to the plaintiff, therefore, is circumscribed. The statute permits him to supervise the activities of insurance companies only so far as to see that they fulfill the obligations imposed upon them by law. It gives him no power over the directors of insurance companies in their individual capacities.

The complaint does not purport to state a cause of action against the company. Indeed, the company is not even a party defendant. Nor has the action been brought against the defendants as directors. In short, the plaintiff seeks to compel neither the company nor its directors to execute any legal duty. The gist of the complaint is that the defendants, as individuals, should respond because of some act of alleged misconduct. Justification for the maintenance of the present action cannot be found in § 6029.

The plaintiff maintains that, on the face of the admitted facts, a grievous wrong, intentional or otherwise, has been done to 192 policyholders. Whether this is so, or what rights, if any, they may have under a different alignment of parties, we do not determine on this appeal. We go no further than to hold that this plaintiff is without power to bring the instant action. However commendable may be his purpose, the plaintiff lacks the necessary authority to sue as he has done.

AVIATION EXCLUSION—PARACHUTE JUMP: *Smith v. Mutual Benefit Health and Accident Association*, (Kansas Supreme Court, July 6, 1953) 258 P. 2d 993. The accident policy excluded from coverage injuries received "as a result of or while participating in aeronautics or air travel" except as otherwise provided. The insured was injured while making a parachute jump from a Civil Air Patrol plane. The jump was a voluntary practice jump made in connection with an air show.

The insurance company claimed that the injury was received while the insured was participating in aeronautics or air travel within the meaning of the exclusion provision and the trial court agreed. On appeal, the Kansas Supreme Court, after reviewing many aviation exclusion cases, likewise held that there could be no recovery under the circumstances.

SETTLEMENT OPTION—TESTAMENTARY DISPOSITION: *Hall v. Mutual Life Insurance Company*, (New York Appellate Division, First Department, June 9, 1953) 122 N.Y.S. 2d 239. Upon the death of her father in 1941 Barbara Corliss Graves, then Barbara Corliss Hall, elected to leave the policy proceeds at interest with Mutual Life under a supplementary contract she then entered into, naming her then husband, Hall, as beneficiary to receive any amounts remaining at her death and reserving to herself the right to withdraw the principal in whole or in part. The supplementary contract differed from the policy option in that the interest payments were to be made quarterly instead of annually and the policy made no reference to partial withdrawals provided for under the supplementary contract. On Mrs. Graves' death Hall claimed the proceeds under the terms of the supplementary contract and Mrs. Graves' executors claimed the proceeds on the basis that the supplementary contract was not life insurance, was not in strict accord with the option granted under the policy and therefore was an attempted testamentary disposition contrary to the New York Statute of Wills and hence void. The trial court agreed with the executors that the supplementary contract was void and awarded the proceeds to them. See digest of trial court's opinion, *TSA* IV, 188–89.

On further appeal, the Appellate Division of the Supreme Court, First Department, reversed, one Justice dissenting, holding that in spite of the minor deviation from the contractual policy option the supplementary contract was valid and enforceable and that the ex-husband, Hall, was entitled to the proceeds in accordance with such contract. The Court in its opinion pointed out that the legislation which immediately followed the Armstrong Investigation in New York provided for optional settlements and that optional settlements, especially those contained in older policies, were often most advantageous to beneficiaries.

The Court also referred to the remedial legislation enacted in New York in 1952 which served to make it entirely clear that an agreement such as this hereafter entered into was valid, and to the statement in such remedial legislation to the effect that the enactment should not create any implication of invalidity as to arrangements entered into before the enactment of the remedial legislation.

In commenting on the value of settlement options, Justice Breitel, speaking for the Court, said:

> It does not merit extended discussion to prove the very high public interest in the extension of the life insurance system, as a major provision for thrift and security for individuals and families. Mutualization of insurance companies, beneficial tax provisions and tax exemptions, government life insurance for members of the armed services, savings bank life insurance, and the close attention paid to insurance matters by the Legislature, all devoted to its greater use and the finding of additional uses and outlets for its development, are pointed evidence of its significance, in modern and especially American, society. Part and parcel of this system for many decades, is the optional mode of settlement, with power to make gift over of the unused principal. This is no evil to be hobbled; no course of conduct with incidence of recurring injustice to be limited by safeguards, slowing but necessary.

The Hall case is now on appeal to the New York Court of Appeals, the court of last resort in that state.

A somewhat similar arrangement was held valid by the Washington Supreme Court in a 5 to 4 decision in 1952. See *TSA* IV, 832–33.

PURCHASE OF HOME OFFICE PROPERTY—INSURANCE SUPERINTENDENT'S APPROVAL: *Guardian Life Insurance Company v. Bohlinger*, (New York Supreme Court, June 18, 1953) 124 N.Y.S. 2d 112. The Guardian purchased real estate in Westchester County for investment. This did not under New York law require approval by the Superintendent of Insurance. Thereafter Guardian decided that it would like to use for principal office purposes the projected building on the property acquired for investment pending the eventual location, acquisition and development of a new principal office building in that area. Under the New York law as amended after the Armstrong Investigation the approval of the Superintendent was required for the purchase of real estate for principal office purposes.

Superintendent Bohlinger refused to approve the proposal of Guardian to use the property for its own purposes on the basis that the company had not demonstrated that its present quarters were inadequate for the convenient transaction of its business or that economies in the best interests of the policyholders would flow from such acquisition. The Guardian brought this action to annul the determination by Superintendent Bohlinger, claiming that he was attempting to usurp management's function and substitute his judgment for the judgment of Guardian's officers and directors.

The Supreme Court (the trial court) refused to annul the determination of Superintendent Bohlinger, stating that the Superintendent, as the representa-

tive of the policyholders' interest, must have his own judgment satisfied that the investment is a wise one. The Court, Hecht, Justice, stated:

> I do not question petitioner's good faith in the premises, but proper enforcement of the statute demands that if an insurer in good faith acquires real estate for investment purpose without approval of the Superintendent and then in good faith finds it desirable to devote such real estate to Company use (even on an interim basis) approval of the Superintendent is required before it may be used for that purpose.

This case is now on appeal to the intermediate appellate court of New York.

LOAN VALUE—DISABILITY AND DOUBLE INDEMNITY RESERVES: *Chastang v. Mutual Life Insurance Company*, (Ohio Supreme Court, Mar. 25, 1953) 159 Ohio St. 167, 111 N.E. 2d 395. The insured brought this declaratory judgment action to determine the loan value of his policy, his claim being that the reserves on account of disability and double indemnity should be included in determining how much he was entitled to borrow. The Mutual Life admittedly maintained separate reserves on account of life insurance, disability benefits and double indemnity; and the insured claimed that the policy provisions as to loans were not consistent with Ohio law in that the loan value was not increased by the amount of any disability or double indemnity reserve.

The trial court dismissed the petition and on appeal to the Court of Appeals the judgment of the trial court was affirmed. The Supreme Court of Ohio in its opinion examined the Ohio statute in question and held that under this statute as well as under the policy provisions the loan values properly were based on the reserve for the life insurance feature alone, not including the reserves for disability and double indemnity. The Mutual Life was always willing to loan the amount specified in the policy and hence the holdings of the lower courts were affirmed.

In a suit by this same insured involving this same policy the Supreme Court of Ohio had previously determined that the action of Mutual Life in paying less dividends on this policy than on a policy otherwise similar but without disability benefits was proper. For a digest of this opinion, see *TASA* XLVIII, 128–29.

CONVERSION OF GROUP INSURANCE—SUICIDE: *Lineberry v. Security Life and Trust Company*, (North Carolina Supreme Court, Sept. 30, 1953) 77 S.E. 2d 652. Dr. Lineberry was insured as an employee of Washington Mills under a group life policy issued by Security Life. The group policy provided for its termination at the end of the month in which employment was terminated, contained a one-year incontestable provision and contained also a provision for conversion of the employee's insurance on termination of employment to an individual policy at attained age without evidence of insurability.

In July of 1948 Dr. Lineberry terminated his employment and applied for and received, in accordance with the conversion privilege, an individual ordinary life policy dated July 28, 1948, and containing a two-year suicide provision. He committed suicide just prior to the expiration of the two-year period and the Security Life, relying on the suicide provision, claimed its liability was limited

to the return of premiums paid, as therein provided. The beneficiary claimed that since the insured's death occurred more than two years after he was originally insured under the group contract the suicide provision of the new policy was no longer effective and the face amount was payable.

The trial court agreed with the contention of the beneficiary but, on appeal, the Supreme Court of North Carolina reversed, holding that the group insurance was at an end and that the new policy was not merely a continuation of the group coverage but was a separate and independent contract. The Court pointed out that the group policy was a contract between the employer and the insurance company and that the new ordinary life policy was a contract between Dr. Lineberry and the insurance company in which the former employer had no interest. The Court therefore held that the reference in the suicide clause in the new policy to its "date of issue" referred to the actual date of issue of the new individual policy and that the suicide clause was fully effective.

This appears to be the first case directly in point on the issue by a court of last resort.

DOUBLE INDEMNITY—MILITARY EXCLUSION: *Western Reserve Life Insurance Company v. Meadows*, (Texas Supreme Court, Oct. 7, 1953) 261 S.W. 2d 554. The five life policies issued in 1932 provided that the accidental death benefits should be void "if the Insured shall be in military, naval, or allied service in time of war at the date of the accident." The insured, a Lieutenant Colonel in the Army Engineers Corps of the United States, was in the military service, traveling as a passenger in an Army plane under official orders, when he was killed in August 1951 in a crash in Alaska. The insurance company paid the single indemnity but refused to pay the accidental death benefits on the basis that the insured at the time of his death was participating in aeronautics and also was in the military service "in time of war." The trial court and, on appeal, the Texas Court of Civil Appeals held against the company on both points. (See *TSA* V, 94–95.) The company then appealed to the Texas Supreme Court, claiming that when the insured was killed in August 1951 he was in military service "in time of war."

The Texas Supreme Court reviewed many of the conflicting cases on the point and held that the term "war" should not be used in its technical or legal sense but should be given its plain, ordinary and generally accepted meaning and that there was war in fact in Korea when the insured died. Judgment was accordingly rendered in favor of the insurance company.