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LEGAL NOTES

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AVIATION EXCLUSION—PILOT: *Ezell v. Atlantic Life Insurance Company*, (D.C. Tenn., Aug. 20, 1953) 119 F. Supp. 614. Atlantic Life issued two Life policies with double indemnity to Martin, a former commercial airline pilot. The double indemnity provision excluded death "from being or having been in or on any kind of aircraft, except as a fare-paying passenger on a commercial air line, flying on a regularly scheduled route. . . ." The single indemnity provision of one of the policies excluded death "resulting directly or indirectly from flight or travel in, or descent from or with, any kind of aircraft while the Insured is a pilot, co-pilot, or any other member of the crew . . . "; and the single indemnity exclusion language of the other policy was essentially the same.

The insured met his death while piloting a private airplane which was so equipped that only the pilot could participate in the operation of the plane. The Atlantic Life claimed that its liability was limited to the reduced benefit provided for aviation deaths other than fare-paying passenger deaths and the beneficiary, conceding no liability for double indemnity, claimed that the single indemnity exclusion did not apply because the airplane did not carry a co-pilot or a crew. The United States District Court agreed with the contention of the beneficiary, stating:

> It is obvious that the two riders in question were not as all inclusive as the double indemnity rider attached to each policy which very clearly states that the double indemnity benefit would not apply if the injury should result directly or indirectly from the Insured's being or having been in any kind of aircraft, except as a fare-paying passenger on a commercial airline. The Court attaches considerable significance to the wording of these different riders. It is apparent that the double indemnity rider excludes every injury resulting from the Insured's being or having been in or on any kind of aircraft, except as a fare-paying passenger on a commercial airline. If the defendant had desired the same exclusion to apply to the face value of the policies, it would have so stipulated; but instead of doing so, it narrowed the exclusions to death resulting directly or indirectly from flight or travel in, or descent from or with, any kind of aircraft while the Insured is a pilot, co-pilot, or any other member of the crew thereof, or while such aircraft is being operated for the purpose of instructing, training, or learning how to fly. It is the opinion of the Court that such exclusion does not apply to the Insured while piloting a private airplane that does not carry a co-pilot or a crew.
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> In view of the history of the Insured's previous activities as a pilot, the Court is of the opinion that the riders in question were attached to the policies so as to exclude coverage in the event that the Insured was acting as a pilot, co-pilot, or any other

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member of the crew on a commercial or military type plane that usually carries a crew, in addition to the pilot and co-pilot, or while acting as a pilot, co-pilot, or any other member of the crew on any aircraft being operated for the purpose of instructing, training, or learning how to fly; all of which appears, on account of regular and more numerous flights, to be considered more hazardous than the mere occasional piloting of a private plane.

This case illustrates the length to which some courts will go in finding ambiguity and it also illustrates the desirability of uniformity in language in the several portions of the same contract.

LIFE INSURANCE COMPANY FEDERAL INCOME TAX—OIL ROYALTIES AND BONUS: *Great National Life Insurance Company v. Campbell* (D.C. Texas, Oct. 30, 1953) 119 F. Supp. 57. The Commissioner of Internal Revenue assessed deficiencies against Great National on the basis that oil royalties and bonus money received by the company during 1949 and 1950 were "rents" within the meaning of the Internal Revenue Code provisions relating to the taxation of life insurance companies. The Great National paid the amount of the deficiencies and then brought this action to recover these amounts, claiming that the payments in question did not constitute rents.

The United States District Court agreed with the contention of Great National that the law as written did not tax oil royalties and bonus money received by life insurance companies and stated in effect that if the items should be taxed it was the function of the Congress to change the law. The Court in its opinion stated:

> There are many items of income to life insurance companies that cannot be classed as rents, dividends or interest. Life insurance income from the sales of property, from premiums, from underwriting profits, from favorable mortality experiences, from dealings in property, and from capital gains and losses, do not constitute taxable income to life insurance companies; nor are the expenses or State taxes imposed in relation to such items of income deductible expenses by such life insurance companies.

SIMILAR CORPORATE NAMES—ADMISSION TO DO BUSINESS IN STATE: *United Life Insurance Company v. United Insurance Company* (Florida Supreme Court, Feb. 2, 1954) 70 So. 2d 310. United Life Insurance Company, a Florida corporation doing a life insurance business in Florida on a weekly premium basis covering white lives only, brought this action against United Insurance Company, an Illinois corporation, to enjoin that corporation from doing business in Florida. United Insurance Company likewise did a weekly premium business, but with persons of the colored race. The Secretary of State of Florida was joined in this action because he had issued the permit to the Illinois corporation to do business in Florida and the Florida Insurance Commissioner was also joined. The trial court dismissed the suit after the United Insurance Company had agreed to add "of Illinois" to its corporate name in connection with insurance policies and with advertising in Florida.

United Life Insurance Company appealed from this decree dismissing its suit. On appeal, the Supreme Court of Florida upheld the judgment, stating:

We cannot agree with the second contention of the plaintiff, that the trial court erred in finding that the Illinois corporation could do a life and accident and health insurance business in Florida provided they would add the qualifying words "of Illinois" to their corporate name. As we understand the law in respect to the use of corporate names in connection with the doing of business the rule is as follows: "Where the words selected [by a corporation] for a corporate name are chosen from the public domain and imply a national business, and where the territory in which it operates is one that will probably be reached through the natural expansion of an established institution, which is in fact national in scope, [said corporation] cannot demand a complete exclusion when the [established institution] bids entry, but must be content with such explanatory matter as will prevent deception, although it may not entirely eliminate confusion by the careless."

DOUBLE INDEMNITY MILITARY EXCLUSION: *Langlas v. Iowa Life Insurance Company* (Iowa Supreme Court, April 7, 1954) 63 N.W. 2d 885. The two Life policies issued in 1945 and 1949 excluded from double indemnity benefits death resulting directly or indirectly from "military or naval service in time of war; . . . war, riot or insurrection; . . . " On March 25, 1952 the insured, then a member of the United States Marine Corps, was killed in action in Korea. The company paid the single indemnity benefits, as to which there was no dispute, but denied liability for double indemnity benefits on the basis of the exclusion language quoted above. The trial court held that such benefits were payable and the company appealed from this judgment to the Iowa Supreme Court.

The Iowa Supreme Court considered in detail the many cases on this point from other jurisdictions and also an Iowa case somewhat in point. The Court took the position that this being a private contract its primary search was for the intent of the parties. The Court pointed out that while there had been no declaration by the United States Congress that a state of war existed, yet the United States casualties as of March 28, 1952, three days after the insured's death, totaled 106,596 with 16,739 killed, 77,651 wounded, and 9,916 missing in action. The Iowa Supreme Court also pointed out that the policy language was adequate to exclude war deaths, even though the war was one in which the United States was not involved. It concluded that in spite of the fact that the policy exclusion did not refer to war "declared or undeclared" yet the intent was clear to exclude war deaths such as the one in question. Accordingly, the judgment below was reversed with directions to enter judgment in favor of the insurance company.

The United States Supreme Court on March 15, 1954 denied certiorari in *Western Reserve Life Insurance Company v. Meadows* (*TSA* V, 371), a Texas Supreme Court decision which held that the insured killed in August 1951 was killed "in time of war." In *Podos v. Equitable Life Assurance Society* (D.C. California, March 16, 1954) — F. Supp. —, the double indemnity provisions lapsed by the terms of the policy if the insured became a member of the military, naval or air forces of any country at war, "declared or undeclared," and the beneficiary of the insured killed in action in Korea was denied such benefits.

STATUTE REQUIRING COPY OF APPLICATION TO BE ATTACHED—FRATERNAL BENEFIT SOCIETY: *Wheeler v. Ben Hur Life Association*, (Kentucky Court of Appeals, Nov. 20, 1953) 264 S.W. 2d 289. The Association was licensed by the Director of Insurance of Kentucky as a fraternal benefit society. It issued a $5,000 life policy to Wheeler in 1947 and on his death some months later the Association refused to pay, claiming that material false statements were contained in the application. The beneficiary claimed that the application was not admissible in evidence because the Association, although licensed as a fraternal benefit society, was, in fact, doing business as an old line life insurance company and a copy of the application was not attached to the policy. A fraternal benefit society need not, under Kentucky law, attach a copy of its application to the policy in order for such application to be admissible in evidence, but under Kentucky law an old line life insurance company is required to attach a copy of the application to the policy.

The trial court held that the Association was a fraternal benefit society and that the application was therefore admissible. Judgment was granted in favor of the Association on the basis of material misrepresentation. On appeal this judgment was reversed, and the Kentucky Court of Appeals held that the Association was, in fact, operating as an old line life insurance company. The Court also held that the fact that the Association was licensed as a fraternal benefit society by the Director of Insurance of Kentucky would not foreclose an inquiry into the question of whether it was, in fact, operating as an old line life insurance company.

In its opinion the court stated:

We come now to the question whether the Association was in effect an insurance company at the time of issuance of the certificate. We are convinced from the evidence that it was. It is elementary that the law looks at substance instead of form, and is not deceived by the gloss of words. As is required by KRS 300.010, the Association's constitution and by-laws duly provide for a lodge system, ritualistic form of work, and representative form of government. It has no capital stock and is ostensibly organized solely for the mutual benefit of its members. But actually, while giving superficial attention to these requirements, the Association has been engaged in the life insurance business. The local agent of the Association draws a salary and receives as a commission 50% of the first premium on all insurance policies. He receives a smaller percentage of subsequent premiums. To assist him, he has another agent who is paid a small salary, plus a commission of 40% of the first premium. The commissions in both cases are based upon the amount of insurance sold and not upon the number of members procured. This is substantially the same system followed by old line insurance companies. The efforts of the Association's agents are directed primarily toward selling insurance rather than recruiting members for the lodge. Little, if any, emphasis is placed upon the membership of an insured in the lodge. The Association's constitutional and by-laws provisions relative to ritualistic work are observed only perfunctorily. No new member has gone through an initiation ceremony since 1941. The meetings of the lodge are held from place to place without notice to the members, and are attended usually by only five or six persons who are officers of the Company. The officers comply with the formality of electing members, but no one has been refused membership in the

last 42 years. On many occasions the insurance policy is issued before the so-called election is held. Practically all members of the Louisville organization are now or have been holders of life insurance policies issued by the Association. There is little or no solicitation of social members. Only insured members are desired. There is nothing in the application to indicate that members are required to pay dues. Membership dues are deducted from premium payments on the policies.

BENEFICIARY'S RIGHT TO ASCERTAIN AND TO PAY PREMIUM: *American Life Insurance Company v. Hauer*, (Mississippi Supreme Court, Nov. 2, 1953) 67 So. 2d 523. All premiums on the life policy issued in 1944 had been paid up to August 28, 1950. On September 19, 1950, during the 31-day grace period, the insured shot himself and thereafter remained unconscious until his death, September 29, 1950. On September 21, 1950, within the grace period, the named beneficiary wrote to the company inquiring as to the premium status of the policy and the company replied, refusing to give her this information. The policy was not in her possession at the time.

The insurance company claimed that the policy was forfeited for nonpayment of the premium in question. The beneficiary commenced this action for the policy proceeds, claiming that she was ready, willing, and able to pay the premium but the Company wrongfully refused to advise her as to the premium status. The trial court entered judgment for the beneficiary and on appeal this judgment was affirmed, the Mississippi Supreme Court holding that even though the beneficiary was revocable the company did owe her a duty to inform her of the status of the policy in response to her inquiry as to such status.

QUARTERLY PREMIUM IN EXCESS OF ONE-QUARTER OF ANNUAL RATE: *Cohen v. John Hancock Mutual Life Insurance Company*, (New Hampshire Supreme Court, Nov. 30, 1953) 101 A. 2d 270. The life policy issued in 1939 provided for an annual premium of $567.56, but allowed quarterly installments at the company's published rate. The quarterly premium payment was 26½ percent of the annual premium, or $150.43, and this amount appeared on the amended application which the insured signed. The quarterly premiums were paid until May 14, 1949, but not thereafter. The company notified the insured in August 1949 that the policy had lapsed and again in October 1949, telling him that it was being continued as participating paid-up insurance. In October, after receiving the notice, the insured forwarded an amount representing two quarterly premiums which the company retained pending receipt of evidence of insurability. This evidence was not forthcoming and in March 1950 the company refunded the amount by its check, which was not cashed prior to the insured's death in April 1950.

The company admitted liability for the paid-up insurance, but refused to pay the face amount. The beneficiary contended that since four quarterly premiums amounted to $34.16 more than an annual premium, there were total overpayments of $332.62 which, if applied to the May and August 1949 quarterly premiums, were adequate to continue the policy in force until after the insured's

death. The beneficiary also contended that the company was estopped to assert the defense of late payment because the insured had another policy with the company and the premium had been taken up under an automatic premium loan provision after the grace period had expired.

The trial court and the New Hampshire Supreme Court both held in favor of the company. The Supreme Court pointed out that the quarterly premium rate was in accordance with the provisions of the policy and that it was perfectly proper and customary to charge more on a quarterly basis than on an annual basis. As to the estoppel or waiver, the Court stated that the evidence was properly excluded by the trial court because the policies were not similar.

The attorneys for the plaintiff admitted that there was no case in support of their contention as to the quarterly premium, but they pursued the issue through the New Hampshire Supreme Court and after an unfavorable decision they sought a rehearing, which was denied.

SETTLEMENT OPTION—TESTAMENTARY DISPOSITION: *Hall v. Mutual Life Insurance Company*, (New York Court of Appeals, April 8, 1953) 119 N.E. 2d 598. The New York Court of Appeals, the court of last resort in that state, affirmed without opinion the Appellate Division's judgment which held that the named beneficiary under the life policy could designate a beneficiary under a supplementary contract entered into after the policy matured, even though such supplementary contract differed from the policy option and even though the beneficiary who entered into the supplementary contract reserved the right to withdraw the principal. For the opinions in the two lower courts see *TSA* IV, 188–89 and *TSA* V, 368–69.

DEATH DUTIES—LIABILITY OF COMPANY UNDER ANNUITY: *Mutual Benefit Life Insurance Company v. Dimond*, (New York Supreme Court, Appellate Division, April 20, 1954) 130 NYS 2d 103. In 1937 Mutual Benefit issued its single premium annuity contract on the lives of the decedent and her daughter, Janet B. Dimond. By the terms of its contract the company was obligated to pay a monthly annuity of $103.60 to the decedent during the joint lives of the decedent and her daughter. The company further agreed that after the decedent's death the monthly payments, in the same amount, were to be paid to the daughter until March 5, 1957, or until the prior death of the daughter. There was no guaranteed minimum total amount or guaranteed minimum number of monthly payments, nor was there any surrender or terminal value.

The decedent died in 1945 and in 1953 a decree was entered settling the intermediate account of the daughter as executrix. This decree directed Mutual Benefit to pay $1,525.15 to the executrix as the proportionate share of Federal and New York estate taxes previously paid by the executrix. The claim was that Mutual Benefit was "among the persons interested in the estate" and was "in possession" of property in which the estate was interested within the meaning of New York law. Mutual Benefit was permitted, under the decree appealed from, to deduct a proportionate amount from each monthly payment being

made to the daughter, but its liability under its annuity contract ceased in the event the daughter died prior to 1957 and, in such event, there was no source from which the Mutual Benefit could be reimbursed.

The Mutual Benefit appealed from the Surrogate's degree and the Appellate Division reversed, holding that the Mutual Benefit was not in possession of any property from which the apportioned tax might be recovered by the executrix. Any other conclusion would have resulted in an increase in the liability of the Mutual Benefit without any consideration to the company for such increase.

DELIVERY OF POLICY—POLICY MAILED TO AGENT: *Mid-Continent Life Insurance Company v. Dees*, (Oklahoma Supreme Court, January 19, 1954) 269 P. 2d 322. Hubbard applied for a life policy and on March 10, 1948 paid the agent the first year's premium. The application provided that the company would not incur any liability upon the application until the policy "has been delivered to and accepted by me during my lifetime and good health." The policy was issued as applied for and mailed to the company's agent on March 16, 1948. The insured was asphyxiated by gas fumes and found dead the next day, which was the day the postal authorities delivered the policy to the agent.

The insurance company denied liability for the face amount of the policy on the basis that the policy was not delivered to and accepted by the applicant during his lifetime and good health. The beneficiary sued and the trial court granted judgment for the beneficiary. On appeal this judgment was affirmed (4 of the 9 judges dissenting). The court in its majority opinion stated:

> This conception of what constitutes delivery may hold true in some instances, but not where the first premium has been paid, the application has been approved, the policy executed in accord therewith thereby completing the insurance contract, and nothing remains to be done but to deliver the policy to the insured. In such case, the mailing of the policy to the agent unconditionally while insured was in good health and alive, to be given by him to the insured person constitutes delivery in law, manual delivery, or further acceptance, being unnecessary.