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LEGAL NOTES

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INTERPLEADER—TENDER OF CASH VALUE—INSUFFICIENCY OF TENDER: *New York Life Insurance Company v. Lee* (C.A. 9, April 11, 1956) 232 F. 2d 811. The insured demanded the cash value of his policy. The New York Life refused to pay this cash value without a release from a former wife who had been beneficiary and who asserted a claim to the proceeds. The insured thereafter commenced an action to recover the cash value, and some weeks later and more than six months after the original demand the New York Life commenced this action under the Federal interpleader statute in Oregon. The company paid into court the cash surrender value as of the date of the demand and joined in this suit the former wife, who lived in California.

The trial court held that the amount deposited by New York Life was insufficient in that interest on the cash value was not included and also the company did not offer a bond to guarantee the payment of attorney's fees for the insured as provided for under Oregon law where payment had not been made within six months from the date of "proof of loss." The Court did not pass on the insured's contention that the former wife's claim was sham and frivolous and not of sufficient substance to justify an interpleader.

The Court of Appeals held that the District Court properly dismissed the action in that the company had not tendered an adequate amount.

FEDERAL EMPLOYEES GROUP LIFE—AUTOMATIC BENEFICIARY CHANGE ON RETIREMENT: *Smith v. Metropolitan Life Insurance Company* (D.C. California, June 30, 1956) 142 F. Supp. 320. Smith, a Post Office employee, designated his divorced first wife, Christina Smith, as beneficiary under his Federal Group Life Insurance. Three weeks before his death and while he was incompetent he was placed on a retired status by the Post Office Department. The Federal Group Life Policy provided for automatic revocation of beneficiary designation on retirement and provided further for payment to designated classes of persons in the event no beneficiary was named. In the absence of a beneficiary designation the insured's father would have been entitled to receive the proceeds.

On the insured's death Christina Smith, the divorced first wife, and the father both claimed the policy proceeds and the Metropolitan interpleaded the two claimants. The District Court found that it was the intent of the insured to benefit Christina, who was designated as beneficiary after her divorce and after the insured's second marriage and divorce; that the provisions of the policy were for the benefit of the Government and the insurance company; and that

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these provisions were waived by the interpleader. The Court accordingly awarded the proceeds to the designated beneficiary, Christina Smith.

WAR EXCLUSION—KOREAN CONFLICT: *Pyramid Life Insurance Company v. Masch* (Colorado Supreme Court, July 9, 1956) 299 P. 2d 117. The life policy issued in 1941 limited liability for the insured's death "while in military service or naval service in time of war" to the premiums paid unless the company permitted such service in return for an extra premium. In 1951 the insured, a private in the United States Army, was killed in action in Korea. The insurance company claimed that its liability was limited to the return of premiums, but the beneficiary sued, claiming that under the circumstances the exclusion provision did not apply.

The trial court and, on appeal, the Supreme Court of Colorado agreed with the beneficiary, holding that the insured did not die "in time of war" within the meaning of the exclusion clause. The Colorado Supreme Court, Knauss, J., stated:

> We are asked to take judicial notice that the engagements of United States troops in Korea constituted "War"; this, in spite of the fact, as counsel for defendant admit, that "war" was never declared by Congress, the only authority competent to declare it, with respect to the action in Korea. The existence or nonexistence of a state of war is a political, not a judicial, question and it is only when a formal declaration of war had been made by the Congress that judicial cognizance may be taken thereof. Once so declared by the political department, it becomes binding upon the courts, otherwise not.
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> Any doubt concerning the meaning of a word or clause in a life insurance policy should be resolved in favor of the insured. Had the defendant desired to cover the contingency here involved it would have been a simple matter to include proper words to indicate that "war" meant "hostilities," whether or not declared by Congress to be a state of war.

The result might have been influenced to a degree by technicalities of pleading.

INSURED KILLED BY BENEFICIARY—RIGHT OF CONTINGENT BENEFICIARY: *Carter v. Carter* (Florida Supreme Court, June 6, 1956) 88 So. 2d 153. The named beneficiary was accused of killing her husband, the insured. She originally pleaded guilty to manslaughter but withdrew this plea and the jury acquitted her. She was named as primary beneficiary under a group insurance policy and the father was contingent beneficiary under a class designation if there were "no beneficiary surviving at the death." The insurance company commenced an interpleader action against the widow in her capacity as beneficiary and also as administratrix of the insured's estate and against the father. The widow claimed that her acquittal in the criminal action determined that she was not guilty in connection with the death and she should be awarded the proceeds as beneficiary or, in the alternative, she claimed that the class beneficiaries could receive

only if the insured died with "no beneficiary surviving" and she did survive even though she might not be entitled to take. Under Florida law if the proceeds were paid to her as administratrix, she was entitled to the proceeds because she was disqualified only if convicted of murder. The widow appealed from the denial of her motion for summary judgment.

On appeal, the Florida Supreme Court held that there must be a determination anew as to whether she feloniously killed the insured. The Court expressed the opinion that her admission by a guilty plea, later withdrawn, could not be used against her nor could her acquittal in the criminal action be used in her favor. The Court also adopted the view that even though the disqualified beneficiary were still living, the proceeds in the event of disqualification should go to the contingent beneficiary.

The case was sent back to the trial court to determine anew whether the widow feloniously killed her husband.

AMOUNT OF EXTENDED INSURANCE—EFFECT OF POLICY LOAN—DISCRIMINATION: *Praetorians v. Fisher* (Florida Supreme Court, July 25, 1956) — So. 2d —. The life policy provision stipulated that in the event of a policy loan the term of any extended insurance would remain the same but the amount of the extended insurance would be reduced in the proportion that the indebtedness bore to the cash value. The insured was killed shortly after his policy was permitted to lapse. The company claimed that its liability as provided under the policy would be only a small fraction of the $1,000 face amount in that the cash value at the time of lapse was $182 and the principal indebtedness was $167. The beneficiary claimed that the policy provision which reduced the amount of extended insurance in this substantial degree was invalid as in conflict with the antidiscrimination statute of Florida.

The trial court and, on appeal, the Supreme Court of Florida agreed with the beneficiary, holding invalid as in conflict with the Florida antidiscrimination statute this proportionate reduction in the amount of the extended insurance. The Court recognized that proportionate reduction provisions in the event of policy loans had been upheld in other jurisdictions but attempted to distinguish this case from the cases in other states.

DOUBLE INDEMNITY—DUE PROOF—SUICIDE OR ACCIDENT: *Begley v. Prudential Insurance Company* (New York Court of Appeals, July 11, 1956) 1 N.Y. 2d 530, 136 N.E. 2d 839. The insured had suffered for many years from rheumatic heart disease with resulting complications. His body was found beneath his hospital room window. Both sashes of his window were drawn into the upper half and the screen was broken and "flapped" outward. Proof was offered that the insured was mentally depressed during the weeks immediately preceding his death.

The beneficiary submitted written proofs of death, including a copy of the death certificate, which stated that the cause of death was "fractured skull: cerebral hemorrhage and laceration" and further stated that the insured

"jumped or fell from window of Veteran's Hospital 7/4/52." Upon receipt of this proof Prudential paid the single indemnity benefits but did not pay the double indemnity benefits.

The beneficiary furnished no additional proof but, instead, commenced this suit. Prudential defended on the basis that "due proof" of death by accidental means was not submitted as required by the policy. The trial court held that while due proof of death by accidental means was a condition precedent to liability of Prudential, yet the death certificate furnished this proof. The jury found that the death of the insured was due to accident and not to suicide and judgment was entered for the beneficiary.

On appeal, the Appellate Division reversed on the basis that due proof of death by accidental means had not been submitted as required prior to the institution of the suit. On further appeal to the Court of Appeals of New York, that Court reversed the decision of the Appellate Division and granted a new trial. The Court in its opinion, Dye, J., stated:

> When death has resulted from violence, the presumption against suicide does more than shift the burden of proof and upon having done so disappears [*sic*] from the case; it continues to the end of the case and if a fair question of fact is presented as to whether death was due to suicide or accident, then the jury should answer accident.
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> In the absence of words defining the constituent elements of accidental means, it must follow that the "due proof" intended is that from which a reasonable person might reasonably draw an inference of accidental means. Plaintiff's proof of claim and supporting documents showing that death was due to "fractured skull: hemorrhage and laceration," a condition which could have resulted from falling from a second-story window, furnishes a prima facie basis from which an inference of accidental means might reasonably be drawn. The added words—"jumped or fell"—appearing in the death certificate and report of the medical examiner may not be read as conclusively establishing death by suicide. No one saw decedent jump. In the absence of more specific requirements the proof as furnished, we believe, was sufficient to satisfy the policy requirement of "due proof" that death of the insured had occurred as the result of accidental means and that the company was not justified in rejecting the plaintiff's claim for accidental means death benefits (double indemnity).

MISREPRESENTATION—CONDITION PRECEDENT—AMBIGUITY: *Bronx Savings Bank v. Weigandt* (New York Court of Appeals, July 11, 1956) 1 N.Y. 2d 545, 136 N.E. 2d 848. The insured applied for a Savings Bank Life Insurance Policy, stating in his application that he had never had or been told he had tuberculosis or any disease of the glands or bones. The application contained the provision hereafter quoted as to good health. Three months after the insured was examined and the policy was issued the insured jumped or fell from the roof of a building and was killed. The autopsy disclosed that at the time the insured was suffering from active tuberculosis of the spine.

The Bronx Savings Bank, which issued the policy, claimed that it was not liable because of misrepresentation and because the insured was not in good health as required when the policy was issued and the first premium paid. The

bank brought this declaratory judgment action to have the policy declared invalid.

The trial court dismissed the complaint and granted judgment to the beneficiary. On appeal, this judgment was affirmed by the Appellate Division. On further appeal to the New York Court of Appeals, the judgment was likewise affirmed.

The Court of Appeals stated that there was no misrepresentation because the statement of the insured that he was in good health was a mere representation not part of the contract and the bank failed to prove that the insured knew or had reason to know that his health was substantially impaired at the time he made the application.

The Court had a great deal more difficulty with the good health provision in the application, which was made a part of the policy. This provision was as follows:

> I agree that: 1. If the first premium has been paid when this application is delivered to the Bank and a conditional advance premium receipt has been issued by the Bank, the policy shall take effect as of the date of completion of the medical examination or the date of receipt of this application by the Bank if no medical examination is required, provided the Bank shall be satisfied that under its rules and standards the person to be insured was a risk acceptable to it on said date . . . and provided further that the person to be insured was in good health on said date.
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> 2. If the first premium has not been so paid, the policy shall not take effect until the first premium is paid and the policy delivered while the person to be insured is in good health.

The second paragraph applied in that the first premium was not paid when the application was taken but, rather, when the policy was delivered.

The Appellate Division and the Court of Appeals construed the above quoted language to mean that where the applicant was given a medical examination and the policy delivered and the first premium paid at a subsequent date the policy would become effective in the absence of an adverse intervening change of health. The Court in its opinion, Burke, J., stated:

> The policy in this case admits of such ambiguity. The clause numbered "1" expresses an intent upon the part of the insurer to cover the risk on the date of the medical examination if the first premium is paid with the application and the applicant is in good health at that time and the insurer approves the application. Thus a person reading it could reasonably interpret the dominant intent of this clause to be that the insurer is willing to accept the risk if the medical examination proves satisfactory and the answers to the questions in the application do not persuade it to take a contrary view. Therefore, where everything required by this clause is accomplished and satisfactory to the insurer but the payment of the first premium and delivery of the policy, a person might reasonably read the clause marked "2" as intending to mean that he is an acceptable risk if there is no change in his health between the time of the medical examination and the delivery of the policy and payment of the first premium.

It would appear that the Court may have regarded this as a "hard" case. At any rate, the decision is rather difficult to justify.

DOUBLE INDEMNITY—PRESUMPTION AGAINST SUICIDE: *Carson v. Metropolitan Life Insurance Company* (Ohio Supreme Court, May 9, 1956) 165 Ohio St. 238, 135 N.E. 2d 259. The insured, who suffered some health trouble and who was not too prosperous, was found at his desk shot through his chest with his own revolver. There were no witnesses. The coroner found that his death was by suicide.

The Metropolitan paid the single indemnity benefit but refused to pay the double indemnity on the ground that the insured met his death through suicide, which was not covered under the additional indemnity provision. The beneficiary brought suit, and at the first trial after admission of the coroner's certificate the jury found for the company. This judgment was affirmed, on appeal, by the Ohio Court of Appeals, but the Supreme Court of Ohio reversed on the basis that the coroner's finding was not admissible under Ohio law.

At the second trial the court excluded that portion of the coroner's certificate relating to suicide but charged the jury in effect that the presumption against suicide might be weighed by the jury as evidence. The jury found for the beneficiary and the judgment of the trial court in her favor was affirmed, on appeal, by the Ohio Court of Appeals. On further appeal to the Ohio Supreme Court, that Court reversed the judgment on the ground that the trial court's charge that the presumption against suicide was entitled to probative weight as evidence was improper. The Court held that the presumption against suicide disappears from the case after evidence pointing to the suicide is presented by insurer and that the presumption against suicide is not evidence.

GOOD HEALTH AS CONDITION PRECEDENT: *Ellis v. Capital Life and Health Insurance Company* (South Carolina Supreme Court, May 23, 1956) 93 S.E. 2d 118. The insured applied for a life policy, stating in his application that he was in good health. The policy contained a provision that:

> No obligation is assumed by the company prior to the date hereof, nor unless on said date the insured is alive and in sound health, and the policy delivered and the first premium paid thereon. . . .

On the day the policy was delivered to the sister and the first premium paid by her the insured was admitted to a hospital, where he gave a history to the effect that for three or four months he had suffered from drowsiness and from headache. He was operated on for a brain tumor shortly thereafter and died the next month.

After the insured's death the company denied liability both on the basis of misrepresentation and on the basis, entirely independent of misrepresentation, that the insured was not on the day the policy was delivered and the first premium paid in sound health as required. The beneficiary brought suit for the face amount of the policy and the trial court entered judgment for the beneficiary. On appeal to the South Carolina Supreme Court, that Court stated that on the question of misrepresentation the insurance company "completely failed to establish fraudulent intent" as required by South Carolina law. However, the

Court on the basis of testimony presented as to the probable duration of the brain tumor found that the insured was not in good health as required when the policy was delivered and the first premium paid. Hence judgment in the beneficiary's favor was reversed and the case was remanded for entry of judgment in favor of the beneficiary for the premium paid, which liability the insurance company admitted.

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

> Quite another question is presented by the exceptions based upon the policy provisions hereinbefore quoted. Provision that the policy shall not take effect unless on the date of its issuance or at the time of its delivery the insured is in sound health is valid and enforceable, and is generally considered a condition precedent to insurer's liability; and in such respect the insured's ignorance of his condition is immaterial.

Many persons fail to recognize this distinction between misrepresentation and nonfulfillment of conditions precedent.

AVIATION RESTRICTIONS—AMBIGUITY: *Trahan v. Southland Life Insurance Company* (Texas Supreme Court, April 11, 1956) 289 S.W. 2d 753. The insured applied for life insurance in another company but while the application was pending the Southland agent convinced him that he should take the insurance in Southland. At the time and until his death the insured was on flying status with the United States Air Force.

The Southland offered the insured a policy with both war and aviation and aviation exclusion riders. He refused to take the policy because of the aviation restriction. The agent then returned the policy to the company, where the war and aviation rider was removed but the aviation rider remained, and it was claimed that the agent stated at the time that the policy "takes care of the flying coverage." The aviation rider provided that:

> If, at any time, the Insured is a pilot, officer, or member of the crew of any aircraft, or is operating or assisting in the operation of any aircraft, or is giving or receiving any kind of training or instruction or has any duties whatsoever with respect to any aircraft while aboard it during travel or flight, and if the death of the Insured results, directly or indirectly, from travel or flight in, or descent from or with, such aircraft, . . .

The insured was killed a few months later while making a military flight over the Gulf of Mexico. The Southland claimed that the aviation rider served to limit its liability, but the beneficiary claimed that she was entitled under the circumstances to the face amount of the policy. The beneficiary brought suit and in the trial court the jury found that the soliciting agent of the Southland represented to the insured that the policy covered aviation risks and that the insured relied on these representations in accepting the policy. The trial court disregarded this verdict, however, and properly so according to the opinions of the two Appellate Courts, because the agent's power to waive was restricted by the policy consistent with Texas law. Nevertheless, the trial court granted judgment for the beneficiary for the face amount of the policy, but this judgment was reversed by the Texas Court of Civil Appeals. On further appeal to the Texas

Supreme Court, that Court found for the beneficiary. The basis of its holding was that the policy was of doubtful meaning in this respect and that the ambiguity should be construed in favor of the insured and his beneficiary. The Court suggested that the war and aviation rider, removed from the policy, might have been intended to apply to one in the service and the other rider to a civilian. The Court stated that it was referred to no authority "which we consider directly in point" on the question presented.

Walker, J., wrote a dissenting opinion, in which another Justice joined, in which he stated:

> It is my opinion that an otherwise unambiguous written contract cannot be rendered ambiguous by provisions which are deleted from the instrument prior to the consummation of the contract. I would affirm the judgment of the Court of Civil Appeals.

It is difficult to justify this decision on any rational basis.