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LEGAL NOTES

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SOLDIERS' AND SAILORS' CIVIL RELIEF ACT OF 1940—GOVERNMENT'S ADVANCE AS A DEBT: *United States v. Plesha* (United States Supreme Court, January 14, 1957) 252 U.S. 202. The Soldiers' and Sailors' Civil Relief Act of 1940 provided a plan under which persons inducted into the armed forces might have their premiums paid on a limited amount of private insurance by the Government. The Act contained no specific provisions requiring repayment of the Government's advance except out of the proceeds or cash value. The Veterans Administration, which administered the Act, prepared forms which did not provide for repayment except out of the proceeds or cash value and the Veterans Administration also construed the Act as imposing no personal liability on the serviceman.

In 1942 the Act was amended to provide personal liability for repayment, but this change was not made retroactive. Later the Veterans Administration construed the 1940 Act as imposing personal liability on the serviceman.

Plesha and others allowed their policies to lapse after leaving the service and the cash values did not reimburse the Government for its expenditures. The Government deducted the balance of the amount it had paid on account of the private insurance from dividends declared under National Service Life Insurance policies. This suit was brought by Plesha and others to recover the National Service Life dividends which the Government had withheld and the Government attempted to offset the amount it had paid as premiums on the private insurance.

The District Court agreed with the Government that the amount represented an advance and that the Government was entitled to reimbursement. On appeal, the Court of Appeals reversed, holding that the serviceman had no statutory or contractual obligation to repay the Government. The Supreme Court in its opinion reviewed the history of the Act, including statements made at the time of passage in 1940 and at the time of the 1942 amendment. The Court also considered the legislative history and the interpretation of a similar 1918 Act of which the 1940 Act was essentially a copy. In its opinion the Court, Mr. Justice Black, stated:

> This contract, prepared by the Veterans' Administration, contained no suggestion to soldiers that they would be expected to reimburse the Government for its payment of premiums if they permitted their policies to lapse. Had the Veterans' Administration construed the Act as imposing such a liability on soldiers, we think it would have mentioned the obligation in the contract that it asked them to sign.

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Congress passed the 1918 and 1940 Acts at a time when men were being called from civilian life into the Army in the face of impending war. Great efforts were made to ease the burden on these men and their dependents. Among these, the Government generously provided family allotments, disability payments, and low-cost government insurance. Similarly the provisions under consideration here were adopted to assist soldiers who had bought insurance before entering the Army and did not require them to reimburse the Government.

Justices Frankfurter, Burton and Harlan dissented.

FEDERAL INCOME TAX—DEDUCTION OF SICK BENEFITS UNDER WELFARE PLAN: *Haynes v. United States* (United States Supreme Court, April 1, 1957) 353 U.S. 81. The Southern Bell Telephone and Telegraph Company, the employer of Haynes, had in effect a comprehensive plan providing pension, disability and death benefits. The plan was contractual in nature. The company reserved the right to change or terminate the plan but agreed that no change would be retroactive as to any benefit or pension to which the employee had previously become entitled.

Haynes became ill and was paid $2,100 in sickness benefits during 1949. He claimed that these benefits were not taxable under an Internal Revenue Code exemption of "amounts received, through accident or health insurance . . . as compensation for personal injuries or sickness." The Government, however, collected an income tax on account of the benefits and Haynes sued for recovery of the amount paid.

The United States District Court agreed with Haynes, holding that the payments received on account of sickness were not taxable, and the Court ordered a refund. The Court of Appeals reversed, agreeing with the Government that the plan was not "health insurance" but, rather, a "wage continuation plan." Haynes then sought and was granted a review by the United States Supreme Court.

The United States Supreme Court reversed the decision of the Court of Appeals, holding that the contractual plan constituted health insurance within the meaning of the statute. The Court, Mr. Justice Black, in its opinion stated:

If Southern Bell had purchased from a commercial insurance company health insurance that provided its employees with precisely the same kind of protection promised under its own plan, the Government concedes that the payments received by ailing employees from the commercial company would not have been taxable. Nevertheless it argues that Southern Bell's plan should not be treated as "health insurance" because the employees paid no fixed periodic premiums, there was no definite fund created to assure payment of the disability benefits, and the amount and duration of the benefits varied with the length of service. We do not believe that these facts remove the plan from the general category of health insurance. The payment of premiums in a fixed amount at regular intervals is not a necessary element of insurance. Similarly there is no necessity for a definite fund set aside to meet the insurer's obligations. And the fact that the amount and duration of benefits increased with the length of time that an employee worked for Southern Bell reflected the added value to the company of extra years of experience and service. Apparently the Government relies on these facts primarily to show that Southern Bell's plan did not contain features which would be

present in the normal commercial insurance contract. The Government, however, offers no persuasive reason why the term "health insurance" in § 22(b)(5) should be limited to the particular forms of insurance conventionally made available by commercial companies. Certainly there is nothing in the language of § 22(b)(5) which compels this limitation.

There is no support in the legislative history for the Government's argument that Congress intended to restrict the exemption provided in § 22(b)(5) to "conventional modes of insurance" and not to include employer disability plans. For reasons deemed satisfactory, Congress, since 1918, has chosen not to tax receipts from health and accident insurance contracts. The language of § 22(b)(5) appeared in the Revenue Act of 1918 and has reappeared without relevant change in all succeeding revenue acts up to 1954. The term "health insurance" was not defined in any of these acts or in any of the committee reports. There has been no uniform administrative practice which can be drawn upon to support the narrow meaning of § 22(b)(5) now urged by the Government. Administrative rulings since 1918 appear to have regularly vacillated between holding receipts under company disability plans taxable and holding that they are not taxable. Under these circumstances we see no reason why the term "health insurance" in § 22(b)(5) should not be given its broad general meaning. See *Helvering* v. *LeGierse*, 312 U.S. 531.

Justices Burton and Harlan dissented.

APPLICATION FOR REINSTATEMENT—EFFECTIVE DATE OF REINSTATEMENT: *Fisher v. American National Insurance Company* (C.A. 3, February 13, 1957) 241 F. 2d 175. The life policy containing the usual reinstatement provision was permitted to lapse about two months. Thereafter and apparently prior to a heart attack which resulted in his death later that same day the insured mailed an application for reinstatement to the agent of the company. It was not received by the agent prior to the insured's death and the company claimed that the reinstatement was not effective.

The beneficiary sued, claiming that the policy was reinstated when the application for reinstatement together with a check was mailed to the agent. The District Court and, on appeal, the Court of Appeals held that the insured had not, as required, presented evidence of insurability to the home office of the company prior to his death and that there had been no waiver of this requirement. The Court rejected the contention that the requirement that evidence of insurability be presented to the home office was an enlargement of the Pennsylvania statute that such evidence need only be presented to the "Company." The Court held that "Home Office" and "Company" were synonymous.

FEDERAL TRADE COMMISSION—JURISDICTION OVER INSURANCE ADVERTISING: *American Hospital and Life Insurance Company v. Federal Trade Commission* (C.A. 5, April 9, 1957) — F. 2d —. The insurance company with its home office in Texas was writing health and accident insurance in fourteen states, all but one of which had statutes forbidding deceptive and misleading advertising.

The Federal Trade Commission issued its complaint against the insurance company, charging unfair and deceptive advertising practices contrary to the Federal Trade Commission Act. The hearing Examiner of the Commission held that the charges had not been sustained and also held that the Commission did not have jurisdiction except as to transactions in Mississippi, where at the time there was no adequate law regulating false and deceptive acts and practices.

On appeal to the Commission the Examiner's decision was set aside by a 3 to 2 vote. The majority of the Commission held that the Congress in passing the McCarran Act in 1945 did not intend to deprive the Commission of the power to regulate and control the interstate activities of insurance companies in the advertising field, and it also found that the advertising brochures were false and deceptive. A Cease and Desist order was accordingly entered.

On appeal to the Court of Appeals that Court reversed on the basis that the Federal Trade Commission did not have jurisdiction by reason of the fact that there was state regulation in the particular area. The Court treated in some detail the *South-Eastern Underwriters* opinion of 1944 and the McCarran Act the following year. Because of its finding that the Federal Trade Commission had no jurisdiction the Court did not concern itself with the merits of the case.

This is one of several cases arising out of the efforts of the Federal Trade Commission to control advertising and certain trade practices in the accident and health field. Other cases involving somewhat different fact situations are pending elsewhere and it is likely that this case or one or more of these other cases will eventually reach the United States Supreme Court in an effort to determine the limits of the Federal Trade Commission's jurisdiction in this field. The American Hospital case represented one of the weakest cases so far as jurisdiction of the Federal Trade Commission is concerned. It is possible that in other cases jurisdiction of the Commission may be upheld.

AVIATION EXCLUSION—DEATH AFTER LEAVING PLANE: *Eschweiler v. General Accident Fire & Life Assurance Corporation* (C.A. 7, February 14, 1957) 241 F. 2d 101. The accident policy excluded death sustained by the insured "while in or on any vehicle or mechanical device for aerial navigation, or in falling therefrom or therewith or while operating or handling any such vehicle or device." The insured made a forced landing of his private plane on the ice-covered surface of a lake during a snow storm. The plane turned over, but the insured escaped and started on foot across the ice and snow to the nearest highway one-half mile away. He had not been injured in the forced landing or in escaping from the plane, but the physical effort in crossing the ice during the snow storm caused cardiac failure and his death.

The insurance company denied liability and the beneficiary sued. The District Court granted judgment for the beneficiary and, on appeal, the Court of Appeals affirmed this judgment on the basis that the death was accidental within the meaning of the policy and that the circumstances of the death did not bring it within the terms of the aviation exclusion.

Poliomyelitis Expense Policy—Treatment in Veterans Hospital: *United States v. St. Paul Mercury Indemnity Company* (C.A. 8, December 4, 1956) 238 F. 2d 594. The indemnity company issued its policy, agreeing to pay the insured in case he was stricken with poliomyelitis "for expenses actually incurred" by him and required hospital care, medical care and the like, subject to a top limit of $5,000. The insured, stricken with poliomyelitis, entered a veterans hospital, signed a statement that he was unable to defray the necessary expenses for treatment and, in accordance with the governing statute, was relieved of obligation for such expenses.

The Veterans Administration took an assignment from the insured of his rights under the policy when he was admitted to the hospital and submitted statements to the insurer for the reasonable value of the care and treatment provided. These statements totaled $3,796.69. The indemnity company refused to pay the Veterans Administration on the ground that the statement did not represent "expenses actually incurred" by the veteran. The Government brought suit but the District Court disagreed with the Government and dismissed this suit.

On this appeal the Court of Appeals for the 8th Circuit affirmed the judgment in favor of the indemnity company on the basis that the expenses had not actually been incurred. The Court, Johnsen, C.J., stated:

> What has been said seems to us sufficient to demonstrate the lack of any right on the part of the insured, and so also on the part of the Administrator, to recover on the policy for the care and treatment furnished to the veteran, under the provisions of § 706. The summary of the situation made by the trial court may be repeated: "The court is impressed with the unreality of the position that Kinnier (the insured) has incurred any expense whose payment by him to plaintiff was ever demanded, insisted upon or even expected by plaintiff. The claim of any debt on his part for that expense is a sham or pretense. It lacks that quality of 'actuality' which, the policy declares, must characterize the 'incurred expense' to support a recovery by Kinnier from defendant."

Construction of Policy—Descriptive Words as Part of Contract: *Sterneck v. Equitable Life Insurance Company* (C.A. 8, October 30, 1956) 237 F. 2d 626. The insured applied for a "Term to Age 65" policy. The company issued a policy on the outside of which appeared the following: "Non-participating Convertible Term Policy (Expiring at Age 65)." Under the insuring clause the company agreed to pay on the insured's death "provided such death occurs before the anniversary of this policy nearest the 65th birthday of the insured and while this policy is in full force." However, under a settlement option the insured or beneficiary was given the right to leave the proceeds with the company "upon the death of the insured or upon maturity or surrender."

The insured brought this action for a declaratory judgment to the effect that the policy was an ordinary life policy rather than a term policy expiring at age 65. His principal claim was that ambiguity was created by the reference in the settlement option provision to maturity of the policy as well as the insured's death or the surrender. The District Court held that considering the policy as a

whole there was no ambiguity but that the policy was a term policy. On appeal the Court of Appeals affirmed, stating that under Missouri law the court must consider general designations, such as words printed on the back or top of the policy describing it, as being part of the contract. The Court referred to the fact that the application was for a term policy and that considered as a whole it was clear that the parties intended that it be a term policy in spite of the unfortunate reference to maturity. The Court affirmed the action of the District Court in granting summary judgment in favor of the company.

GROUP LIFE INSURANCE—INELIGIBLE EMPLOYEE—INCONTESTABLE CLAUSE: *Fisher* v. *United States Life Insurance Company* (D.C. Md., November 2, 1956) 145 F. Supp. 646. The insurance company issued the group life policy in accordance with New York Law to the Trustees of the Oil Heat Institute of America. Under the policy the company agreed to insure all eligible employees of the contributing employers, and Fisher was president of a contributing employer. The policy required, however, that in order to be eligible for insurance the employee must be actively at work with the contributing employer on the effective date of the policy, which was October 1, 1952.

Fisher's company reported him as an eligible employee although he was at the time paralyzed and was never able to work after the effective date of the policy. He died in March 1955 and for the first time the insurance company learned that he was not in fact an eligible employee. The group policy provided that it should be incontestable after one year from its date of issue.

Fisher's beneficiary commenced this action, claiming that the group policy was incontestable and for this reason the insurance company could not question whether Fisher had been an eligible employee. The insurance company contended that the incontestable clause deals with the validity of the group policy itself and that the issue in question did not involve the validity of the group policy but, rather, the question of coverage. The Court submitted to the jury the question whether Fisher was ever an eligible employee under the terms of the policy and the jury found that he was not. The Court then granted judgment in favor of the insurance company, holding that the incontestable clause did not prevent the insurer from defending on the ground that the policy limits coverage to eligible employees as defined therein.