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LEGAL NOTES

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STATE V. FEDERAL REGULATION—MARINE CONTRACT—BREACH OF WARRANTY: *Wilburn Boat Company v. Fireman's Fund Insurance Company* (United States Supreme Court, February 28, 1955) 348 U.S. 310. The marine insurance contract, apparently made and delivered in Texas, contained warranties which the insurance company contended had been breached and hence the company denied liability for the loss by fire of the boat operated on an inland lake between Texas and Oklahoma. The insured claimed that the policy was governed by Texas law and that the warranties were invalid under that law. The United States District Court refused to give effect to Texas law, holding that since a marine policy is a maritime contract, federal admiralty law governed and not state law. The Court further held that an established admiralty rule required literal fulfillment of every policy warranty and because there had been a breach there could be no recovery, even though the breach did not contribute to the loss. The insured appealed to the Court of Appeals for the 5th Circuit from the District Court's judgment in favor of the insurance company and the Court of Appeals affirmed.

The insured sought and was granted a hearing by the United States Supreme Court. That Court, two Justices dissenting and one concurring only in the result, held that the marine insurance policy was governed by state law. The majority opinion was written by Mr. Justice Black, who also wrote the majority opinion in *United States v. South-Eastern Underwriters Association*, 1944, 322 U.S. 533. The Court in the majority opinion in the *Wilburn Boat* case reviewed many decisions relating to the regulation of insurance, including marine insurance, by the states. It reached the conclusion that on the issue of the effect of a breach of warranty not contributing to the loss the Court had not spoken. In its majority opinion the Court stated:

> In the *South-Eastern* case, however, all the opinions had emphasized the historical fact that States had always been free to regulate insurance. The measure Congress passed shortly thereafter, known as the McCarran Act, was designed to assure that existing state power to regulate insurance would continue. Accordingly, the Act contains a broad declaration of congressional policy that the continued regulation of insurance by the States is in the public interest, and that silence on the part of Congress should not be construed to impose any barrier to continued regulation of insurance by the States.
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> The hearings on the McCarran Act reveal the complexities and difficulties of an attempt to unify insurance law on a nationwide basis, even by Congress. Courts would

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find such a task far more difficult. Congress in passing laws is not limited to the narrow factual situation of a particular controversy as courts are in deciding lawsuits. And Congress could replace the presently functioning state regulations of marine insurance by one comprehensive Act. Courts, however, could only do it piecemeal, on a case-by-case basis. Such a creeping approach would result in leaving marine insurance largely unregulated for years to come.

In this very case, should we attempt to fashion an admiralty rule governing policy provisions, we would at once be faced with the difficulty of determining what should be the consequence of breaches. We could adopt the old common-law doctrine of forfeiting all right of recovery in the absence of strict and literal performance of warranties, but that is a harsh rule. Most States, deeming the old rule a breeder of wrong and injustice, have abandoned it in whole or in part. But that has left open the question of what kind of new rule could be substituted that would be fair both to insurance companies and policyholders. Out of their abundant broad experience in regulating the insurance business, some state legislatures have adopted one kind of new rule and some another. Some States for example have denied companies the right to forfeit policies in the absence of an insured's bad faith or fraud. Other States have thought this kind of rule inadequate to stamp out forfeiture practices deemed evil. The result, as this Court has pointed out, has been state statutes like that of Texas which "go to the root of the evil" and forbid forfeiture for an insured's breach of policy terms unless the breach actually contributes to bring about the loss insured against. *Northwestern National Life Ins. Co. v. Riggs*, 203 U.S. 243, 253–254. Thus there are a number of other possible rules from which this Court could fashion one for admiralty. But such a choice involves varied policy considerations and is obviously one which Congress is peculiarly suited to make. And we decline to undertake the task. See *Halcyon Lines v. Haenn Ship Corp.*, 342 U.S. 282, 285.

Under our present system of diverse state regulations, which is as old as the Union, the insurance business has become one of the great enterprises of the Nation. Congress has been exceedingly cautious about disturbing this system, even as to marine insurance where congressional power is undoubted. We, like Congress, leave the regulation of marine insurance where it has been—with the States.

Mr. Justice Frankfurter concurred in the result but stated, in effect, that the Court in the majority opinion had gone a lot further than was necessary to decide the particular issue.

The two dissenting Justices expressed the view that because the contract was a maritime contract there should be uniformity and that the Court should not leave the formulation of rules governing marine insurance policies to the States in the absence of Congressional action.

This case obviously did not involve a life insurance policy. However, this decision does indicate that the Supreme Court will go slow in invading the state regulatory field by judicial decision.

DISABILITY INCOME BENEFITS—REDUCTION AFTER AGE 60—AMBIGUITY: *Buchanan v. Massachusetts Protective Association* (Court of Appeals, D.C., March 3, 1955) 223 F. 2d 609. The insured under two health and accident policies became disabled prior to age 60 and benefits were commenced. After he reached his 60th birthday the payments were reduced by 50 percent under a policy provision which stated, "After the insured passes his sixtieth birth-

day all indemnities payable under this policy will automatically be reduced Fifty Per Cent." The insured claimed that this provision applied only to disabilities arising after age 60 but the company claimed that it applied to all payments due after age 60 regardless of when the disability originally commenced.

The trial court, and on appeal the Municipal Court of Appeals for the District of Columbia, sustained the company's claim. On further appeal, the United States Court of Appeals for the District of Columbia reversed, holding in effect that where the disability commenced before age 60 the 50 percent reduction provision did not apply. One judge dissented. In so holding, the Court stressed a great deal the general arrangement of the policy and purported to apply the recognized rule of construction that ambiguities in insurance policies are to be construed always in favor of the policyholder.

On October 11, 1955, the United States Supreme Court refused to review this decision.

GRACE PERIOD—EXPIRATION ON HOLIDAY—TIMELY PAYMENT: *Friedman v. Group Hospitalization* (Court of Appeals, D.C., March 31, 1955) 220 F. 2d 827. The Blue Cross hospitalization contract was dated June 1 and provided a grace period of one calendar month for the payment of the monthly premiums. On Friday, May 29, 1953, the participant mailed his check for the May 1 premium to the company. This check was not received until Monday, June 1, because Saturday and Sunday were both holidays. The offices of the company were not open on either one of the two holidays.

The company contended that the contract lapsed because the check was received too late and returned the check uncashed. The participant became disabled early in June, 1953, and claimed that the contract had not lapsed and that the company was liable for the benefits provided therein. The District Court agreed with the company and granted judgment accordingly. On appeal, the District of Columbia Court of Appeals reviewed conflicting authorities from other jurisdictions and held that it preferred to follow the liberal and majority rule, which is that when the grace period ends on a Sunday or a holiday the policyholder is entitled to pay the premium on the following business day. The Court also rejected the contention that the participant had prejudiced his position by applying for reinstatement of his contract after the company claimed it had lapsed.

BINDING RECEIPT—WAIVER BY AGENT OF EFFECTIVE DATE: *Gettins v. United States Life Insurance Company* (C.A. 6, April 15, 1955) 221 F. 2d 782. Gettins signed a written application for a $25,000 life policy and gave the agent his check covering the first annual premium. The application consisted of Parts A and B. The receipt which the agent gave to him provided that the insurance should be effective from the date of Part A or Part B, whichever was later. At the time the application was taken and the receipt given, the agent told Gettins that the policy was effective immediately.

The agent arranged two appointments with the company's medical examiner, giving him Part B of the application for further completion. Gettins did not keep either of these two appointments. He was killed in an automobile accident one month after he applied for the insurance and paid the first premium. Apparently Gettins was in good health until his accident.

The company took the position that the insurance never became effective because the applicant was not examined. The beneficiary sued, contending that the effective date provision in the application was waived by the agent's statement that the policy was effective immediately and that in reliance on the agent's statement Gettins did not submit to the medical examination promptly after the application date. The beneficiary's contention was that under Ohio law the jury should be permitted to pass on this question of waiver.

The United States District Court held that under Ohio law, which admittedly controlled, the policy never became effective because the applicant was not examined. On appeal, the United States Court of Appeals for the 6th Circuit held, one judge dissenting, that under Ohio law the soliciting agent could waive the provision in question as to effective date. In reaching this conclusion, the Court relied on an intermediate Appellate Court's decision, which under United States Supreme Court decisions was binding on the federal courts in the absence of a decision on the point by a higher state court. The Court recognized that both by custom and by the law of Ohio soliciting agents of life insurance companies have substantially less authority to waive or to alter contracts than do agents of fire insurance companies. The Court also recognized that under Ohio decisions a life insurance soliciting agent could not waive the good health requirement of a life application or policy.

One of the three Circuit Judges dissented on the basis that the other two judges had not properly construed the Ohio decisions and that under Ohio law the life insurance soliciting agent was without authority to waive the effective date provision of the application.

The Circuit Court accordingly reversed the decision of the District Court and sent the case back for a new trial. On October 11, 1955, the United States Supreme Court refused to disturb this decision.

This decision is rather serious from the standpoint of life insurance in that it can be contended in many instances that the agent did waive the effective date provision in the application and it is usually quite difficult for the company to meet successfully this contention.

ASSIGNMENT OF POLICIES AS COLLATERAL—SUBROGATION OF BENEFICIARY—INHERITANCE TAX: *Connelly v. Wells* (Connecticut Supreme Court of Errors, June 27, 1955) 142 Conn. 529, 115 A. 2d 444. The insured's widow and executrix had been named as beneficiary under several life policies which the insured had assigned to a bank to secure his indebtedness. He had reserved from the assignment the right to collect disability payments, to change the beneficiary and to select optional modes of settlement. Upon the insured's death the bank presented a claim to the estate which the executrix allowed. Thereupon she

collected the proceeds of several of the policies and turned these proceeds over to the bank along with sufficient additional cash to make up the deficit.

Under the Connecticut inheritance tax law, debts are deductible in computing the tax and life insurance proceeds are not includible where payable to a named beneficiary. The beneficiary claimed that she, having paid the debt out of the policy proceeds, should be subrogated to the claim of the bank against the estate and the debt she paid should be considered as a debt of the estate although she satisfied the debt. The State claimed that since the debt against the estate had been satisfied, there should be no deduction in computing the tax.

The trial court reserved the case for decision by the Connecticut Supreme Court of Errors. That Court in its opinion made the well-recognized distinction between policy loans, which do not constitute debts, and the situation where the insured assigns his policy to a bank or other creditor to cover his debt. The Court held that in the case of such an assignment the life insurance merely constituted collateral security and that the debt for inheritance tax purposes was deductible although satisfied by the beneficiary. The Court held that where the beneficiary had used the proceeds to pay the debt she thereupon became subrogated to all the rights which the bank had against the estate.

DISABILITY BENEFITS—WAIVER OF AGE LIMITATION—*Hunter v. Jefferson Standard Life Insurance Company* (North Carolina Supreme Court, March 9, 1955) 241 N.C. 593, 86 S.E. 2d 78. The Jefferson Standard issued its life policy, with disability income provisions terminating at the policy anniversary on which the insured's age, nearest birthday, was 55. Through clerical error the company continued to collect premiums until the insured reached age 60. The insured claimed that he became totally disabled as required to qualify for benefits prior to age 60 and that by continuing to collect premiums the company had waived its age limitation. The company contended that its liability was limited to the return of the premiums.

The insured brought this action for disability benefits. The trial court submitted to the jury the question whether there had been waiver of this age limitation and, receiving an affirmative answer, judgment was entered in favor of the insured for the amount found by the jury as due under the disability provisions of the policy.

On appeal to the North Carolina Supreme Court the company contended that the doctrine of waiver and estoppel relied on by the insured could not be applied so as to bring within the coverage of the policy risks not covered by the policy terms. The North Carolina Supreme Court agreed with this contention, distinguishing between forfeitures which are subject to waiver or estoppel and matters relating to policy coverage where the doctrine of waiver or estoppel cannot, under the majority view, properly be applied to impose liability on the company. The Court cited numerous decisions from North Carolina and other jurisdictions in support of this majority view as to the operation of waiver and estoppel.

REINSTATEMENT—REQUIREMENT THAT COPY OF APPLICATION BE ATTACHED: *Acacia Mutual Life Insurance Company v. Weissman* (Ohio Supreme Court, July 20, 1955) 128 N.E. 2d 34. The life policy, containing a two-year incontestable clause, lapsed for nonpayment of the second annual premium and was reinstated three months later. The insured died about a year-and-a-half after the policy was reinstated. The company claimed that the reinstatement application contained answers which were fraudulently false and that had the answers been truthful the policy would not have been reinstated. The beneficiary claimed that the company was liable for the policy proceeds and not merely for the return of premium paid. The basis of her claim was, first, that the policy was incontestable and, second, that the company could not rely on any misstatements in the application for reinstatement because a copy had not been furnished to the insured and that it was not adequate merely to furnish the beneficiary a copy of this application after the insured's death.

The company commenced this action to obtain the cancellation of the policy. The beneficiary filed an answer setting out these two defenses and asking for a judgment in her favor for the amount due on the basis of her claim that the policy was valid. The trial court agreed with the company that the policy was not incontestable since the contest came within two years next after reinstatement but held that the company had not complied with the Ohio statute in furnishing a copy of the application to the widow after the insured's death. Accordingly, judgment was granted in favor of the beneficiary.

On appeal, the Supreme Court of Ohio affirmed. In its opinion it considered the applicable Ohio statute, which reads as follows:

> Every company doing business in this state shall return with, and as part of any policy issued by it, to any person taking such policy, a full and complete copy of each application or other document held by it which is intended in any manner to affect the force or validity of such policy. A company which neglects so to do, so long as it is in default for such copy, shall be estopped from denying the truth of any such application or other document. In case such company neglects for thirty days after demand made therefor, to furnish such copies, it shall be forever barred from setting up as a defense to any suit on the policy, any incorrectness or want of truth of such application or other document.

The Ohio Supreme Court held that this statute should properly be construed as applying to an application for reinstatement as well as to an original application for the policy. The Court also held in effect that the last sentence of the statute did not justify the company's action in not furnishing a copy of the reinstatement application until after the insured's death, especially since the insured made no demand for a copy of the reinstatement application.

This decision removes any doubt as to the proper construction to be placed on this statute. Ohio thus joins a limited number of states where it is clear that the company cannot defend on the basis of misstatements contained in an application for reinstatement unless a copy of such application be furnished to the insured.

SLANDER BY AGENT—LIABILITY OF INSURANCE COMPANY: *Johnson v. Life Insurance Company of Georgia* (South Carolina Supreme Court, June 15, 1955) 88 S.E. 2d 260. The industrial agent visited his policyholders to collect premiums and to attempt to increase their insurance coverage. One of the policyholders asked why the Johnson claim had not been paid and the agent replied that it had not been paid because he shot his leg off on purpose. The fact was that the claim had been paid except for a question of waiver of premiums under one policy where there was a controversy with regard to furnishing the required proofs. The agent was not acquainted with Johnson and had nothing to do with the settlement of the other claim.

Johnson learned of the agent's statement and brought an action against the insurance company and the agent for slander. The jury rendered a verdict against both for $25,800 actual and $10,000 punitive damage. The trial judge set aside the judgment as to the insurance company and granted a new trial to the agent unless the plaintiff remitted all but $5,800. Johnson appealed to the South Carolina Supreme Court. On this appeal, the majority of the Justices were of the opinion that the agent was acting within the scope of his employment and in the actual performance of the duties of the corporation and hence the corporation was liable for the slander. The Supreme Court sent the case back for consideration by the trial court of the matter of excessive verdict.

REVOCABLE INSURANCE TRUST—TESTAMENTARY CHARACTER: *Bickers v. Shenandoah Valley National Bank* (Virginia Supreme Court of Appeals, September 14, 1955) 88 S.E. 2d 889. The insured entered into a written agreement with the bank reciting that policies of insurance upon his life had been made payable to and delivered to the bank. By the instrument the bank agreed to act as trustee and to distribute the proceeds as therein provided. The trust was revocable and provided that the trustee's only right in the trust and policies prior to the death of the insured was to hold the policies in safekeeping.

By the terms of the trust the widow, the second wife of the insured, was to receive a share of the insurance trust proceeds in the event that she did not dissent from the terms of the will; but in the event she did dissent, the insurance trust proceeds were to be divided among the four children of the insured.

Upon the insured's death the widow, dissatisfied with the provision made for her, commenced an action, claiming that the insurance trust was invalid as testamentary and that the policy proceeds should properly be paid to the executor of his estate. The trial court held that the insurance trust was valid but, on appeal, four of the seven Justices of the Virginia Supreme Court of Appeals were of the opinion that the trust was testamentary and hence invalid because it was not executed with the formalities required in the case of a will.

The dissenting Justices claimed that the majority decision placed Virginia in a class by itself and overrode several principles previously adhered to by the Virginia Court.

WAR RESTRICTION—COUNTRY AT WAR: *Christensen v. Sterling Insurance Company* (Washington Supreme Court, May 26, 1955) 284 P. 2d 287. The life policy provided that if the insured should die from any cause while in military, naval or air service "of any country at war" the liability of the company should be limited to the greater of the premiums paid or the reserve. The insured died as a result of an automobile accident in Alaska on May 11, 1952, while serving in the military service of the United States. The company contended that its liability was limited to the return of premiums paid. The beneficiary claimed that the exclusion did not apply because there had been no official declaration of war in Korea.

The beneficiary sued and the trial court held for the company. On further appeal to the Washington Supreme Court, that Court reviewed the decisions from many jurisdictions, including the 1953 decisions in the *Beley* and *Harding* cases (*TSA* V, 94–95), and reached the conclusion that the United States was at war when the insured died. The judgment of the lower court was therefore affirmed.

In its opinion the court, Weaver, J., stated:

> When, as in Korea, the military forces of two or more nations, under the direction of their governments, meet in armed combat over an extended period of time and in numerous engagements, such activity is ordinarily called "war." It is war in the ordinary, popular sense of the word.
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> A reading of the whole instrument does not disclose that a different or special meaning was intended by the words "country at war."
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> The purpose of a war service clause is to define a risk and exclude it from the genera coverage of the policy. If "war" is given its ordinary, popular meaning, liability is determined by actual combat, a factor which naturally affects the risk; if given its strict, constitutional meaning, liability is determined by a formal declaration which, unless coupled with actual combat, does not increase or decrease the risk. In the light of the apparent object of the clause, we conclude that the parties did not intend to have the language used, construed in its strict, technical sense.
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> The United States was a "country at war," within the meaning of the terms of the policy.

The present trend of decisions is definitely in favor of a realistic approach to this problem. No longer do the courts shut their eyes to actualities and hold that an official declaration of war is necessary to bring the policy exclusions into play.