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LEGAL NOTES

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TOTAL DISABILITY—EFFECT OF RELEASE: *Dixon v. Pacific Mutual Life Insurance Company* (C.A. 2, June 19, 1959) 268 F. 2d 812. Dr. Dixon procured a policy in 1927 from Pacific Mutual insuring him against loss of business time due to disability. His occupation was described in the policy as "Physician and Surgeon" and as time went on most of his practice was on the surgical side.

In 1949 Dr. Dixon developed dermatitis of the hands due to "scrubbing up" and the wearing of rubber gloves, and in October 1952 he was forced to give up his practice. Some months thereafter he went to work for the Veterans Administration in a position akin to that of a hospital superintendent. This position did require, however, that he be licensed as a physician.

Shortly after he went to work for the Veterans Administration he was told by a Pacific Mutual claim representative that this work meant that he was resuming his occupation and could receive no further disability payments. He accordingly signed a release and received $1,411.32. Thereafter Dr. Dixon brought this action, claiming that he signed the release under a "mistake of fact" contributed to by the claim representative's statement and that the Veterans Administration position did not disqualify him from receiving benefits and that the release was not binding on him. The United States District Court agreed with him, set aside the release and entered judgment in his favor for $24,977.03, the amount due after adjustments and credits.

On appeal, this judgment was affirmed, the Court of Appeals holding that while the borderline between "mistake of law" and "mistake of fact" is not sharp in some instances, the trial court was entitled to regard this as a mistake of fact, justifying rescission. The Court also denied the contention that the fact that the job required that he be licensed as a physician barred him from receiving benefits. The Court held also that, under the circumstances, he was not required to continue to see doctors after it was finally determined that further treatment would serve no useful purpose if he continued to engage in surgery —this in spite of a policy provision providing that the insurance did not cover "any disability for which the Insured is not necessarily and regularly attended by a legally qualified physician other than the Insured."

GROUP LIFE INSURANCE—ERRONEOUS CLASSIFICATION—INCONTESTABLE CLAUSE: *Washington National Insurance Company v. Burch* (C.A. 5, September 15, 1959) 270 F. 2d 300. Washington National issued its group life insurance

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policy covering individual members of American Turpentine Farmers Association Cooperative. The policy provided insurance in several different amounts, depending upon the classification of the individual. A $10,000 certificate had been issued for Burch, a blind gentleman, 80 years old, who devoted no time to the business and who was required by the policy terms to be actively engaged in and to devote a substantial part of his time to the conduct of the business. After his death and after investigation Washington National contended that he did not fit the classification entitling him to $10,000 but that he was entitled only to $2,500. The beneficiary contended that this issue of misclassification could not be raised because the one-year incontestable period had expired. Suit was brought by the beneficiary and the United States District Court agreed with this contention.

On appeal, the Court of Appeals for the Fifth Circuit reversed, holding that Washington National was entitled to establish, if it could, that the deceased did not qualify for the $10,000 of coverage but only for the $2,500. It held specifically that this question was not foreclosed by the one-year incontestable clause.

The Court of Appeals based its decision to a considerable degree on *Fisher v. United States Life Insurance Company*, digested at *TSA* X, 112–3.

CHANGE FROM QUARTERLY TO ANNUAL PREMIUMS—NO WRITTEN EVIDENCE: *Northwestern Mutual Life Insurance Company v. United States National Bank* (C.A. 8, June 10, 1959) 267 F. 2d 565. The Northwestern Mutual issued its $100,000 five-year term policy on a quarterly basis June 6, 1955, and premiums were payable quarterly for the first policy year. In June of 1956, after the policy had been assigned to the bank, an annual premium was paid, consisting of $860 in cash and a dividend of $406. The insured had elected to apply dividends in reduction of premiums.

In June of 1957 a dividend of $458 was payable under this policy. The quarterly premium was $326. Neither the insured nor the assignee had ever given any verbal or written request for a change in the frequency of premium payments, but, as indicated, an annual premium had been paid the second year and the premium for the third policy year was billed on this basis. No further premiums were paid after the annual premium for the second policy year and the insured died July 13, 1957.

The Northwestern Mutual denied liability on the basis that the insured had failed to pay the annual premium for the third policy year. The beneficiary claimed that the company was under an obligation to apply the dividend in reduction of premium, that there had been no election to pay premiums annually, that there had been an election to apply dividends in reduction of premiums and that the dividend payable was more than adequate to cover the quarterly premium.

The United States District Court and, on appeal, the Court of Appeals for the Eighth Circuit agreed with the beneficiary, holding that it was the duty of

the company to apply the dividend in payment of the quarterly premium and that the policy was therefore in force on the date of the insured's death.

There is obvious danger in changing the method of premium payments without written request.

BINDING RECEIPT—EFFECTIVE DATE OF COVERAGE: *Metropolitan Life Insurance Company v. Grant* (C.A. 9, June 16, 1959) 268 F. 2d 307. Peter Grant, an airplane crop duster, made application to Metropolitan for a life insurance policy on August 11, 1954. He signed Part A on that day and paid a monthly premium, but before he could be examined two days later he died as a result of an airplane accident. Parts B and C of the application, contained on the same piece of paper as Part A and relating to the medical examination, were never signed.

The application provided that:

> If an amount equal to the full first premium on the policy applied for is paid to and accepted by the Company at the time Part A of this application is signed and if this application is approved at the Company's Home Office for the class, plan, and amount of insurance herein applied for, then the insurance in accordance with the terms of the policy applied for shall be in force from the date hereof.

The receipt which Grant received contained quite similar language. The Metropolitan denied liability on the basis that the insurance had not taken effect prior to Grant's death because the policy had not been approved at its home office, as Metropolitan contended was required.

The beneficiary sued and in the District Court judgment was entered for the beneficiary on the basis that the policy was in force when Grant died. On appeal, the Court of Appeals considered California decisions bearing on this point and held that the judgment of the District Court was correct. In its opinion the Court stated:

> The same ambiguity present in *Ransom* as to what it means for insurance to be effective from the date of the policy application if some further acts of the company are required is presented to us. Appellant seeks to explain the function of the language of relation back by showing that the premium is based on the age of the applicant at the time of the application rather than at the time of the approval by the home office which is an advantage to the applicant if he pays the premium in advance. That result could be indicated by much clearer language thus eliminating the ambiguity present in the language actually used and thus avoid leading the layman into believing that coverage was in force from the day of application when the premium was paid in advance. Appellant seems to have difficulty with the interpretation of the language itself as it stated in its brief and repeated on oral argument that if the applicant had become sick during the time before final approval he would be covered. We cannot understand how the language used differentiates between intervening mortal sickness and death.
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> The set up in the application reasonably presents a picture to an applicant that two stages are present. First pay the portion of the premium required in advance and in consideration thereof you will have protection until your application is accepted or rejected. Second, if appellant accepts the risk a policy will be issued in due course.

Basing our assumption on the *Ransom* case, we think that under the circumstances of this case the Supreme Court of California would reach the conclusion that interim insurance was in force and effect from the time of the receipt by appellant's agent of the application and check were this case presented to them for decision.

One of the three judges dissented on the basis that there was no coverage, particularly since the insured died even before he could take the medical examination and could sign Parts B and C of the application. He was of the view that the California decisions, reasonably construed, did not require that the Court hold that the policy was in force.

These binding receipt cases are becoming increasingly common and there seems to be a growing inclination in this type of case to hold the company liable if at all possible.

FEDERAL ESTATE TAX—PREMIUM PAYMENT TEST: *Manufacturers National Bank v. United States* (D. C. Michigan, June 1, 1959) 175 F. Supp. 291. In 1936 the insured absolutely assigned the four policies in question to his wife, retaining no incident of ownership. However, he continued to pay premiums on these policies until his death in July of 1954. In 1941 by regulation, and by a change in the law in 1942, the "premium payment test" had been put into effect in connection with the Federal estate tax. The claim of the Government was that under this law the policy proceeds were a part of the insured's estate because the insured continued to pay premiums after the effective date of the regulation and after the passage of the law in 1942, even though he retained no interest in the policies.

The bank, as executor of the insured's estate, paid the tax in dispute and thereafter brought this suit to recover this tax plus interest. The District Court held that in so far as the law attempted to include the policy proceeds in the insured's estate this law was unconstitutional. The Court considered cases more or less directly in point decided by other lower Federal courts and also United States Supreme Court cases which it considered to be pertinent. The Court reached the conclusion that there was no transfer at the insured's death which could properly be subjected to the Federal estate tax.

The Government sought a review of this case by the United States Supreme Court, where it could go directly by reason of the fact that the United States District Court had declared the law unconstitutional. The United States Supreme Court agreed to hear this case by noting "probable jurisdiction" on November 3, 1959. The insured's death occurred only a few weeks before the effective date of the 1954 Code, which abolished the premium payment test. Hence this case applies directly only to the estates of persons dying in the interval between the institution of the rule and the effective date of the 1954 Code. This case is important, however, because if the lower court judgment be upheld, it may be that it is not within the power of the Congress without a Constitutional amendment to reinstate the premium payment test, as has been threatened from time to time.

Heretofore in this type of case the Government has been quite reluctant to

appeal from similar decisions adverse to it. See, for example, *Kohl v. United States*, digested at *TSA* VIII, 96–98. This case seems to present squarely the question of the validity of the premium payment test.

ACCIDENT INSURANCE—EXCLUSION OF DEATH OF CREW MEMBER: *Vander Laan v. Educators Mutual Insurance Company* (Michigan Supreme Court, June 5, 1959) 356 Mich. 318, 97 N.W. 2d 6. The benefit certificate provided air travel benefits but only while the insured was traveling "as a passenger in a powered civil aircraft." There was a specific exclusion of loss, fatal or nonfatal, resulting wholly or partly, directly or indirectly, "(a) while operating, . . . or serving as a member of the crew of any aircraft." The insured, a physician, who owned the airplane, went in it with three others on a fishing trip into Canada. The airplane had dual controls and it was contemplated that one of the three others would do most of the flying, although the doctor-owner of the plane admittedly flew part of the time and was listed in the flight plans as the pilot.

On the return from the fishing trip the plane crashed and the doctor and the other person sitting at the controls were both killed. There was no conclusive evidence as to who was piloting the plane at the time, but the insured was sitting in the seat known as the pilot's seat. The insurance company denied liability for the accidental death benefits on the basis of the exclusion language, and the beneficiary brought this suit. The trial court submitted to the jury the question whether the insured was actually piloting the airplane at the time of the fatal crash, and the jury's conclusion was that he was not. Judgment was entered for the beneficiary. On appeal, the Michigan Supreme Court affirmed on the basis that under the policy language it was the status at the time of the crash which controlled and that the jury's verdict should not be disturbed.

Courts continue to construe strictly against the insurance company any policy language which may be regarded as ambiguous.

AGENT'S PROMISE TO PAY PREMIUM—OBLIGATION OF AGENT AND COMPANY: *Spiegel v. Metropolitan Life Insurance Company* (New York Court of Appeals, May 28, 1959) 6 N.Y. 2d 91, 160 N.E. 2d 40. The second quarterly premium on the life policy with accidental death benefits was not paid, and before the expiration of the period which would have been covered by this second quarterly premium the insured died. The beneficiary contended that the agent on several occasions prior to the lapse of the policy promised her that he would "take care" of the premium and thereafter look to her for reimbursement. The Metropolitan had sent a formal premium notice as required and also a notice of possible lapse, which was sent just before the grace period expired. After the policy lapsed the Metropolitan inadvertently sent a premium notice to the insured covering the third quarterly premium, but this notice specified that the premium should be paid only if "said policy be then in force."

The Metropolitan denied liability on the basis that the policy had lapsed, and the plaintiff brought an action against both the Metropolitan and the agent, Levy, to recover the life insurance proceeds and also the additional

indemnity benefit, the claim being made that the insured died through "accidental means." The trial court dismissed the action as to the Metropolitan and directed a verdict in favor of the agent. On appeal, the Appellate Division affirmed. On further appeal, the Court of Appeals affirmed the judgment dismissing the action as to the Metropolitan on the basis that the policy provided that the agent was not authorized "to extend the due date of any premium" and that the premium notice relating to the third quarterly premium did not waive the lapse. However, the Court held that it was a jury question as to whether or not the agent had made the promises as alleged; and if so, he was personally liable to the beneficiary. Hence the Court sent the case back for a new trial on this point and on the question of whether the death was by accidental means. The Court considered cases holding that the agent was liable for failing to procure insurance after promising to do so and held that this principle should be applied to this fact situation. In its opinion the Court stated:

> Although the cases cited deal with an agent's failure to obtain insurance after a promise to do so, the principle underlying the decisions applies with equal force to the situation now before us. An agent who fails to keep a policy in force after promising to do so is in no better position than one who neglects to procure a policy after agreeing to do so.
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> The amount of Levy's liability will, of course, depend upon whether the insured did or did not die by "accidental means." If he did not, then Levy—if the jury concluded that he made the promise to take care of the premium due—would be liable, at most, for the face or principal amount of the policy, $7,650. On the other hand, if the insured died as a result of an accident (within the meaning of the rider), then, Levy would be liable for the further sum of $3,000.

AUTHORIZATION TO BANK TO PAY PREMIUMS—NEGLIGENCE OF BANK: *Walker Bank & Trust Company v. First Security Corporation* (Utah Supreme Court, August 3, 1959) 9 Utah 2d 215, 341 P. 2d 944. The Commercial Bank, whose obligations were assumed by First Security Corporation, was authorized in writing by the insured to honor sight drafts to be drawn monthly against her account to cover premium payments. Through inadvertence the Commercial Bank, after accepting several such drafts, then returned later drafts as "not authorized." These dishonored drafts resulted in the lapse of the policy prior to the insured's death shortly thereafter. The Walker Bank & Trust Company, as guardian of the minor beneficiaries, brought this action, claiming that the Commercial Bank was negligent in dishonoring the drafts and hence was liable to the beneficiary for an amount equal to the policy proceeds. The insured had been mailed a notice by the insurance company to the effect that the policy had lapsed, but this notice had been sent to a former address. The insured had also received monthly bank statements which, if examined, would have indicated that the drafts had not been charged to her account. Her agreement with the bank in connection with the honoring of the drafts provided:

> I understand and agree that your compliance herewith shall constitute a gratuity and courtesy accorded me as your customer, and that you assume or incur no liability whatsoever in the premises, and I further agree to hold you harmless of and from any and all claims arising hereunder.

The insurance company claimed that the policy had lapsed and denied liability. The trust company, as guardian of the minor beneficiaries, sued the First Security Corporation as successor to the Commercial Bank. The trial court and, on appeal, the Utah Supreme Court held that there was liability to the beneficiaries by reason of the inadvertent dishonoring of the sight drafts and that the bank was not absolved from liability by the agreement quoted above. This agreement was construed strictly against the bank, the Court holding that the liability protected against must arise from "compliance" with the authorization and that there was no compliance. The Court also held that although the agreement was entered into with the insured, there was direct liability to the beneficiaries and that the lapse notice mailed to the wrong address did not adequately warn the insured that the policy had lapsed.

Two of the justices dissented.