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Life, Health and Disability News

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Life, Health and Disability Commitee

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In This Issue

Leadership Notes

Message from the Chair

By Byrne Decker

Greetings LHD Committee members! For the first time as committee chair, I am honored to have this opportunity to update you on our recent committee activities.

Our main event this fall was the DRI Annual Meeting, held last month in San Francisco. The Annual Meeting always provides a great opportunity to connect with other DRI committees, exchange ideas, and take in some can't miss CLE presentations. And this year was no exception.

Our own committee CLE session featured an outstanding presentation on diversity issues in LHD&E litigation by Elizabeth Doolin and Kristina Holmstrom. Despite the early morning start, their timely talk engendered a lively and interactive "roundtable" discussion that everyone very much enjoyed and benefitted from.

Afterwards, Leo Lagamasino held her last committee business meeting as our outgoing chair. During Leo's two years as chair, she spearheaded numerous efforts to move our com mittee forward and significantly expanded on the successes of past leaders who have served our committee so well over the years. Leo's hallmark achievements in the area of diversity are particularly noteworthy. As incoming chair, I am indebted to Leo for all she has done to help prepare me to assume this role. And we are all very excited that DRI has elected her to serve a three year term on the DRI Board of Directors. I hope you will all join me in congratulating Leo on this significant achievement!

Throughout the several days in San Francisco, what struck me the most was the camaraderie and cohesiveness of our committee members. In addition to several impromptu meals and gatherings (including, of all things, an entertaining trip to an old-fashioned speakeasy, coordinated by Kristina Holmstrom), we enjoyed a wonderful afternoon and evening at the Francis Ford Coppola Winery in California's beautiful wine country, which included a winery tour, tasting reception (including competitive games of bocce), and private dinner. This event was a highlight of our time in San Francisco and I can't thank Nancy Marr and Elizabeth Doolin enough for all their hard work in organizing it. It was not only a great success but also a testament to how much our committee members enjoy each other's company and how much value we all derive from our participation in and work for the committee.

Now, with the Annual Meeting in the rear view mirror and as autumn turns to winter, it is time to get on with our work moving our Committee forward. Scott Trager (our new committee vice chair) and I are in the process of updating our committee leadership roster and setting goals for the committee to ensure that we continue to serve our members' interests. I urge all of you to get involved in our committee, whether in a leadership position or just letting us know your thoughts on how the committee can better serve you. Please feel free to e-mail or call Scott and me with any ideas you may have. I can tell you from experience that getting involved in our committee pays real dividends in many ways. You won't regret it!

Byrne J. Decker is the managing shareholder in the Portland, Maine office of Ogletree, Deakins, Nash, Smoak & Stewart, P.C. Mr. Decker has a nation-wide practice that specializes in the defense of employee benefits/ERISA litigation. He has defended benefits cases in federal courts in every federal judicial circuit. Mr. Decker is the chair of DRI's Life, Health and Disability Committee.

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Message from the Editor

By Eileen E. Buholtz

The theme of this issue is rescission. Thank you to Stephen Roach (Roach Ioannidis & Megaloudis, Boston) for his scholarly article on the law of rescission in Massachusetts; to Edna Kersting (Wilson Elser, Chicago) for an article on a life insurance applicant's attestation to the truth of the answers based on the applicant's "knowledge and belief"; and to Matthew Kleiner and Andrea Scripps (Gordon Rees, San Francisco) for an article on the law of rescission in California.

A recent decision from New York County Supreme Court (court of general trial-level jurisdiction, Manhattan) that turned on multiple hearsay in business records took me back to law school evidence class and inspired me to write a case note on it.

Eileen E. Buholtz is a member of Connors, Corcoran & Buholtz, PLLC in Rochester, New York, where she concentrates her practice insurance defense litigation (premises, lead paint, construction site accidents, and auto), insurance coverage litigation, and estate litigation. Ms. Buholtz is president of the Rochester chapter of American Board of Trial Advocates (ABOTA); board member of the Defense Association of New York (DANY); active in various committees of DRI; member of the House of Delegates of the New York State Bar Association (NYSBA); immediate past treasurer of the Monroe County Bar Association (MCBA); past president of the Greater Rochester Association for Women Attorneys (GRAWA); and co-chair of the Courts/Judiciary Committee of the Women's Bar Association of the State of New York (WBASNY).

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Feature Articles

Massachusetts

Rescission of Life and Disability Policies

By Stephen A. Roach

General Rule: Rescission for a Material Misrepresentation in an Application Can Only Be Achieved by a Lawsuit Brought Within the Two-Year Contestable Period

Insurer's Basic Right to Rescind

The primary Massachusetts statute which provides a company the right to rescind is M.G.L. Chapter 175, Section 186. Section 186, which applies to life and disability policies, provides that a company can rescind a policy (1) for a misrepresentation made with the intent to deceive *or* (2) where the matter misrepresented, even if it is an "innocent" misrepresentation, increased the risk of loss to the insurance company.[1] To rescind, the company must return the premiums.

Rescission Cannot Be Achieved Merely By Written Notice with a Refund

Under Massachusetts law an insurer *cannot*, simply by a letter to the policyholder or beneficiary, unilaterally rescind a policy for misrepresentations made in an insurance application, even when it refunds the premiums. With certain potential exceptions, discussed below, a rescission for a material misrepresentation must be accomplished in the context of a lawsuit in court filed within the two-year contestable period. The two-year contestable period for life and disability policies begins to run from the time the policy is issued and is in force, not from the date of the

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application. See M.G.L. c. 175, §132 (2) (two years from date a life policy has been in force); M.GL. c. 175, §108 (3.) (a)(2) (two years from date an accident or health policy is in force). 2

To achieve a rescission, the insurer must, within the two-year contestable period, (1) file a declaratory judgment action and seek a rescission, or (2) ask for the same relief in defense of an action brought by a policyholder or beneficiary against the company. Whether the company brings the action as the plaintiff or counterclaiming defendant, it is also advisable to seek both a declaration to void the policy and injunctive relief to preclude any claim for benefits.

The leading Massachusetts decisions which hold that the insurer must either file or defend a claim in court within the two-year contestable period to rescind include the following: *Protective Life Ins. Co. v. Sullivan*, 682 N.E.2d 624, 635, 425 Mass. 615, 632 (1997); *Bonitz v. Travelers Ins. Co.*, 372 N.E.2d 254, 256–57, 374 Mass. 327, 331–32 (1978); *Massachusetts Mut. Life Ins. Co. v. Shattuck*, 105 N.E.2d 247, 248, 328 Mass. 561, 562 (1952); *Metropolitan Life Ins. Co. v. DeNicola*, 58 N.E.2d 841, 842, 317 Mass. 416, 419–20 (1944).

As explained below, there are exceptions, as well as limitations, to the applicability of the two-year contestable period and the right to rescind. There also are different statutes, with different legal consequences, governing life policies as opposed to disability policies.

Life Insurance Policies – Basic Rescission Rights

The Two-Year Contestability Statute

Chapter 175, Section 132(2) governs the two-year contestable period for individual life insurance policies. Section 132(2) states that a policy must, in relevant part, contain "[a] provision that the policy shall be incontestable after it has been in force during the lifetime of the insured for a period of two years ...." Unlike the statute applicable to disability policies, discussed below, Section 132(2) does *not* provide any exception for fraudulent misrepresentations or any other exception. M.G.L. c. 175, §134 (1) contains a similar provision for group life insurance policies.

Medical Examination Requirement

In addition to the two-year incontestability statute (Section 132(2)), Chapter 175, Section 124 further limits the ability of the company to contest a life insurance policy for a material misrepresentation. It applies even before the two-year contestable period expires. Section 124 makes a distinction between (1) policies issued where the company requires a medical examination of the insured and (2) policies issued where the company did *not* first conduct a medical examination of the insured.

Section 124, which was in force before the Massachusetts Legislature enacted any incontestability statute, provides, in pertinent part, as follows:

> In any claim arising under a policy issued in the commonwealth by any life company, without previous medical examination ... the statements made in the application as to the *age, physical condition and family history* of the insured shall be held to be valid and binding on the company; but the company shall not be debarred from proving as a defense to such claim that said statements were willfully false, fraudulent or misleading. (emphasis added)

In applying Section 124, Massachusetts courts have ruled that if the company has *not* first conducted a medical examination of the insured, the company cannot contest the policy for a non-fraudulent misrepresentation. It cannot avoid the policy even if (1) the "innocent" misrepresentation on the application increased the risk of loss to the company and (2) the company took steps in court, as required, to rescind within the two-year contestable period. *See Torres v. Fidelity & Guar. Life Ins. Co.*, 611 N.E.2d 733, 734–35, 34 Mass. App. Ct. 376, 377–88 (1993).

In other words, where a company chooses to not conduct a medical examination of the insured, rescission is available only if (1) the insured's statements on the application "were willfully false, fraudulent or misleading" and (2) the claim or counterclaim seeking rescission is brought within two-year period. Noticeably missing from Section 124 is any reference to misrepresentation regarding occupation. It controls only misrepresentations about age, physical condition and family history. Consequently, without the prior medical examination, the ability of the insurance company to rescind becomes narrower, and Section 124 would apply. Basically, the company then must show "an actual intent to deceive." *Hardick v. Metropolitan Life Ins. Co.*, 1995 WL 852063 *6 (D. Mass 1995); *see Protective Life Ins. Co. v. Sullivan*, 682 N.E.2d at 630, 425 Mass. at 623 (1997).

A company that ignores the distinction between Sections 124 and 186 does so at its peril. For example, the current Chief Justice of the Massachusetts Supreme Judicial Court, Justice Ralph Gants, once awarded triple damages, attorney's fees and interest on a $1,000,000 life policy against a company which denied coverage under Section 186, and failed "to comply with the dictates" of Section 124. Then a

Justice of the lower Massachusetts Superior Court, Justice Gants said that "[t]his Court recognizes that the trebling of damages is a heavy price" for the company to pay but still issued the judgment under the Massachusetts Consumer Protection Act. *Hejinian v. General American Life Ins. Co.*, 25 Mass.L.Rptr. 408, *10 (2009).

Interestingly, two Massachusetts U.S. District Court cases disagreed on the question of whether alcoholism is a "physical condition" within the purview of Section 124. In *Hardick v. Metropolitan Life Ins. Co.*, the Court held that alcoholism is a physical condition governed by Section 124 because insurers who do not conduct a physical exam are held to "higher standards." *Hardick v. Metropolitan Life Ins. Co.*, 1995 WL 852063 *6 (D. Mass 1995). In *Jenkins v. Aetna Life Ins. Co.*, decided one year later, the Court concluded that questions directed as to alcoholism were *not* within the purview of physical conditions under Section 124 because alcoholism relates only to personal habits. *Jenkins v. Aetna Life Ins. and Annuity Co.*, 1996 WL 617264 *4 (D. Mass 1996). In Massachusetts, it remains an open question.

A Physician, Not a Nurse, Must Conduct the Examination

In 2002, the Massachusetts Appeals Court (a step below the highest Massachusetts court, the Massachusetts Supreme Judicial Court) ruled that the insurance company does *not* satisfy the "medical examination" requirement of M.G.L. Chapter 175, Section 124 if a nurse, rather than a physician, conducts the examination. *Robinson v. Prudential Ins. Co. of America*, 776 N.E.2d 458, 463, 56 Mass. App. Ct. 244, 251 (2002). *Robinson* added that "the purpose of Section 124 is to impose a higher burden of proof on an insurer when it contests a life insurance policy issued without a medical examination...." *Id.* at 463, 56 Mass. App. Ct. at 251.

Furthermore, the *Robinson* Court stated that the insurance company cannot dispose of the case by summary judgment where the insured claims that the incorrect statements were a mistake; it presents a jury issue. *Id.* at 463, 56 Mass. App. Ct. at 252. The Court did grant summary judgment, however, on the claim for multiple damages and attorney's fees under M.G.L. Chapter 93A (the Massachusetts Consumer Protection Act) where the Court determined that the company's denial of the claim was reasonable. *Id.* at 464, 56 Mass. App. Ct. 252.

Reinstatement of Policy

In a positive note, the Supreme Judicial Court in 2004 ruled that the two-year contestable period begins to run *again* when an insured has makes misrepresentations in an application to reinstate a policy which had initially lapsed for non-payment of premiums. Furthermore, in such instances the insurance company need not prove the higher standard of "willfully false, fraudulent or misleading" under Section 124 even if there was no medical examination prior to the reinstatement; in that regard, the court distinguished between the original issuance of the policy and reinstatement. *Opara v. Massachusetts Mutual Life Insurance Company*, 806 N.E.2d 924, 930–31 n.15, 441 Mass. 539, 547–48 n. 15 (2004).

In cases where there was a simple reissuance, however, and there was no lapse for non-payment of premiums (or other similar events like termination of employment or discontinuance of the group policy) the original two-year contestable period likely still applies. *See Bonitz v. Travelers Ins. Co.*, 372 N.E.2d 254, 257, 374 Mass. 327, 332 (1978).

Requirement to Attach Application to Policy Upon Issuance

An insurance company cannot rely on a misrepresentation in an application unless a copy of it is attached to the policy. M.G.L. c. 175, §§131–132 (life policies); M.G.L. c. 175, §108(5)(a) (disability policies); *see John Hancock Mut. Life Ins. Co. v. Banerji*, 848 N.E.2d 277, 283, 447 Mass. 875, 881–82 (2006) (discussing disability policy). The *Opara* Court ruled, however, that those statutes do *not* apply to an application for reinstatement, even where the terms of the policy were amended, on a reinstatement after a lapse for non-payment of premiums. 806 N.E.2d at 928, 441 Mass. at 543.

Rescission of Life Policies for Fraud After the Two-Year Contestable Period Expires Is Prohibited: *Protective Life Ins. Co. v. Sullivan*

In *Protective Life Ins. Co. v. Sullivan*, the insured, Dennis J. Sullivan, unquestionably lied in the policy application about his positive HIV diagnosis. Although Sullivan authorized Protective Life to take medical tests, including a test for HIV, before it issued the policy, Protective Life chose not to conduct a medical test. Before the two-year contestable period expired, Sullivan later became disabled and stopped working after the HIV infection progressed to AIDS. Sullivan purposely did not apply for the disability premium waiver under the policy until after the two-year contestable period had run. *Protective Life Ins. Co. v. Sullivan*, 682 N.E.2d at 627, 425 Mass. at 617.

In the terms of the policy, Protective Life created an exception to the two-year contestable period for fraudulent

statements. *Id.*3 The Commissioner of the Division of Insurance approved the policy form, including the fraud exception. *Id.* at 627, 425 Mass. at 617.

Protective Life argued that even though Section 132(2), which governs the contestable period for life policies, contains no exception for fraud, the Commissioner's approval of the policy form containing the exception created an implied exception for fraud. Protective Life also

contended that in this instance of obvious and blatant fraud, the two-year contestable period should be tolled. The Court found that Sullivan defrauded Protective Life through his "willful concealment of his medical condition," which was "deplorable" and deserving of "condemnation." Nevertheless, the Court ruled in favor of Sullivan. Interestingly, the Court found that Sullivan's delay in applying for a disability waiver until after the two-year contestable period had expired did not constitute an "affirmative act" to defraud Protective Life. *Id.* at 634–35, 425 Mass. at 631.

Prior Federal Court Action in Protective Life

Initially, the *Protective Life* matter was filed in federal court in Massachusetts. In 1995, Judge Keeton of the U.S. District Court for the District of Massachusetts ruled that Protective Life could seek to rescind the policy it had issued to Sullivan on the grounds of a fraudulent misrepresentation after the two-year contestable period has expired even though (1) the policy had been issued without a prior medical examination and (2) Section 132(2) sets forth no exception for fraud. *Protective Life Ins. Co. v. Sullivan*, 892 F. Supp. 299, 302 (D. Mass. 1995).

On appeal, the U.S. Court of Appeals for the First Circuit, *Protective Life Ins. Co. v. Sullivan*, 89 F.3d 1 (1st Cir. 1996), certified the following two issues to the Massachusetts Supreme Judicial Court for answers:

> (1) Does M.G.L. c. 175, §132 (the incontestability act for life insurance policies), taken together with M.G.L. c. 175, §124 (the medical examination act), bar an insurance company from contesting the validity of a life insurance policy more than two years after its date of issue on the ground that the insured made fraudulent misrepresentations in applying the policy, where the policy provided that it was contestable for fraud at any time and where the Massachusetts Commissioner of Insurance approved the policy form?
>
> (2) If the incontestability statute bars such an action, is the contestability period nonetheless equitably tolled under the circumstances of this case by [the insured's] failure to apply for the disability waiver to which he was entitled until two years after the policy was issued?

3 *Id.* at 2–3.

Massachusetts' Answers to the Two Certified Questions

- **Rescission for a fraudulent misrepresentation is not available after the two- year contestable period expires where no medical exam was done, even though the Commissioner of the Division of Insurance has approved the language of the policy form which provided an exception to the contestability period for fraud.**

With respect to the first question set forth above, the Supreme Judicial Court, as discussed above, answered in the affirmative. In other words, a *life* insurance policy *cannot* be contested after two years where the company did not first conduct a medical examination. The policy cannot be defeated after the two-year contestable period has run even if the company can prove that the policyholder made fraudulent misrepresentations in the application. It is also incontestable even though the Commissioner of the Division of Insurance had approved a policy form which gave Protective Life the right to contest the policy for fraudulent misrepresentations in the application after the two-year period expired. *See Protective Life Ins. Co. v. Sullivan*, 682 N.E.2d 624, 627, 425 Mass. 615, 617.

As stated above, Section 186 provides that a company can rescind a policy within the two-year contestable period (1) for a misrepresentation made with the intent to deceive or (2) where the matter misrepresented increased the risk of loss. In construing the interplay of Sections 186, 132 and 124, however, the Court's holding narrowed the scope of Section 186.

Consequences for No Medical Examination

The *Protective Life v. Sullivan* ruling is significant because it means that a company which has *not* first conducted a medical examination of the applicant now can contest a life insurance policy only on very narrow terms. First, it can contest the policy only for a *fraudulent* misrepresentation. Second, it can contest the policy (meaning by an action in court) for fraud only within the time frame of the two-year contestable clause.

If the company has not first conducted a medical examination of the insured, the Court has determined that the company cannot contest the policy for a non-fraudulent misrepresentation at any time. It cannot avoid the policy even if the "innocent" misrepresentation on the application increased the risk of loss to the company and even if

the company takes steps to rescind within the two-year contestable period. *See Torres v. Fidelity & Guar. Life Ins. Co.*, 611 N.E.2d 733, 734–35, 34 Mass. App. Ct. 376, 377–88 (1993).

Additional Rights When a Medical Examination Is Conducted

If a company first has conducted a medical examination it then can attempt to rescind a policy under Section 186 where (1) there has been a fraudulent misrepresentation or (2) where there has been an "innocent" misrepresentation on the application which increased the risk of loss. Even so, the company still must bring an action in court to rescind within the two-year contestable period.

The *Protective Life v. Sullivan* Court pointed out that Section 186 (the right to rescind law) was enacted 14 years before Section 124 (the medical exam act) was adopted, and that Section 124 was in force before Section 132(2) (the incontestable period statute) was passed. Accordingly, the court reasoned, Section 124 did not create a fraud exception to the incontestability statute. *See Protective Life Ins. Co. v. Sullivan*, 682 N.E.2d 624, 629, 425 Mass. 615, 623.4

Quite the contrary, the purpose of Section 124, the Court said, was to impose a *heavier* burden on companies which sought to rescind under Section 186, the statute which provides the basic right to do so. *Id.* at 631, 425 Mass. at 625. The purpose of Section 132(2), the court ruled, was to *further* limit the insurer's right to contest a life policy under Section 186 by forcing the company to investigate and take steps to rescind within the first two years. *Id.* at 631, 425 Mass. at 625.

With respect to Section 132(2), the court noted that the Legislature did not carve out for life policies an exception for fraud like it did for disability policies. *Id*. at 631, 425 Mass. at 627; *compare* M.G.L. c. 175, §108(3)(a)(2) (Fraudulent misstatements in *disability* policy can be contested after expiration of two-year contestable period). The Court stated that the incontestability clause is "designed to require the insurer to investigate and act with reasonable promptness if it wishes to deny liability on the ground of false representation or warranty.... It prevents an insurer from lulling the insured, by inaction, into fancied security during the time when the facts could best be ascertained and proved, only to litigate them belatedly, possibly after the death of the insured." *Id.* at 633, 425 Mass. at 628 (quoting from *Metropolitan Life Ins. Co. v. DeNicola*, 58 N.E.2d 841, 842, 317 Mass. 416, 418 (1944)).

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- **The contestability period is not equitably tolled where an insured waits until the two year contestable period has expired before applying for the premium disability waiver; affirmative fraudulent acts are required.**

The Supreme Judicial Court's answer to the second certified question was in the negative, *i.e.* the policy could not be equitably tolled in the circumstances of the case. As discussed above, after Sullivan became disabled he did not apply for the disability premium waiver until after the two-year contestable period had run.5

The Court held that the contestability period was not tolled because Sullivan was under no obligation to file a claim for a disability waiver of his premium. The Court stated that "[t]he incontestability period cannot be tolled where, as here, the insured did not perform any *affirmative* act to conceal the existence of his original fraud in the application." *Protective Life v. Sullivan*, at 635, 425 Mass. at 632. (emphasis added)

The Court remarked that the insurance company's attempt to rescind was not based on an

"inherently unknowable" wrong on the part of Sullivan. *Id*. at 635, 425 Mass. at 632. Through the exercise of reasonable inquiry, the Court stated, Protective Life could have learned of Sullivan's medical condition either before issuing Sullivan the policy or within the two-year contestable period. *Id*. at 635, 425 Mass. at 632.

Declining to address Sullivan's argument that Section 132(2) (the life insurance two-year contestability statute) is in the nature of a statute of repose rather than a statute of limitations, the Court left open the question of whether Section 132(2) can be tolled under other circumstances. *Id*. at 634, 425 Mass. at 631.6 Consequently, the Court did not resolve completely whether an insurance company can successfully argue that Section 132(2) can be tolled in instances where the insured takes affirmative steps to conceal the fraud.

While the Court's decision in *Protective Life* is somewhat discouraging for insurers, I believe that there may be a small sign for hope in the Court's rationale regarding equitable tolling. With respect to whether the contestability statute, Section 132(2), is a statute of repose (which cannot be tolled) or a statute of limitations (which can be tolled) the Court stated that it did not need to decide the issue in this case and it declined to do so. Even so, the Court relied on the discovery rule, which suggests that equitable tolling might apply in future cases. *Id.* at 637, 425 Mass. at 630–31.

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As discussed above, the Court stated that the discovery rule applies only to equitable tolling of the statute of limitations, but not to this type of case. Even so, however, the Court, to some extent, proceeded to recognize that principle may apply in certain instances. *Id.* at 634, 425 Mass. at 631.

Specifically, the Court said that Sullivan's condition was not inherently unknowable and that Sullivan had taken no affirmative steps to hide his medical condition or to cover-up his original misrepresentation in the policy application. *Id.* at 635, 425 Mass. at 632. Accordingly, it appears as though a company now cannot rely only on the misrepresentation in the application in those instances where no medical examination is performed. It seems, however, that at least until the Court decides whether the two-year incontestability statute is like a statute of repose or a statute of limitations, an insurer can still maintain that the contestable period is tolled where an insured continues to lie or takes additional affirmative steps to conceal the undisclosed medical history or condition.

Disability Policies – Rescission Rights

For individual disability insurance policies, an insurer can issue polices which provide certain terms allowing for rescission even after the two-year contestable period has expired. Unlike life insurance policies, companies which offer disability policies have the right, by statute, to provide for tolling of the two-year contestable clause under the terms of the policy. *See* M.G.L. c. 175, §108(3)(a)(2). Section 108(3)(a)(2) allows insurers two options to toll the two-year contestable period. An insurer can choose only *one* of the two options.

*Firs*t, after the two-year period expires the company can still rescind for fraudulent misstatements made in the application. *Id.*

Second, as an alternative, the company can extend the two-year contestable period for the same amount of time during which an insured was disabled within the two-year period. The second choice is authorized only when the policy allows the insured to keep it in force to age fifty or, in the case of a policy issued after age forty-four, for at least five years after the date of issue. *Id.*

By statute, therefore, the *Protective Life* holding does *not* pertain to disability policies but only to life insurance contracts. Similarly, Chapter 175, Section 124, which limits a company's rights where there is no medical examination, as discussed above, does *not* apply to disability policies.

As to group policies, there is no specific statute which requires the inclusion of a two-year contestable clause. The group policy statute specifically states that the act governing individual policies in this and other respects, M.G.L. Chapter 175, Section 108(3)(a)(2), does not apply to group policies. See M.G.L. c. 175, §110 (A). It should be kept in mind, however, that in discussion of the difference between these two statutes, courts can sometimes analogize to other acts or regulations and find ways to rule in favor of the policyholder. See, *e.g.* Kates v. St. Paul Fire and Marine Ins. Co., 509 F. Supp. 477, 486–90 (D. Mass. 1981) (discussing overriding "public policy" to find for policyholder). That is not to say, however, that the Massachusetts Supreme Judicial Court will ignore the established and clear provisions of an insurance contract or the law. See Cody v. Connecticut Gen. Life Ins. Co., 439 N.E.2d 234, 238–40, 387 Mass. 148–51 (1982) (enforcing clear terms of policy and distinguishing Kates by not finding a "public policy" argument).

Potential Options or Exceptions to Deal with the Two-Year Contestable Period

Assuming the policy is in force, *i.e.* has not been cancelled, lapsed for non-payment of premiums, or is otherwise null and void, there are potential, albeit uphill, options to the harsh two-year non-contestability period rule laid down in *Protective Life* for life insurance policies.

Mutual Rescission

The insurer and the insured could agree to a mutual rescission. In 2001, a Massachusetts Court stated that "[t]he parties may, however, by mutual consent cancel the policy in ways other than those expressed in the policy." *Nagel v. Provident Mut. Life Ins. Co. of Philadelphia*, 749 N.E.2d 710, 713, 51 Mass. App. Ct. 763, 765 (2001). While this case contains helpful language, I have not yet seen a Massachusetts court rule on this issue after the two contestable period has expired.

Other authorities and other courts, however, have commented favorably on the issue. For example, in a case applying Rhode Island law, the First Circuit ruled that if an insurance company discovers a material misrepresentation before the contestable period expires, it may agree to a mutual rescission rather than file a lawsuit. The First Circuit enforced the mutual rescission after the two-year contestable period expired. *Pruco Life Ins. Co. v. Wilmington Trust Co.*, 721 F.3d 1, 8 (1st Cir. 2013). Moreover, in *Pruco*, the mutual rescission was enforced even though there was

no explicit agreement to rescind. *Id.* at 5; *see also Drake Boatbuilding Co., Inc. v. Davenport*, 981 N.E.2d 233, 233, 83 Mass. App. Ct. 1107, 1107 (2013) (mutual rescission can be implied on the facts); *Puma v. Gordon*, 402 N.E.2d 110, 115, 9 Mass. App. Ct. 489, 495 (1980) (same).

"The presence of an incontestability clause does not prevent the insurer, when sued after the expiration of the contestability period, from showing that the contract of insurance had been

mutually rescinded prior to that time." *Couch on Insurance*, 17 §240:86 (3rd ed. 2018); *see also Billington v. Prudential Insurance Company of America*, 254 F.2d 428, 429 (7th Cir. 1958); *Tully v. New York Life Ins. Co.,* 240 N.Y.S. 118, 119 (1930). If the facts are clear that the parties so agreed, courts in other states also have found that there was a mutual rescission. *See Pruco Life Ins. Co.*, 721 F.3d at 8.

Equitable Tolling

The doctrine of equitable tolling of the two-year contestable period is applicable only where the "prospective plaintiff did not have, and could not have had with due diligence, the information essential to bringing suit." *Protective Life v. Sullivan*, 682 N.E.2d at 635, 425 Mass. at 630–31. As a practical matter, therefore, the company always will be "held to a duty of reasonable inquiry" and this defense generally will be a steep uphill climb. As the Court said, "[h]ad Protective Life exercised reasonable diligence, and had it not chosen to waive the authorized medical tests, it presumably would have discovered Sullivan's fraud." *Id.*

Discovery Rule

"Under the discovery rule, a statute of limitations does not begin to run until the prospective plaintiff learns or should have learned that he has been injured." *Id.* But this rule operates to toll a limitations period "only where a misrepresentation concerns a fact that was `inherently unknowable' to the aggrieved *or* where a wrongdoer concealed the existence of a cause of action through some *affirmative* act done with the intent to deceive, or breached some duty of disclosure." *Id.* (emphasis added).

As to an inherently unknowable fact, again the Court said that the company's action for rescission was not based on an "inherently unknowable" wrong on the part of Sullivan. The Court said that "through the exercise of reasonable inquiry, Protective Life could have learned of Sullivan's medical condition either before granting him the policy or within the two-year period." *Id.*

As for an affirmative act done with the intent to deceive, the Court said "we do not believe that Sullivan's delay constitutes an 'affirmative act' that warrants application of the discovery rule. Sullivan was under no obligation to file a claim for a disability waiver of his premium. The incontestability period cannot be tolled where, as here, the insured did not perform any affirmative acts to conceal the existence of his original fraud in the application." *Id.* Consequently, to invoke this tolling argument, the company must show that the insured actively took affirmative and intentionally deceitful acts to conceal the fraud, beyond the original fraud in the application.

Obviously, successfully invoking the "discovery rule" will be a tall order.

Conclusions

A rescission letter and refund of premiums is not effective: A company *cannot* rescind either a life or individual disability policy for misrepresentations where the insurer simply sends a "rescission letter," even when the letter is accompanied by a premium refund check. The rescission must be accomplished in the context of a lawsuit filed within the two-year contestable period or, where applicable for individual disability policies, within one of the two exception periods extending the two-year period.

Life policies issued after with a medical exam by a physician: As for life insurance policies, both individual and group policies, an insurer can rescind before the two-year contestable period has expired by filing an action in court either (1) for a misrepresentation made with the intent to deceive *or* (2) where the matter misrepresented, even if it is an "innocent" misrepresentation, increased the risk of loss to the insurance company. This right exists only if a licensed physician first conducted a medical exam of the applicant.

Life policies issues without a medical exam: Where the company has *not* conducted a medical examination, an individual or group life policy can be rescinded before the two-year contestable period has expired where the company can show that, as to age, physical condition and family history, the insured made statements in the application which were "willfully false, fraudulent or misleading."

Disability policy distinctions: Unlike life insurance policies, there is no medical examination requirement restricting a company's right to rescind an individual disability policy within the two-year contestable period. Individual disability policies, by statute, also can be rescinded after the two-year contestable period has run under either one

of two options reserved in a policy. They can be rescinded for fraudulent misstatements. Alternatively, the two-year contestable period can be extended for the same amount of time which the insured was disabled as long as the disability occurred within the initial two-year period. Group disability policies appear to not be specifically subject to the two-year contestable restrictions.

Mutual rescission - a potential exception: If a company and insured agree before the two-year period has expired to a mutual rescission of the policy, it can be a defense. Mutual rescission may be inferred from the circumstances absent a formal written document. Silent acceptance of a premium refund check involving an unliquidated amount in dispute *may* suffice for the purposes of achieving a rescission. It is less clear that a court will uphold a mutual rescission after the two-year period has expired but, as in all cases, it depends on the facts and circumstances.

Equitable tolling: Equitable tolling of the two-year contestable period is applicable where the company could not have had, with due diligence, the information essential to bringing suit. As a practical matter this defense likely will generally be unavailing. As the Court said, medical tests, if conducted, presumably would have discovered Sullivan's fraud.

Discovery rule: This rule operates to toll a limitations period "only where a misrepresentation concerns a fact that was "inherently unknowable" to the insurer or where a wrongdoer concealed the existence of a cause of action through some *affirmative* act done with the intent to deceive, or breached some duty of disclosure.

Endnotes

M.G.L. c. 175, §186 states, in pertinent part: "[n]o oral or written misrepresentation or warranty made in the negotiation of a policy of insurance by the insured ... shall be deemed material or defeat or avoid the policy ... unless such misrepresentation or warranty is made with actual intent to deceive, or unless the matter misrepresented or made a warranty increased the risk of loss."

2 By definition, "accident and health" policies include disability policies. *See* M.GL. c. 175, §108 (1.) & M.G.L. c. 175, §47 sixth (a) & (d).

3 The policy provided that Protective Life could not "bring any legal action to contest the validity of this *Id.* at 2–3.

4 The Court stated that "[n]either the purpose nor the effect of ... §124, was to create a fraud exception to the later enacted incontestability statute," *i.e.* §132(2). *Id.* at 631.

5 He did, however, apply for disability benefits from another company. *Id.* at 627, 425 Mass. at 617.

6 The policy at issue was a viatical policy Sullivan sold to Dignity Viatical Settlement Partners, L.P. Protective Life v. Sullivan, Id. at 627, 425 Mass. at 617.

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Fifteen Years After *Golden Rule Insurance Company v. Schwartz*

Is Summary Judgment in Rescission Cases a Realistic Possibility?

By Edna S. Kersting

The criterion for rescinding an insurance policy in the State of Illinois is set forth in Section 154 of the Illinois Insurance Code, 215 ILCS 5/154. This section provide in pertinent part as follows:

> No misrepresentation or false warranty made by the insured or in his behalf in the negotiation for a policy of insurance, or breach of a condition of such policy shall defeat or avoid the policy or prevent its attaching unless such misrepresentation, false warranty or condition shall have been stated in the policy or endorsement or rider attached thereto, or in the written application therefor. No such misrepresentation or false warranty shall defeat or avoid the policy unless it shall have been made with actual intent to deceive or materially affects either the acceptance of the risk or the hazard assumed by the company. [...]

Section 154 allows rescission in case of a misrepresentation made with actual intent to deceive or in case of an innocent misrepresentation as long as it materially affects

either the acceptance of the risk or the hazard assumed by the company.

In 2003, the Illinois Supreme Court in *Golden Rule Ins. Co. v. Schwartz*, 203 Ill. 2d 550, 786 N.E.2d 730 (Ill. 2003) significantly relaxed the burden on the applicant and ruled that the commonly used "knowledge and belief" language contained in insurance applications meant that the veracity of the applicant's answers could only be evaluated based on the applicant's subjective knowledge and belief. *Id.*

In *Schwartz*, Mr. Spencer Schwartz telephonically completed an insurance application on behalf of his son Mark Schwartz, a full time medical student, who was too old to be covered as a dependent under his father's health insurance policy. Question nine of the application asked whether Mark had applied for or had been issued other health coverage – a question Spencer answered on behalf of Mark with "no."

Above the signature line, the application contained the following language:

> I represent that the statements and answers in this application are true and complete to the best of my knowledge and belief. I agree that [...] the statements and answers given in this application and any amendments to it will form the basis of any insurance issued.

In March 1985, Mark was involved in an automobile accident and suffered serious injuries. Subsequent to the accident, Spencer Schwartz realized that Mark was covered not only by the Golden Rule policy but also by another policy Spencer had been issued through the American Bar Endowment. Golden Rule learned of the additional coverage during its investigation and subsequently filed a declaratory judgment action against Mark Schwartz rescinding the coverage it had issued to Mark. Mark counterclaimed for breach of contract and vexatious denial under Section 155 of the Illinois insurance code.

The trial court granted summary judgment to Mark, including on his Section 155 claim. The appellate court reversed, reiterating the statutory language of Section 154, determining that a misrepresentation was sufficient to trigger rescission if it was made with intent to deceive, or if it materially affected the risk or hazard assumed by the insurer. *Golden Rule Ins. Co. v. Schwartz*, 323 Ill. App. 3d 86, 751 N.E.2d 123 (Ill. App. 1st Dist. 2001). Given that it found a question of fact as to whether the misrepresentation was material, it vacated the summary judgment for Mark, and remanded for trial. The Illinois Supreme Court agreed to hear the case.

Recognizing that Section 154 provides the basic framework for a rescission action in Illinois, the court pointed out that parties to a contract could certainly enter into an agreement which is more favorable to the insured than the statute provides, including relying on an application for coverage that was more liberal or advantageous to the insured.

To that end, the court then noted that the "knowledge and belief" language used in the application was broader than the specific requirements in Section 154 and that such language had been interpreted by courts in other jurisdictions as shifting the focus from an objective evaluation of whether the answer to a particular question was false to an evaluation of the subjective knowledge and intent of the applicant at the time the question was answered. The court stated:

> In this case, Golden Rule opted to include language in its application that had the effect of shifting the focus, in a determination of the truth or falsity of an applicant's statement, from an inquiry into whether the facts asserted were true to whether, on the basis of what he knew, the applicant believed them to be true. Thus, the response given to question 9 must be assessed in the light of the applicant's actual knowledge and belief. [...]
>
> Notwithstanding the above, we note that the presence of "knowledge and belief" provision in a policy will not insulate an applicant's responses from all review. To that end, we approve the following test, adopted by the District of Columbia Circuit Court of Appeals, for examining responses to questions asked according to an applicant's knowledge and belief:
>
> > "[T]he twin qualifiers [knowledge and belief] require[] that knowledge not defy belief ***. *** What the applicant in fact believed to be true is the determining factor in judging the truth or falsity of his answer, but only so far as that belief is not clearly contradicted by the factual knowledge on which it is based. In such event, a court may properly find a statement false as a matter of law, however sincerely it may be believed. To conclude otherwise would be to place insurance companies at the mercy of those capable of the most invincible self-deception - persons who, having witnessed the Apollo landings, still believe the moon is made of cheese." (Emphasis omitted.) *Skinner [v. Aetna Life & Cas.*,] 804 F.2d [148,] 151 [(D.C. Cir. 1986).]

Id. at 466–467.

While *Golden Rule* certainly changed the landscape in Illinois for rescission actions, the last 15 years have shown that the subjective emphasis placed upon the evaluation of an applicant's answers by the "knowledge and belief"

language continued to be largely unaffected by the Illinois Supreme Court's statement that "knowledge may not defy belief' and instead, continues to make it exceedingly difficult for insurance companies to obtain summary judgment in rescission cases.

Pekin Ins. Co. v. Adams

In *Pekin Ins. Co. v. Adams*, 343 Ill. App.3d 272, 796 N.E.2d 175 (Ill. App. 4th Dist. 2003), Ms. Adams had bought a renter's liability insurance policy through an insurance agency and after several telephone conversations with an agent, who had asked her questions about her eligibility, she received an application in the mail with answers to many of the questions already typed in. Among them was a typed in "x" in the box corresponding to "no" in response to the question whether the applicant or any tenant had animals or exotic pets—a question Ms. Adams stated during her deposition she had never been asked. The agency had highlighted questions that still needed to be answered and Ms. Adams testified that those were the only parts of the application she read. She completed the not-yet-answered questions, signed the application and mailed it back to the agency without reading the attestation above the signature line, indicating that she declared that "to the best of [her] knowledge and belief all of the foregoing statements are true [...]."

Subsequently, Pekin received a claim related to Ms. Adams' Doberman pinscher biting a seven-year old boy. During its investigation, Pekin learned that Ms. Adams had owned the dog since it had been a puppy, that she kept it on her premises, and that it had previously bitten a child. Pekin provided an affidavit setting out that had it known of Ms. Adams' ownership of a dog with a bite history, it would never have issued the policy.

After the circuit court's grant of summary judgment to Pekin, concluding that the policy was rescinded due to material misrepresentations, Ms. Adams' appealed. After being asked to reconsider its previous decision in the light of *Golden Rule,* the appellate court discussed the *Golden Rule* decision at length and pointed out that the "to the best of my knowledge and belief" language "established a less standard of accuracy" that that which section 154 of the Illinois Insurance Code established. *Golden Rule,* 203 Ill. 2d at 466. Finding based on the record evidence that there was no genuine issue that Ms. Adams actually believed she had a dog when she signed the application, the appellate court found that Pekin was nonetheless estopped from seeking rescission as its agent filled in the answer to the relevant question without inquiry. As no inquiry had taken place, even though Pekin presented evidence to the contrary, the appellate court also found that a reasonable trier of fact would not have to believe Pekin that dog ownership and a bite history was indeed material to Pekin's risk. As a result, the appellate court reversed the award of summary judgment to Pekin and remanded to the trial court for further proceedings.

Noteworthy is Justice Myerscough's partial dissent, which, applying *Golden Rule*, noted that there was a material issue of fact regarding Ms. Adams' belief that "an animal" included a dog.

Siudut v. Banner Life Ins. Co.

The difficulty of obtaining summary judgment in rescission cases in Illinois is further illustrated by the United States District Court's decision in *Siudut v. Banner Life Ins. Co.*, No. 12-cv-1726, 2013 U.S. Dist. LEXIS 124383 (N.D. Ill. Aug. 30, 2013). In *Siudut*, Banner Life issued a $450,000.00 life insurance policy on Paul Siudut's ("Paul") life pursuant to Paul's application for insurance, which Paul had signed and dated. The application contained knowledge and belief language in the attestation. Question 4(a) asked Paul whether "within the past 10 years, have you (a) had any treatment for, or been advised to have treatment for or to refrain from, the use of alcohol or any drug." Any "yes" answer required "full details"; however, the application did not ask about the frequency of the applicant's alcohol consumption.

Paul died within the policy's contestability period and during the subsequent investigation of Siudut's claim, Banner learned that Paul reported to his doctor in 2007 that he was drinking three to four beers or two to three glasses of wine per day. "Alcohol abuse" was listed in his medical records and his doctor also wrote "hold alcohol +wine" in his records. During his deposition, Paul's physician testified that he told Paul to stop drinking.

Subsequent medical records included referral of Paul to an addiction specialist to determine whether he suffered from alcohol abuse. Paul's physician testified that he "must have" informed Paul of his diagnosis of alcohol abuse given that he referred him to addiction counseling. He also explained, however, that he would have referred to the addiction consultant's opinion regarding whether Paul actually suffered from alcohol abuse. Subsequent medical records demonstrated that Paul reported "reducing alcohol intake considerably."

The medical records of two other physicians from the same time period did not include references to alcohol

abuse and neither physician held the opinion that Paul was an alcoholic or alcohol abuser.

When evaluating the parties' cross-motions for summary judgment, based on the conclusion that the record did not adequately solve the question as to whether Paul had been advised of his physician's opinion that he was abusing alcohol and what he indeed had been told by his physician, the court noted that there was a genuine dispute as to the content of Paul's "actual knowledge and belief" at the time he stated on the application that he had not had any treatment for, and had not been advised to have treatment for or to refrain from, the use of alcohol. Without discussing specifically whether Paul's belief that his answer was correct would have been reasonable in light of the language in *Golden Rule* that "knowledge may not defy" belief, the court found that a jury should resolve the question as to Paul's actual knowledge and belief.

Considering whether it should grant summary judgment to Siudut on the argument that the misrepresentation was immaterial, the court credited Banner Life's underwriter's declaration that the policy would not have been issued had Banner Life been aware of Paul's physician's medical records and found that it could not conclude that the misrepresentation was immaterial.

The court did grant summary judgment to Banner Life on Siudut's Section 155 claim on the basis that rescission actions are "bona fide disputes." *Golden Rule*, 786 N.E. 2d at 1018.

Take Away

Fifteen years after the Illinois Supreme Court's ruling in *Golden Rule*, it appears that obtaining summary judgment in cases where the application contains language attesting to the truth of the answers based on the applicant's "knowledge and belief" remains difficult with courts not placing too much weight on the statement that "knowledge may not defy belief." Additionally, insurers' chances to obtain summary judgment on a rescission decrease further when telephonic applications are taken and insurance agents are involved in the application process. To improve the odds, absent removal of the knowledge and belief language, it certainly appears that written applications completed in full by the applicant are preferable to applications taken by agents over the telephone. In all events, however, insurers should continue to be prepared for a jury trial on the issue of the applicant's subjective belief at the time of application when seeking rescission relative to answers given on an application, provided to the best of the applicant's "knowledge and belief."

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Rescission in California

Protecting an Insurer's Right to Rescind and Avoiding Waiver

By Matthew Kleiner and Andrea Scripps


Under California law, an insurer may rescind a contract due to concealment of material facts or misstatements, whether intentional or unintentional. Cal. Ins. Code. §§331 and 359 (all code sections refer to California codes); *TIG Ins. Co. of Mich. v. Homestore, Inc.*, 137 Cal. App.4th 749, 755–56 (2006) ("Governing law permits an insurer to rescind a policy when the insured has misrepresented or concealed material information in connection with obtaining insurance."). Rescinding a policy may be easier said than done if the action is delayed, premiums are not returned, or the misstatements at issue are not considered material. This article discusses how to raise rescission

as a defense and the common problems which arise in response to such a defense. Let us consider the following hypothetical:

Ms. Miller was employed by a church which offered a life insurance policy fully insured and administered by a third party. The church is responsible for collecting and refunding premium payments from and to its employees. Ms. Miller had standard life insurance benefits but also applied for $3 million in supplemental coverage. In her application for the supplemental coverage Ms. Miller checked "no" in response to a question asking if she has been diagnosed with or treated for cancer in the past seven years. The application was submitted to the insurer and approved.

Six months after submitting her application, Ms. Miller died in a plane crash. Her beneficiary filed a claim for distribution of the life insurance benefits. Based on an incontestability clause in the policy allowing the insurer to contest the validity of the coverage for up to twenty-four months, the insurer investigated Ms. Miller's application. Ms. Miller's medical records revealed she had been diagnosed with basal cell carcinoma approximately one year before completing her application. Further investigation revealed that Ms. Miller was regularly seeing a dermatologist and an oncologist for treatment of skin cancer. Her treatment included prescription creams, laser therapy, and, just four days after submitting her application, for supplemental coverage, excisional surgery of a tumor on her nose.

The insurer's policy states the administrator has discretion to deny coverage if material misstatements are made on the application. Furthermore, the insurer's underwriting guidelines allow for denial of coverage when an applicant has been diagnosed or treated for cancer. Based on Ms. Miller's medical history and the misstatements on her application, the insurer denied payment of the supplemental life insurance benefits and told Ms. Miller's beneficiary that the policy had been rescinded. The church, however, due to a miscommunication with the insurer did not refund the premiums. Almost a year after Ms. Miller's death, the beneficiary filed a lawsuit against the insurer for breach of contract seeking payment of the supplemental life insurance benefits. The insurer, after receipt of the complaint and upon learning that the church had not done so, immediately refunded the premiums and asserted rescission as a defense to the beneficiary's claim.

To effect rescission, an insurer may either file an affirmative action seeking relief based on rescission or assert rescission as a defense to a claim for benefits. Civ. Code §§1691 and 1692. This article focuses on the latter option.[7] When asserting rescission as a defense, the insurer must establish that: (1) rescission was timely; (2) a misstatement or omission was made; (3) the misstatement or omission was material such that the insured's application would *not* have been approved had the information been disclosed; and (4) the premiums were refunded. Civ. Code §§169 and 1692; Ins. Code §§331, 359, and 481.

As to timeliness, under California law an insurer may investigate and contest a life insurance contract for up to two years after the policy issued. Ins. Code §10113.5; *Amex Life Assurance Co. v. Superior Court*, 14 Cal.4th 1231, 1233 (1997). In our hypothetical, the insurer seeks rescission of the contract approximately eighteen months after the policy issued; this is well within the two-year time period for contestability.

Next, the insurer must demonstrate that Ms. Miller made a misstatement on her application. "[A]n insurer has a right to know all that the applicant for insurance knows regarding the state of his health and medical history." *Thompson v. Occidental Life Ins. Co.*, 9 Cal.3d 904, 915 (1973). Here, Ms. Miller answered "no" to a question on the application regarding the treatment or diagnosis of cancer, which she had been actively treating at the time she completed her application. As such, Ms. Miller had made a misstatement.

Once a misstatement has been made, the insurer must show that the misstatement was material and that the true facts would have affected the existence or amount of coverage. "[M]ateriality … must be determined solely by the probable and reasonable influence which the admittedly undisclosed information would have had upon [the insurer's] decision to issue the policy." *Imperial Cas. & Indem. Co. v. Sogomonian*, 198 Cal.App.3d 169, 181 (1988) (internal quotations omitted); *Nieto v. Blue Shield of Cal. Life & Health Ins. Co.*, 181 Cal.App.4th 60, 77–78 (2010) (finding that an insured's misstatements regarding her medical condition and treatment were material because truthful responses would have altered the insurer's decision to issue the policy). Materiality is not dependent on the insured's intent in making the misstatement. *Mitchell v. United Nat'l Ins. Co.*, 127 Cal.App.4th 457, 469 (2005).

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7 It should be noted that if the insurer had brought an affirmative action for relief based on rescission, it would not be required to immediately return the premiums, but instead must do so upon issuance of a judgment. (*PHL Variable Ins. Co. v. Clifton Wright Family Ins. Tr.*, No. 09cv2344 BTM (POR), 2010 U.S. Dist. LEXIS 35643, at *6 (S.D. Cal. Apr. 12, 2010).)

To determine the materiality of Ms. Miller's misstatement the insurer must carefully review the policy and the underwriting guidelines. Ms. Miller's representation that she had not been diagnosed with or treated for cancer was material because had she answered truthfully the insurer could have denied her application. The fact that Ms. Miller's death was caused by an unrelated accident—a plane crash—does not change the fact that Ms. Miller misrepresented her health status on the application. "It is not necessary that the misrepresentation have any causal connection with the death of the insured."*Torbensen v. Family Life Ins. Co.*, 163 Cal.App.2d 401, 405 (1958).

The final requirement in effecting rescission is return of unearned premiums within a reasonable time. This is a critical issue. The general rule requires the insurer to timely refund unearned premiums to the insured. *DuBeck v. Cal. Physicians' Serv.*, 234 Cal.App.4th 1254, 1266; *Imperial Cas. & Indem. Co.,* 198 Cal.App.3d at 184. "A party 'may lose his or her right to rescind by failure to give timely notice, or by conduct (such as retention of benefits) indicating an election to affirm the contract.'" *Wells Fargo Bank, N.A. v. Am. Nat'l Ins. Co.*, No. CV 09-01840 DDP (Rzx), 2010 U.S. Dist. LEXIS 144441, at *16–17 (C.D. Cal. Aug. 4, 2010) (quoting 1 Witkin, Summary 10th (2005) Contracts, §939, p. 1033).

In California whether a delay becomes unreasonable is specific to the facts of each case. "It is not possible to designate a definite period of time within which a party must give notice of rescission of a contract because of misrepresentation, fraud, etc., but the facts peculiar to each case are determinative thereof." *Cole v. Calaway*, 140 Cal. App.2d 340, 347 (1956) (citing *Fabian v. Alphonzo E. Bell Corp.*, 55 Cal.App.2d 413, 415 (1942).). Some jurisdictions have found that a three-month delay was not unreasonable and others have held that thirteen months is too long. See *Jaunich v. Nat'l Union Fire Ins. Co.*, 647 F.Supp. 209, 215–16 (N.D. Cal. 1986); *Kermeen v. State Farm Fire & Cas. Co.*, 183 F.Supp.3d 978, 984 (D. Neb. April 19, 2016). Delay may also be justified during an investigation of the facts which lead to discovery of the grounds for rescission. *Wells Fargo Bank*, 2010 U.S. Dist. LEXIS 144441, at *17–18 ("An insurer is entitled to a reasonable amount of time to investigate and act upon information regarding its right to rescind an insurance policy…."). However, the insurer may not rely on the church's failure to refund premiums as a defense in light of a recent Ninth Circuit decision finding the action or inaction of the employer may be attributed to the insurer under *Salyers v. Metro. Life Ins. Co.*, 871 F.3d 934, 940–41 (9th Cir. 2017). If unexplained, a reasonable trier of fact could conclude the insurer's delay in refunding the premium resulted in a waiver of the insurer's right to rescind the contract.

To effect rescission, the insurer must act swiftly upon discovering facts leading to rescission to avoid waiver. Contract language, severity of the misstatement, the misstatement's effect on coverage, timeliness of the action, and return of premium payments all influence an insurer's right to rescind a contract. If executed properly rescission is an effective means for an insurer to defend itself against misstatements and to avoid liability for a loss it never intended to cover.

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Admissions Against Interest

A Lesson in Evidence from a Life Insurance Rescission Case

By Eileen E. Buholtz

A recent decision on a policy holder's motion for summary judgment provides us with a lesson on admissions against interest vis-à-vis a policy owners' motion for summary judgment against the life insurer: *Glob. Energy Efficiency Holdings, Inc. v William Penn Life Ins. Co. of New York, 59* Misc. 3d 1228(A) (Sup. Ct. N.Y.Co. 2018). The motion court held that the Life Insurer could use the Widow's statements about Decedent's drug use against the Policy Owners, who were the Company which Decedent had founded and owned and its Assignee, in the Company-Owner's and Assignee's suit to enforce the policies.

The Company-Owner had applied for two policies on Decedent's life: one in December 2011 and the second in December of 2012. On both applications, Decedent had denied using tobacco during his lifetime and had denied using marijuana or other illegal drugs. The policies were issued under the Insurer's "standard plus non-tobacco rating." Decedent died on January 3, 2014.

After submitting its claims to the Life Insurer, the Company-Owner assigned the policies to the Assignee. In August of 2014, the Life Insurer denied the claims under both policies on the ground that Decedent had materially misrepresented his smoking history and drug use. An autopsy had concluded that Decedent's immediate cause of death was atherosclerotic cardiovascular disease and that a contributing factor was an acute mixed drug intoxication of ketamine and ecstasy.

The parties conceded that the relevant time periods for material misrepresentations on the applications were the 12 months preceding the application for each policy, *i.e.*, December, 2010 to December 2011 for the first policy and December 2011 to December 2012 for the second.

The Widow's Admissions About Decedent's Drug Use and Smoking

After Decedent's death, the police interviewed his Widow and reported that the Widow had stated that Decedent had smoked marijuana "for years" and that she thought he had taken ecstasy and possibly ketamine (a "molly") the night before he died. The Widow also reportedly told the police that she had first discovered marijuana and ecstasy in her home in August of *2013* but did not know how long or how frequently Decedent was using drugs; that she never asked him about it; and that she never saw him smoke tobacco products.

Before issuing its denial in August of 2014, the Life Insurer likewise interviewed the Widow, and did so twice: once before the autopsy report came out and once after. In the first interview, the Widow reportedly said that Decedent had never used drugs or smoked, but in the second interview, the Widow reportedly stated that Decedent had started using marijuana about "three years ago, most evenings, using when he was with friends about once every 2–3 months"; she had found out about the ketamine about "1–2 years ago" and had told Decedent "about a year ago" to stop; and she did not know the frequency of his use and thought he had stopped until she discovered in December of 2013 that he was still using it. (These statements put Decedent's drug use within the time periods relevant to material misrepresentations.)

At her deposition in the subject suit, however, the Widow denied making any of these statements.

Physician's Evidence of Decedent's Tobacco Use

Decedent's medical records from his physician dated February 2013 (after both policies were issued) contained a handwritten note "+smoke" in the margin. The physician testified at his deposition in the subject suit that the notation meant either that Decedent had a history of smoking or was currently smoking.

Plaintiffs' Initial Motion for Summary Judgment

The Company-Owner and the Assignee had previously moved for summary judgment on the ground that the only admissible evidence of Decedent's drug use was that it had commenced after the policies were issued. The court denied plaintiffs' orginial motion for summary judgment without prejudice to permit further discovery, but stated (presumably in dicta) that the Widow's admissions against interest could not be used against plaintiffs; the physician's notation was too tenuous to prove that Decedent was smoking cigarettes when the doctor saw him; and each of

these items was too speculative to raise a question of fact to defeat plaintiffs' motion for summary judgment.

Further Discovery and Litigation

During the additional discovery, the Life Insurer obtained the autopsy slides of Decedent's tissue, which the Life Insurer's expert pathologist reviewed and testified at his deposition that they showed that Decedent had smoked for years. The Life Insurer also impleaded the Widow, making her a party (presumably to bind plaintiffs with her admissions against interest). The Widow thereupon fell into the trap and asserted six counterclaims against plaintiffs, claiming a prior right to the policies' proceeds, and one counterclaim against the Life Insurer. Then, upon the eventual realization of her tactical mistake, the Widow attempted a unilateral withdrawal of all her counterclaims, but she did so without the opposing parties' requisite consent, which the Life Insurer refused (for obvious reasons) to give.

The Current Motions at Issue

Plaintiffs then renewed their motion for summary judgment and the Widow moved for court approval of her discontinuance of her counterclaims. With regard to the latter, the court granted the Widow's motion, notwithstanding the Life Insurer's multiple objections on procedural and substantive grounds. The procedural objections dealt with arcane details of a party's right *vel non* to discontinue action, which the court disposed of in the Widow's favor. The substantive issues dealt with double jeopardy (*i.e.*, that the Widow would later sue the Life Insurer for the policy proceeds after the Life Insurer paid them to the plaintiffs). The court held that *res judicata* would prevent the Widow from ever coming back against the Life Insurer with any claims that the Widow could have raised in this suit regarding these policies.

But on plaintiffs' renewed motion for summary judgment, the court denied plaintiffs' summary judgment motion on the merits, holding that the Life Insurer now had sufficient admissible evidence to raise a question of fact about the Decedent's smoking and drug use during the relevant time periods.

The Life Insurer's Pathologist

After reviewing the autopsy slides, the Life Insurer's pathologist opined that Decedent was a smoker for an extended period of time. The autopsy report contained a review of the respiratory system and stated that the visceral pleural surface was covered with a moderate amount of "anthracotic pigment," which the pathologist confirmed after examination of the slides, and he further opined that this black material could be produced by cigarette or marijuana smoking. During the application process, the Life Insurer tested the Decedent for nicotine, the results of which were negative, but that test established only that Decedent had not smoked for a few days before the test.

The pathologist could not distinguish whether the microscopic findings indicated someone who was currently smoking as opposed to someone who had stopped smoking ten years earlier and he could not state for precisely how long decedent had been smoking, aside for "some time" and there was a possibility that Decedent was not a smoker. However, he did testify that the microscopic findings would take years to develop, and it was more likely than not that Decedent did not stop and then restart smoking. The pathologist also noted that the nicotine test performed by the insurance company would have demonstrated only that Decedent hadn't smoked for a few days prior to the test, and he also opined that the various medical articles presented to him at the deposition were essentially inapposite to these facts.

The motion court therefore held that the pathologist's opinion was supported by a rational basis, reflected an acceptable level of certainty, and was therefore admissible on the issue of whether Decedent was a "smoker" at the time of his insurance policy applications.

Although the pathologist relied in part on hearsay evidence (to wit, the Widow's statements to police contained in the autopsy report), he testified that pathologists typically rely on hearsay information from the next of kin and that the autopsy report was not the sole or principal basis for his opinion. Therefore the pathologist's opinion was admissible evidence and raised a question of fact in opposition to the plaintiffs' motion for summary judgment.

The Widow's Admissions Against Interest

The motion court also held that the Widow's admissions were usable against plaintiffs. The Widow's statements to the police and to the Life Insurer's interviewer presented the classic double hearsay situation found in *Johnson v. Lutz*, 253 N.Y. 124, 170 N.E. 517 (1930)—that the exception to the hearsay rule for records of regularly conducted business activities does not encompass documents like police reports, which contain statements made by third parties

not under any duty to prepare the document or to tell the truth when talking to the officer preparing the report.

Here plaintiffs argued that (a) the law of the case precluded the court from changing its previous ruling that the Widow's statements could not bind plaintiffs as other parties to the suit and (b) the Widow's statements contained in the autopsy report and the investigator's report constituted inadmissible double hearsay under *Johson v. Lutz* because the Widow had no business duty to report any information to the police or the investigator.

Regarding the first point, the court held that the court always has the authority during the pendency of an action to revisit a previous decision that it has made.

Regarding the second point, the court held that the Widow and plaintiffs had joint or common interests of privity in the suit, so the Widow's admissions could be used against plaintiffs. The court cited these facts in reaching that conclusion:

- After the original motion was submitted, the Life Insurer had impleaded the Widow and the Widow had asserted counterclaims against the Life Insurer and cross claims against the Life Insurer and plaintiffs which she had later voluntarily discontinued.
- At the Widow's deposition, counsel had noted that there was a "joint prosecution agreement" between the Widow and plaintiffs.
- The beneficiary of the policies was the Company in which Decedent owned an 18 percent interest.
- The Widow's denial that she had made these statements was a matter for the trier of fact.

The court therefore denied plaintiffs' renewed motion for summary judgment.

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