1968

The Prudential Insurance Company of America v. Opal Johnson, Individually and as Administratrix of the Estate of Clyde W. Johnson, Deceased : Brief of Appellant

Utah Supreme Court

In the
Supreme Court of the State of Utah

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA,
Plaintiff and Apellant,

vs.

OPAL JOHNSON, individually and as Administratrix of the Estate of Clyde W. Johnson, deceased,
Defendant and Respondent.

Case No. 11[illegible]

BRIEF OF APPELLA[illegible]

Appeal from the Judgment of the Fourth Di[illegible]
for Utah County
Honorable Joseph E. Nelson, Judge

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In the
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THE PRUDENTIAL INSURANCE COMPANY OF AMERICA,
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vs.

OPAL JOHNSON, individually and as Administratrix of the Estate of Clyde W. Johnson, deceased,
Defendant and Respondent.

Case No. 11159

BRIEF OF APPELLANT

PRELIMINARY STATEMENT

The parties will be referred to as they appeared in the lower court.

STATEMENT OF THE KIND OF CASE

Plaintiff commenced this suit to cancel a policy of insurance obtained by false and fraudulent representations. Defendant counterclaimed for recovery of insurance benefits under the policy.

DISPOSITION IN THE LOWER COURT

The trial court dismissed plaintiff's complaint and awarded judgment on the counterclaim.

RELIEF SOUGHT ON APPEAL

Plaintiff seeks an order reversing the judgment of the trial court, directing judgment on plaintiff's complaint and dismissing the counterclaim or, in the alternative, a new trial.

STATEMENT OF FACTS

Plaintiff commenced this suit to cancel a policy of insurance issued to Clyde W. Johnson in September, 1965. The action is grounded upon the contention that the policy was obtained by false and fraudulent representations. Clyde W. Johnson and his survivors claim death benefits and hospital and medical benefits under the policy. Defendant counterclaimed for recovery of these benefits.

There is no material conflict as to the facts of the case. The pre-trial order sets forth the uncontroverted facts and the contentions of the parties (R. 48-50). The trial court adopted by reference the entire statement of unconroverted facts as a part of his findings of fact (R. 56).

The cause was tried non-jury and the testimony of witnesses was offered by the respective parties to supplement the statement of uncontroverted facts. The defendant concedes that the insured Clyde W. Johnson falsely answered concerning his health in the application for insurance. The principal defense asserted was that the plaintiff had issued two prior policies to the insured,

each of which contained certain "incontestable" clauses and that the clauses of the prior policies should bar the plaintiff's action for cancellation of the policy in question.

The trial court by his memorandum decision and by his conclusions of law held that the "incontestable" provisions contained in the earlier policies "carried over and became effective provisions of the policy issued on September 3, 1965, WP2 510 001 and, therefore, the benefits under said policy were in full force and effect."

On or about October 17, 1957, the plaintiff's insurance agent, Mr. Niles M. Wing, received an application from Mr. Johnson pursuant to which a policy of insurance was issued. This policy, known as an Employer's Security Policy, provided certain health, hospital and surgical benefits. One eligibility requirement for the issuance of the policy was that the policy be issued to an employer of at least three persons. Mr. Johnson later became ineligible for this coverage because of a reduction in the number of employees retained by him. The coverage of the first policy was therefore cancelled in 1960 (Tr. 32).

Upon the recommendation of Mr. Wing, a new policy was issued February 2, 1960. The new policy, known as a Gibraltar 325 policy, provided health, hospital and surgical benefits. It did not provide any life insurance or major medical coverage (Tr. 32-33). This policy remained in force until the policy now in question was issued by the plaintiff.

In the spring of 1965, Mr. Johnson's firm was employing sufficient employees to again qualify for an Employer's Security Policy. As Mr. Johnson's insurance agent, Mr. Wing contacted Johnson and suggested to him that he consider taking out the Employer's Security Policy. The basis for the recommendation was that the new policy would provide life insurance coverage, and would also provide major medical expense which would take care of catastrophe-type sickness or accident (Tr. 34). Application for the new policy was made September 3, 1965 and the policy was issued by Prudential pursuant to this application.

At the time the new application was made, the agent explained to Johnson that this would be a "brand new policy" (Tr. 46-47).

Mr. Johnson's application was made on a form provided by the company (received in evidence as Exhibit 2); was completed in the handwriting of the company's agent, Niles M. Wing, and was signed by Mr. Johnson in the presence of the agent. As a part of the taking of the application, the agent read to Mr. Johnson the following questions to which Mr. Johnson answered as follows (Part II, Paragraph 2(a), (b), (c) and (d)):

> (a) Have you at any time been treated for or been told you had trouble with any of the following: . . . heart, high blood pressure. . . .?
>
> Answer: No.
>
> (b) Have you been in any hospital or other institution for observation, rest, diagnosis or treatment during the past five years?
>
> Answer: No.

(c) Have you been examined by or consulted a physician during the past five years?

Answer: No.

(d) Have you any known physical impairments or ill health not covered by the answers through 2(a) to 2(c). . . .

Answer: No.

The agent testified positively that each of these questions was read to Mr. Johnson and that to each separate question Mr. Johnson answered "No" (Tr. 37-39). The application was submitted to the underwriting department of the insurance company and no physical examination was required. The application was approved and Policy No. WP2 510 001 was issued insuring Clyde W. Johnson.

The testimony of K. E. Noyes, M.D., family physician of Clyde W. Johnson, was that in 1964 prior to the making of the application, Dr. Noyes had treated Mr. Johnson for heart failure; had advised the patient of his serious heart condition and had instructed him to "slow down" and to discontinue certain parts of his work. The significant particulars of Dr. Noyes' testimony are as follows:

On March 16, 1964, Mr. Clyde Johnson saw Dr. Noyes with complaints of shortness of breath and swelling of the ankles. The doctor took a history from Mr. Johnson and examined him to diagnose his malady (Tr. 6). The doctor's notes show that the patient "has had rheumatic mitral valve lesions for many years" (Tr. 27-28). Dr. Noyes' examination disclosed that he had a

heart rate of 100; that the patient's heart was enlarged; and that he had both systolic and diastolic murmers. The doctor concluded that he was suffering from double mitral valvular lesions and that the heart was "fibrillating" (Tr. 6-10).

The doctor testified that the symptoms of shortness of breath and swelling of the ankles were typical and consistent with the other findings and that it was evident that Johnson was suffering from "heart failure" (Tr. 11-2). This diagnosis was further confirmed the following day, March 17, at which time the doctor performed an electrocardiogram which clinically demonstrated fibrillation of the heart (Tr. 10-11).

The doctor testified that Mr. Johnson knew that he had some problem with his heart for some time prior to the time he came into the doctor's office (Tr. 28). On the occasion of the first visit on March 16, 1964, the doctor told Mr. Johnson that he was suffering from heart failure; that the condition would be treated with digitalis and that if "he would take it easy and not do the hard work he could get by" (Tr. 12). The condition of the mitral valve of the heart which was diagnosed was a condition which prevented this important valve of the heart from fully opening or closing. It was a chronic condition and could not be treated by medication and the only medical treatment which could be employed to correct the condition was heart surgery (Tr. 16).

Digitalis was prescribed to slow the heart to a normal rate and to give the heart muscle a rest and permit

it to build up strength. The initial prescription required Johnson to take certain dosages of digitalis three times a day which the doctor described as strong dosages (Tr. 14). Dr. Noyes saw Mr. Johnson on five separate occasions in March of 1964. He testified that he talked with Mr. Johnson about surgery to correct the mitral valve problem. He testified that the first conversation about surgery was probably in March of 1964 (Tr. 15).

Part of Dr. Noyes' deposition was published. This testimony was to the effect that during the visits in March, 1964, the doctor talked to Johnson about possible surgery; that he indicated that Johnson had reached the time when he was getting symptoms; that "when your patient begins to get symptoms, that is the time to have surgery"; that "I told him to consider it"; and that when Johnson came in later on (in October of 1965) he said "he was ready for it" (Tr. 18-20).

Following March of 1964, Dr. Noyes did not see Mr. Johnson again about his heart condition until October of 1965 when Johnson came in again complaining of shortness of breath (Tr. 17). The insurance application had been made the month before.

The doctor saw Mr. Johnson on two occasions in October and three occasions in November of 1965. The doctor's diagnosis during these visits remained the same and the patient was again treated with digitalis. In February of 1966, Dr. Noyes referred Mr. Johnson to Dr. Roy Kimball, a heart specialist in Salt Lake City.

Dr. Kimball associated Dr. Jensen and in March of 1966, Mr. Johnson was admitted to a hospital in Salt Lake City for surgery to replace the mitral valve of the heart. Mr. Johnson died on March 30, 1966 following heart surgery.

It was stipulated by the parties that if a Mr. William H. De Silva of the underwriting department of Prudential Insurance Company were called as a witness, he would testify that his department was charged with the responsibility of reviewing applications for insurance and determining the insurability of applicants; that the company relied upon the representations of Mr. Johnson on the application that was submitted; that the company had no notice that Mr. Johnson had a heart condition and that if the company had known that Mr. Johnson had a heart condition or had known of Dr. Noyes' diagnosis or had known that Mr. Johnson had been treated with digitalis, that his application for insurance would have been rejected and that the policy would not have been issued. It was stipulated that the agreed testimony of Mr. De Silva be considered by the court as evidence (Tr. 62-64).

The trial court awarded judgment on defendant's counterclaim for the benefits claimed under the policy issued September 3, 1965 including life insurance and hospital and medical benefits aggregating $6,506.79 plus interest. This appeal seeks reversal of the judgment.

ARGUMENT

POINT I

THE TRIAL COURT ERRED IN FAILING TO ENTER JUDGMENT IN FAVOR OF THE PLAINTIFF AND AGAINST THE DEFENDANT.

A. *Plaintiff is entitled to cancellation of Policy No. WP2 510 001 for the reason that the issuance of the policy was induced by fraud and misrepresentation of the insured, Clyde W. Johnson.*

The evidence, without conflict, discloses that on September 3, 1965, Clyde Johnson represented to Prudential Insurance Company in his application for insurance coverage that he had not been examined by or consulted a physician for a period of five years preceding the examination; that he had never been told that he had any trouble with his heart; that he had not been in any institution for observation, rest, diagnosis or treatment for five years preceding the application and that he had no knowledge of any physical impairment or ill health. Each of these statements was untrue.

Mr. Johnson knew that his application was false. He had received extensive care for his heart condition the very year before. At the very time the application was made he was suffering from a serious heart condition diagnosed as heart failure. He knew that it was incurable except by surgery; that he had taken digitalis under the doctor's direction to control it; and that he had been told by the doctor that he must slow down and

discontinue strenuous work in his business. The company relied upon the application and the false representations of Johnson and was deceived thereby.

The evidence as hereinabove recited, the uncontroverted facts as set forth in the pre-trial order (see particularly Paragraphs 5, 6 and 7, R. 51-52 and the court's Findings of Fact, Paragraph 3, R. 57) conclusively show that the policy was obtained by deceit. Upon the facts of this case, plaintiff is entitled as a matter of law to cancellation of the insurance policy issued on the fraudulent application.

Chadwick vs. Beneficial Life Insurance Company, 54 Utah 443, 181 Pac. 448, also reported at 56 Utah 480, 191 P. 240, is probably the leading Utah case dealing with fraudulent insurance applications. In the *Chadwick* case, the applicant answered questions on his application for insurance as follows:

> Have you ever had any of the following diseases. . . . rheumatism or gout?
>
> Answer: No.
>
> Give name and address of physician last consulted.
>
> Answer: None.
>
> Are you in good health, so far as you know or believe?
>
> Answer: Yes.

At the time the application was made, the applicant was suffering from a condition which had been diagnosed as rheumatism. The applicant's condition became pro-

gressively worse after the policy was issued until his death a few months after the writing of the policy. An autopsy disclosed that he had died of tuberculosis of the spine. The Utah Supreme Court held that the policy was obtained by fraud and that intent to deceive was established as a matter of law. The reasoning of the court is reflected in the following quote from the main opinion:

> "If the insured at the time of making his application for a policy has knowledge or good reason to know that he is afflicted with a disease that renders his condition serious, and that thereby his longevity will be prejudicially impaired, his statements and representations to the contrary in reply to specific inquiries constitute a fraud practiced upon the insurer, and which, when successfully proven, invalidates the policy."

In a separate concurring opinion, Justice Frick stated:

> "While it is true that the deceased may not have appreciated the nature of his disease, he, as the undisputed evidence shows, did know that he was seriously afflicted with some malady, and that he had not only consulted doctors, but was being treated by them therefor. The evidence thus stands uncontradicted that the deceased did conceal material facts from the defendant, and it is but fair, just, and right that the consequences of such concealment should fall upon the beneficiaries of the insured rather than upon the defendant, and indirectly upon the policy holders."

The recent case of *Theros vs. Metropolitan Life Insurance Company,* 17 Utah 2d 205, 407 P. 2d 685, also deals with the issue of fraud in insurance applications. The insured had a history of past rheumatic heart disease

which he failed to disclose on the application for insurance. The insurance company moved for summary judgment. The District Court granted the motion for summary judgment holding as a matter of law that the policy was obtained by fraud and the Supreme Court affirmed.

The beneficiaries of the policy contended that the insured gave truthful answers concerning his health and medical history; that the agent had incorrectly recorded the answers, and that the applicant had not read he applicaion before signing it. The Supreme Court held that the applicant was bound by the application which he signed whether he read it or not and that if he did not read it, he was at least bound by "constructive knowledge" of the misrepresentations on the application which was submitted to the insurance company. In so holding, the court said:

> "In order to defeat recovery on an insurance policy because of misrepresentation in the application, the misrepresentations must have been made with an intent to deceive and defraud the insurance company. However, such an intent may be inferred where the applicant knowingly misrepresents facts which he knows would influence the insurer in accepting or rejecting the risk. The same rule should apply where the applicant knowingly, or with constructive knowledge, permits such misrepresentations to be submitted to the insurance company . . .
>
> * * *
>
> "It is also the majority rule that an insured is under a duty to read his application before signing it, and will be considered bound by a knowledge of the contents of his signed application.

> This is merely an application of fundamental contract law. While courts generally are inclined to treat insurance contracts as special and do not always vigorously apply all the principles of contract law, that tendency should not be allowed to overrun the bounds of legitimate exception.
>
> "The facts here presented provide absolutely no basis for applying any exception to the basic contract law. The record is devoid of any facts or circumstances that would indicate or imply that Theros was by fraud, accident, misrepresentation, imposition, illiteracy, artifice or device reasonably prevented from reading the application before signing it. Therefore, he is, by law, conclusively presumed to have read the application and his beneficiary is bound by the contents thereof. It therefore follows that the lower court should be affirmed."

Plaintiff is clearly entitled to cancel the policy issued on the 1965 application.

B. *The provisions of the policies issued in* 1957 *and* 1960 *do not preclude cancellation of the* 1965 *policy.*

(1) *The* 1965 *policy is a contract entirely separate and independent from the earlier contracts issued in* 1957 *and* 1960 *and must be construed by its own terms.*

Each of the three policies issued to Johnson was a separate and independent contract of insurance.

The 1957 policy was cancelled in 1960. When the 1960 policy was issued there was certainly no question

that the coverage of the earlier policy had been terminated. Had Mr. Johnson chosen to do so, he could have maintained the 1960 policy in full force and effect rather than obtain the benefits of the new coverage offered by the agent in 1965. The agent explained to Johnson when the 1965 application was made that the policy to be issued would be a "brand new" policy (Tr. 46-47).

When Johnson made the 1965 application, he had no life insurance coverage or major medical coverage with Prudential. This coverage was issued solely upon the basis of the false application.

Each policy was issued on a separate written application. Each policy provided different and distinct benefits for a different premium charge. There is neither argument nor proof that any of the policies contained any provision for substitution or that the 1965 policy was issued by reason of any right which Johnson had under either of the prior policies.

We find absolutely no legal basis for the court's conclusion that the so-called "incontestable" provisions contained in the policies of 1957 and 1960 "carried over" and became effective provisions of the policy issued in September of 1965.

When the case was argued before the trial court, counsel for the defendant relied upon authorities dealing with "substituted policies" and instances where one insurer had assumed outstanding policies of another insurer. See 110 A.L.R. 1139, 105 A.L.R. 997, 85 A.L.R. 240, 29A Am. Jur., Section 1127. A "substituted policy" is a

policy secured by the insured pursuant to a privilege granted to him by the original policy. None of these authorities even remotely sustain the defendant's contention or the conclusion reached by the court in this case, because under the circumstances of this case, it is clear that each policy issued by the plaintiff was entirely separate and independent from each of the other policies. Furthermore, the 1965 policy provided new and additional coverage of an entirely different character.

The 1965 policy must be construed upon the basis of its own terms and conditions. This is basic contract law. See e.g., *Provident Life and Accident Insurance Company vs. Kegley,* 99 S. E. 2d 601, and *Nielsen vs. General American Life Insurance Company,* 89 F.2d 90 (10th Cir. 1937). No provision of the 1965 policy bars the plaintiff's action for cancellation of the policy or the assertion of a fraud defense.

(2) *The so-called "incontestable" provisions of the earlier policies do not by their terms preclude cancellation for fraudulent misstatements in the application.*

The provisions of the policies issued in 1957 and 1960 which are relied upon by defendant provide as follows (R. 57):

> "Time Limit on Certain Defenses: (a) After two years from the date a person becomes covered under this Policy, no misstatements, *except fraudulent misstatements, made by the applicant in the application for coverage of such person* shall be

used to void the Policy or to deny a claim for loss incurred after the expiration of such two year period.

(b) No claim for loss incurred with respect to any person after two years from the date such person becomes covered under this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of such person." (Emphasis added.)

The foregoing provisions of the policies are not incontestable clauses but rather "time limits" on certain defenses. These same provisions are contained in the 1965 policy (see Exhibit 1). The 1965 policy also contains a one-year incontestable clause as to the life insurance coverage (see "Incontestability" paragraph of the policy provisions of Exhibit 1). The incontestability clause has no effect because the insured died within a period of one year from the issuance of the policy. There was no incontestability clause in the earlier policy because it did not provide any life insurance coverage.

It is at once apparent that as to the life insurance and major medical coverage, there could be no possible merit to the claim that such new coverage would be barred by the provisions of any earlier policy since it was new coverage issued in reliance upon the false application.

We now turn to the so-called "incontestable" provisions relied upon by the defendant which are actually just "time limits on *certain* defenses." These provisions

do not bar the plaintiff's action for cancellation of the insurance policy.

The "time limit" relates only to defenses and does not purport to prohibit cancellation of a policy procured by false and fraudulent representations.

Paragraph (a) demolishes the defendant's argument because it expressly *reserves* plaintiff's right to defend for *"fraudulent misstatements made by the applicant in the application for coverage."*

Paragraph (b) of the time limit relates to the scope of coverage and not to the right to defend or cancel for *fraud*. This paragraph by its terms is applicable to restrictions of coverage or defenses based upon the "existence" of a pre-existing physical condition and has no reference or application to an action to rescind for fraud or misrepresentation with respect to a *known* pre-existing condition.

Looking to the merit of the position that the provisions in question constitue a bar to the plaintiff's action or a bar to the defense of the counterclaim, here are actually two questions involved: (1) do the provisions by their terms bar assertion of the fraud?, and (2) when do the provisions become effective or, put another way, when does the time commence to run with respect to the two-year time limit? It is actually beside the point to say that the provisions of he earlier policies "carried over," because the 1965 policy contained the same provisions. From what has been said, we think it is manifest that even if the time limit was in effect, these provisions

do not bar the right of the plaintiff to cancel the policy for fraud. The final answer to defendant's position, however, is that there is no legal reason whatever why a time limit for the assertion of fraud should commence to run in 1960 when the fraud was not committed until 1965. Such an analysis of the holding of the trial court brings into focus the manifest injustice of the judgment below.

CONCLUSION

The policy obtained by Johnson in 1965 was issued on the basis of his fraudulent application and plaintiff is entitled to cancel this policy. The policy is entirely independent of the policies previously written by the plaintiff and must be governed by its own terms and provisions. In any event, there is no provision in any of the policies which bars the plaintiff's action for cancellation of the policies on the ground of fraud. The judgment of the trial court should be reversed and the court should be directed to enter judgment of cancellation in favor of the plaintiff dismissing defendant's counterclaim with prejudice and awarding plaintiff its costs herein.

Respectfully submitted,

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