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IN THE SUPREME COURT

OF THE STATE OF UTAH

BEATRICE WULFFENSTEIN, Plaintiff and Appellant, vs. DESERET MUTUAL BENEFIT ASSOCIATION, Defendant and Respondent.	)	Case No. 16335

BRIEF OF APPELLANT

Appeal from a Judgment of Dismissal of the Third Judicial District Court for Salt Lake County

The Honorable Christine M. Durham, Judge

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IN THE SUPREME COURT

OF THE STATE OF UTAH

BEATRICE WULFFENSTEIN,)
)
Plaintiff and Appellant,)
)
vs.) Case No.
) 16335
DESERET MUTUAL BENEFIT)
ASSOCIATION,)
)
Defendant and Respondent.)

BRIEF OF APPELLANT

STATEMENT OF THE NATURE OF THE CASE

Appellant commenced an action against Respondent for compensation under a group insurance policy for medical services rendered to her after she terminated employment with Respondent's policy holder, Intermountain Health Care Services, on the basis the injury sustained occured during the effective period of the policy. Respondent denies liability on the grounds that the policy in question covered only medical expenses incurred during the period of employment.

DISPOSITION IN LOWER COURT

At the conclusion of Plaintiff's evidence at trial, Defendant moved for and was granted judgment of dismissal pursuant to Rule 41(b) of the Utah Rules of Civil Procedure on the grounds that the facts and law before the court showed no right to relief.

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RELIEF SOUGHT ON APPEAL

Appellant seeks a reversal of the order of the lower court dismissing the case and remand for further proceedings consistent with an opinion of this court determining that the facts and law as presented state a cause of action for relief.

STATEMENT OF FACTS

At the dismissal of Appellant's case below, the trial court entered findings of fact and [illegible] of law, (R-391-399), upon which Appellant relies to [illegible] her cause of action. The pertinent facts, as found by the court, are set forth below:

Beatrice Wulffenstein, Appellant, was employed by the LDS Hospital, [Health Services Corporation of the Church of Jesus Christ of Latter Day Saints (now Intermountain Health Care, Inc.)] and had been for several years prior to her sustained injury, the [illegible] of this action. [illegible] her employment she applied for and obtained a group [illegible] policy of insurance to compensate for expenses related to health and injuries. From the date of application for coverage by Appellant through December, 1973, all premiums required to be paid were deducted from her paycheck, and such insurance was in force on the date she sustained the injuries involved in this action.

As a consequence of injuries [illegible] in an automobile collision in which Appellant was [illegible] on December 28, 1973, she received medical attention and other professional care through 1974 and in January, 19[illegible] [illegible] her [illegible] with follow up care, all of [illegible] consequence of her accident [illegible]

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From the date of the accident Appellant applied for and received, through Respondent, insurance benefit coverage for her expenses incurred up through March of 1974, even though no further premiums were paid by Appellant after January, 1974.

Near the forepart of April, 1974, Appellant, feeling that her injuries would not allow her to return to work, terminated her employment with the hospital. Nevertheless, she continued to seek medical assistance and submitted claims to Respondent through October 7, 1974. However, Respondent declined to pay any expenses incurred after March of 1974.

ARGUMENT OF APPELLANT

POINT I

WHETHER AN EMPLOYEE, QUALIFIED AT THE TIME OF AN INJURY, UNDER A GROUP PLAN OF INSURANCE FOR MEDICAL CARE WHICH PLAN PROVIDES FOR TERMINATION OF BENEFITS UPON TERMINATION OF EMPLOYMENT, IS NEVERTHELESS ENTITLED TO CONTINUING BENEFITS UNDER THE POLICY PROVISIONS FOR MEDICAL ASSISTANCE RENDERED BEYOND THE DATE OF EMPLOYMENT, FOR AN INJURY SUSTAINED DURING EMPLOYMENT.

The general rule relating to the issue above is set forth in an annotation at 68 A.L.R. 2d 8, dealing with the subject matter of "Termination of coverage under group policy with regard to termination of employment." At page 20 of the annotation, the following is found:

> Most group insurance contracts contain provisions which limit the coverage of the employee insured thereunder to the time of his employment.... Regardless of the particular language used in the so-called "termination of employment" clauses they all have in common the termination of employment as the determining factor in the discontinuance of the policy coverage. In view of this

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common characteristic, all of the cases agree that the termination of employment ends the employee's insurance coverage in accordance with the specific terms of the policy. More specifically, the general rule as to the effect of the above clauses is that where a loss insured against occurs before the insured's employment is terminated within the meaning of the "termination of employment" clause, the insurer is liable under the policy, but where such loss occurs after the insured's employment has been terminated the insurer is relieved of liability provided none of the special policy provisions extending coverage under certain circumstances is applicable. The above principles have been uniformly applied and are recognized by courts from practically every jurisdiction.

The rationale of this rule is reviewed in the case of Service Life Insurance Company v. Branscum, 352 S.W. 2d 586 (Ark. 1962.) In the Branscum case, Plaintiff brought an action to recover under a policy of insurance for medical services rendered to her minor child necessitated by virtue of an injury sustained but which services were received after the insurer declined to renew the policy. From an award for the Plaintiff the insurance company appealed and the decision was affirmed.

Although the Service Life Insurance Company case did not involve an employment termination, it did speak to the issue of the obligation of an insurance carrier to cover losses sustained, and subsequent medical [illegible] arising after the termination of the policy, where the injury was sustained prior to the termination of the policy. The court in citing [illegible] v. American Casualty Company, [illegible] 1957) relates:

'A contract of insurance [illegible] indemnify the insured [illegible] contingencies which [illegible]

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When the contingency arises, then and only then does the liability of the insurer become a contractual obligation [citing authorities]. There then remains no "risk" which could be the subject matter of insurance. The contingency having occurred, there is nothing the insurer can unilaterally do to alter the policy with respect to a loss that is already in being. All that remains is the determination of the extent of the damage.'

The reasoning and conclusion of the Harmon case, supra appears consistent with our own statutory definition found in Section 31-1-7, Utah Code Annotated, (as amended 1963) which reads:

Insurance is a contract whereby one undertakes to indemnify another or pay or allow a specified or ascertainable amount or benefit upon determinable risk contingencies.

Under the Utah definition, the benefit and amount involved should be ascertainable but must also be measured by the determinable "risk" contingencies, or in other words the risk sought to be covered such as life, disability, sickness, accident, fire and etc. The effective dates of the policy such as "renewable annually," "termination on non-payment of premium," or as in the case here, "termination of employment" are not "risk" contingencies but rather periods beyond which the insurer would not be liable for "risk" insured against arising outside the limitation periods.

In other words, when a policy specifies a date of termination or termination upon a contingent event, the happening of that contingency or the passing of that date will relieve the insurance carrier from any liability sustained after that time period. However, where the injury is sustained prior to the

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termination of the policy or the occurrence of the contingenc[y] terminating the policy, the insurance carrier is liable for a[ll] obligations arising out of and relating to the injury.

In Clardy v. Universal Life Insurance Company, 229 Mo. [App.] 632, 79 S.W. 2d 509 (1935), a question arose about cancellati[on] of a policy on an anniversary date and the effect of the pend[ing] claim. The insurance carrier had sought to terminate liabil[ity] for obligations after the anniversary date. However, the cou[rt] in reviewing the case found a provision in the policy which indicated that cancellation on any anniversary date would be without prejudice to any pending or existing claim. After quoting the pertinent language in the contract, the court neve[r]theless went on to say, "Such of course, would be the law eve[n] if not expressed in the clause."

In citing the foregoing authorities for Appellant, counse[l] is not unmindful of the fact that there are authorities which can be cited in favor of the position of Respondent. For example, in the case of Bartulis v. Metropolitan Life Insurance Company, 218 N.E. 2d 225 (Ill. App. 1966), an award by the tri[al] court to plaintiff insured, for medical expenses incurred afte[r] termination of the insurer's policy, though expenses resulted from an injury sustained while the policy was in force, was re[-]versed. The court reasoned because the policy provisions extended coverage only for hospital confinement or surgery actually undergone while the policy was in force, that subsequent surgery and hospitalization after termination of the policy would not be covered. Similarly, in Blue Cross of Florida Inc. v. Dysart, 340 So. 2d [illegible] (Fla. App. 1977), (Boa[...]

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man, Acting C.J., dissenting), the appellate court reversed a summary judgment award below which had granted Appellant's administrator insurance benefits for expenses incurred after the expiration of the contract for an injury sustained by the decedent while the policy was in force. The court suggested that judgment for the plaintiff might have been proper had the policy been a health and accident plan rather than a hospitalization and medical expense policy. Nevertheless, it reasoned that by nature of the policy in question, the termination of the policy by the employer's failure to renew the policy, also terminated any claim to benefits.

The apparent conflict between the cases above cited is examined in an annotation at 75 A.L.R. 2d 876. There it is suggested that differences are explained by differences in language of the policies or the types of policies involved (i.e., individual accident or group insurance policies). The author then suggests at page 876 - 877:

> However, there seems also to be a basic reason for the conflict of authority which goes farther and to the heart of the matter. It relates, apparently, to a conceptual difference, namely, whether the accident gives rise immediately to all claims based on its occurrence, or whether such claims originate when the specific loss for which the insured seeks indemnification occurs. It is submitted that the better view, which is supported not only by the more closely reasoned cases but which also conforms to what may be described as the general understanding as to the coverage of accident policies, is the one which extends the liability of the insurer to subsequent medical expenses.

In harmony with supporting decisions cited by Appellant counsel would also submit that the occurrence of Appellant's

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injury during the period while the policy was in force entitle her to receive benefits for medical expenses necessarily occasioned as a consequence of said accident, even after her termination of employment and that the order of dismissal below should be reversed.

POINT II

WHETHER A CONTRACT OF INSURANCE PROVIDING MEDICAL BENEFIT COVERAGE TO EMPLOYEES FOR CHARGES INCURRED BY EMPLOYEES FOR INJURIES SUSTAINED WHILE THE POLICY IS IN FORCE AND WHICH TERMINATES BENEFITS ON TERMINATION OF EMPLOYMENT LACKS CLARITY TO THE AVERAGE PERSON AS TO REQUIRE A CONTINUATION OF BENEFITS AFTER EMPLOYMENT TERMINATION.

It is recognized that in interpreting insurance contracts any ambiguity therein should be resolved in a light most favorable to the insured. Wardlow v. Kalispell General Hospital, 5[illegible] P. 2d 1167, 1166 (Mont. 1964). Further, it is recognized that the language of an insurance contract should be interpreted in the way that it would be understood by the average man purchasing insurance Meyers v. Kitsap Physicians Service, 474 P. 2d 109 (Wash. 1970).

In the case of Meyers v. Kitsap Physicians Service, supra plaintiff appealed an order dismissing his claim for compensation for medical services under a group health care service plan sponsored by the defendant. Plaintiff had been enrolled with the defendant's insurance plan through his employer for several years. Subsequent to the enrollment he began to suffer a kidney disorder and received medical treatment. Thereafter, the group carrier, at the end of its annual contract period, modified it

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plan to exclude kidney disorder treatments and thereafter declined payment to the plaintiff. The trial and appellate courts held that the defendant, by its contract, was only obligated for medical services actually rendered during the calendar year of the policy, which could be modified each year.

In reversing, the Washington Supreme Court reviewed the contract and stated at pg. 111:

> "Kitsap Medical agrees to provide medical, surgical hospital and other services to each member enrolled hereunder, as occasion demands, during the life of this contract" is susceptible of the reasonable interpretation that the "life of the contract" is automatically extended to such time as may be required to medically treat and medically care for the injury or illness that occurs during the year of the contract. We find it difficult to believe that the "average man purchasing insurance" would, or could, contemplate from a reading of this contract that the defendant's obligation terminates when the clock strikes midnight and the contract year ends, even though the insured may still be hospitalized or in need of further medical treatment for an illness incurred during the contract year.

Notwithstanding the fact that the contract in question was a health service contract rather than a health and accident policy the court reasoned the existence of the ambiguity made applicable the rule as applied to the health and accident policies heretofore cited in 75 A.L.R. 2d 876, supra stating at 111:

> ... plaintiff's rights under the contract became vested when medical treatment became necessary. Those rights being vested, the subsequent termination of the policy which created the right did not terminate the vested right of the plaintiff to payment of services rendered and to be rendered.

In light of the foregoing principles, the contract before

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this Court should be examined.

The policy in question, (Defendant's Exhibit 22-d) contains the following:

> The term "Employee" means a person directly employed in the regular business of, and compensated for service by, the Employer. (pg. 2)

> The term "Eligible Charges" as used in this Policy means those charges incurred by an employee... (pg. 4)

> INDIVIDUAL TERMINATION OF EMPLOYEE'S INSURANCE: The insurance of an employee shall automatically terminate immediately upon the earliest of the following dates: (1) The date termination of his employment occurs. (pg. 14)

A further clause of interest is found in Exhibit 22-d pg. [illegible] which states:

> EMPLOYEE'S CERTIFICATE: The Association will issue to the policyholder for delivery to each insured employee an individual certificate setting forth a statement as to the insurance protection to which he is entitled, to whom the benefits are payable, and such limitations or requirements in this Policy as may pertain to the insured employee. The word "certificate" as used in this Policy shall include certificate riders and certificate supplements, if any. <u>Such certificates shall not constitute a part of this Policy</u>. (Emphasis added.)

There is no question under the terms of the policy that [illegible] "employee" is one directly employed in the business of the employer and that "Eligible Charges" would be those incurred by [illegible] employee, and that to obtain the benefits of the group policy one need be an employee. However, to the average person purchasing or qualifying for this insurance, one could question whether the applicant could reasonably [illegible] that once sustained an injury, after having [illegible] as an employee, [illegible]

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all benefits would be lost from the moment he was no longer an employee, though he had been eligible at the time he was employed. Such contract could as likely be understood to mean that an employee qualifying under the group policy would be entitled to "Eligible Charges" incurred, if he was an "employee" at the time his injury was sustained, even though his status as an "employee" might thereafter change.

The provision at page 14 of ex. 22-d suggesting that the insurance of an employee would automatically terminate at termination of employment also adds little assistance. For though the insurance terminates, it remains uncertain whether benefits provided under the policy for existing injuries are likewise terminated or whether such termination relates only to such incidents as occur after termination.

It is submitted that the average person obtaining the policy in question would understand that injuries occassioned while the policy was in force would be compensated to conclusion and that the "striking of midnight" or termination of employment would not eliminate the obligation to finalize the existing difficulties. Meyers v. Kitsap Physicians Service, supra.

As a further indication that one could not understand any other position is evidenced by the fact that the insurer was able to control the information contained in certificates given to employees, which were not a part of the policy. (Ex. 22-d pg. 7)

Counsel would contend that the provisions of the policy, when viewed through the eyes of the average insurance purchaser, are ambiguous and uncertain as to whether benefits for an injury

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compensable under the policy would be extended beyond employment termination. Such ambiguity should be viewed in light favorable to Appellant and her rights to compensation would then be vested as the date of injury, and accordingly the decision of the lower court should be reversed. Meyer v. Kitsap Physicians Service, supra.

POINT III

WHETHER A POLICY OF INSURANCE WHICH PURPORTS TO SET OUT A PROVISION OF CANCELLATION AFTER OCCURRENCE OF AN INJURY IS VOID OR AGAINST PUBLIC POLICY.

Section 31-19-25, Utah Code Ann., (1953) provides:

> No insurance contract insuring against loss or damage through legal liability for the bodily injury or death by accident of any person, or for damage to the property of any person, shall be retroactively annulled by any agreement between the insurer and insured after the occurrence of any such injury, death, or damage for which the insured may be liable, and any such annulment attempted shall be void.

Under the instant policy it is the position of the Respondent that, by virtue of its contract, all benefits, rights and claims of an insured terminate when employment ceases. It is submitted that such a construction of the contract would be either an attempt retroactively to annul an agreement to provide coverage for a previous injury or an attempt to circumvent the policy of the statute. In the instant case, although the agreement is entered between the Respondent and Appellant's employer LDS Hospital, prior to any injury being sustained, the employment termination clause of the policy anticipates not only dissolving liability to extend coverage of an insured after term-

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ation but also effects an agreement to cancel responsibility for expenses incurred after the occurrence of an injury. Such provision should be void or in violation of public policy.

That insurance contracts have an effect upon the public interest is evident by the provisions of Section 31-1-8, Utah Code Ann., (1953) which reads:

> Within the intent of this code the business of insurance is one affected with the public interest, requiring that all persons be actuated by good faith, abstain from deception and practice honesty and equity in all insurance matters. Upon the insurer, the insured, and their representatives rests the duty of preserving inviolate the integrity of insurance.

Under a group insurance policy for the benefit of the policyholder's employees, the employer/policyholder, becomes the negotiating party for insurance for the employees. Employees have the right to obtain the coverage or seek some other or none at all. Futher, insurance coverage for accident and sickness is of importance to the citizens of this state, in that coverage thereof reduces potential responsibility from state agencies and the taxpayers. Therefore, it would seem appropriate, that as a matter of public interest, an insurance carrier should be required to extend coverage to an employee under a group plan for the consequences of an injury incurred within the effective dates of the policy, or alternatively, make known to the employee, in such plainness as a lay person can understand, that benefits will be limited by employment termination or other factors unrelated to the risks to be covered, that the employee may be afforded the choice of rejecting the policy or assuming the same with its limited restrictions. See <u>Meyers</u> v. <u>Kitsap</u>

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Physicians Service, supra; see also, dissenting opinion of Boardman, Acting C.J. in Blue Cross of Florida Inc. v. Dysart, supra.

Whether the termination clause be void or against public policy, such conclusion would afford the Appellant opportunity for reversal of the lower court decision.

CONCLUSION

For the reasons as set forth above, counsel respectfully contends that the decision of the lower court should be reversed and the cause remanded for further proceedings.

Respectfully submitted,

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