

1953

Norma Lois Cooper v. Foresters Underwriters, Inc. : Brief of Respondent

Utah Supreme Court

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IN THE SUPREME COURT
OF THE STATE OF UTAH

- - -oOo- - -

NORMA LOIS COOPER,)

Plaintiff and)
Respondent,)

RESPONDENT'S

BRIEF

-vs-

Case No. 7941

FORESTERS UNDER-)
WRITERS, INC.,)
a corporation,)

Defendant and)
Appellant.)

- - -oOo- - -

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Received two copies this _____ day of
_____ 1953

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Clerk, Supreme Court, Utah

Attorneys for Appellant

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NORMA LOIS COOPER,)

Plaintiff and)
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RESPONDENT'S

-VS-

FORESTERS UNDER-
WRITERS, INC.,)
a corporation,)

Defendant and)
Appellant.)

Case No. **7941**

On July 17, 1941, the
plaintiff paid pre-
mium on October 31,
Salt Lake City for
life and two insurance
policies. Before she
died and was
buried.

STATEMENT OF FACTS

Appellant in its Statement of Facts presents a statement altogether too limited. It is correct so far as it goes, but it does not present all of the facts. In the proceedings in the District Court, the Court said, "I have read that Stipulation." (Tr. 9) referring to the Stipulation in the record sent up from the City Court. Following is that Stipulation or Statement of Facts:

"At about 5:00 o'clock P.M. on the 31st day of March, 1951, Mrs. Norma Lois Cooper, plaintiff, executed an application for an insurance policy, which provided for medical, surgical and hospital benefits with the Foresters Underwriters, Incorporated, defendant. Said policy was known as 'The Gold Leaf Plan'. Plaintiff paid over \$5.00 to defendant's agent, Moses Leese, who countersigned said application. 'Certificate No. A-145' was issued to plaintiff. (See Exhibit 'A' attached to complaint.)

"On May 7, June 18, July 17, August 27 and October 1, plaintiff paid premiums of \$6.00 each. On October 31, plaintiff went to Salt Lake City for the purpose of paying two insurance premiums and other bills. Before she paid said premiums she fell and was injured. That afternoon her husband called defendant to ask how late he could make a premium payment and was told '5:00 P.M.'. When he reached defendant's office, it was closed so he proceeded to the home of Moses Leese, the agent who solicited the policy, and paid to him \$12.00, or two months' premiums. Plaintiff paid her next regular premium on November 21st, another on January 4th, and has since paid her premium every month. Never at any time did defendant tender back the premium payment in question or demand a new application for insurance from plaintiff, but defendant did reject plaintiff's claim for benefits under the policy.

"As a result of her fall, plaintiff was injured and expended more than \$500.00 for medical, surgical and hospital ex-

penses. Plaintiff made demand for recovery under her policy, but defendant denied liability and refused, and now refuses to pay.

Counsel for Appellant objection in the

District Court to the Statement of Facts from below and wished to limit the statement.

(Tr. 10). Counsel for Respondent stated that he agreed with the Statement of Facts of Appellant so far as it went, but "it leaves out two or three points which might be important."

(Tr. 11). Without deciding whether or not the fuller statement of Respondent should be considered, the Court then ruled that even under Appellant's Statement of Facts, summary judgment should be granted since the premium in question had been paid within the Grace Period. But the fuller Statement of Facts from the City Court below was before the District Court and should be considered in this appeal.

STATEMENT OF POINTS

I

THE POLICY WAS IN FULL FORCE AND EFFECT

AT THE TIME OF THE ACCIDENT AND INJURY.

II

THE APPELLANT ACCEPTED AND RETAINED THE PREMIUM FOR THE MONTH OF OCTOBER 1951 AND HAS DEMANDED AND ACCEPTED ALL SUBSEQUENT PREMIUMS, THEREBY WAIVING ANY RIGHT IT MIGHT HAVE HAD TO DECLARE THE POLICY FORFEITED AND TERMINATED.

III

BY ITS PRACTICE OF ACCEPTING LATE PREMIUMS AND APPLYING THEM RETROACTIVELY, APPELLANT HAS WAIVED DECEPT PAYMENT OF PREMIUMS.

I

THE POLICY WAS IN FULL FORCE AND EFFECT AT THE TIME OF THE ACCIDENT AND INJURY.

By its terms the policy provides a grace period of thirty-one days during which time said policy remains in full force and effect. Therefore, at 3:30 P.M. on the 31st day of October, 1951, the policy was still in effect because the full thirty-one days of the

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grace period had not expired. The term of the policy was from the last day of each month through the last day of the succeeding month, and the last day would extend until 12:00 o'clock midnight. Therefore, plaintiff was injured at a time when the policy was in full force and effect.

Defendant argues that the provisions on page 1 of the Insurance Policy "All periods of insurance hereinafter shall begin and end at twelve o'clock noon, standard time, at the residence of the insured" (Italics added), in some way modifies or limits the Grace Period provision, which is Section V on page 2 of the policy. But the two are separate and distinct. Insurance coverage has to do with time of injury, but the grace period has to do with the time in which a premium may be paid to keep the policy in continuous force and effect. The policy, specifically provides, "a grace period of thirty-one (31) days will be allowed for payment of any renewal premium during which

grace period the Certificate will remain
 remain in full force." (Italics added.)

What could be clearer? This is the policy written by the Insurance Company. It could have provided a grace period of thirty and one-half (30½) days (which in this action it does claim) or of twenty-nine (29) days, or ten (10) days, or eight (8) hours. But it provided thirty-one (31) days as a grace period. Plaintiff paid her premium within that period. The Insurance Company in its Policy of Insurance defined "grace period" as thirty-one (31) days and then provided during which grace period the Certificate will remain in full force." (Italics added.) In Penn Plate-Glass Co. v Spring Garden Ins. Co. (Pa) 42 A 138, the Supreme Court of Pennsylvania ruled squarely on this point and held that the noon to noon insurance coverage provision did not apply in computing time on other provisions of the policy such as notice of cancellation. That court held that the rule of construction

of excluding the first day and counting the last until twelve (12) midnight was the proper rule to follow. Indeed the insurance cases on grace periods seem, without exception, to hold that the time runs to midnight of the last day of said period, whatever its length, excluding the date when the premium was due and payable and counting every day after that. See: Swayze v. Mutual Life Ins. Co. 32 F 2d 784; Elgutter v Mutual Reserve Fund Life Asso. 28 So. 289; Campbell v International Life Assur. Soc. 4 Bosw (NY) 298; and United Order, G. S. v. Grigsby 22 SW 2d 31. The United Order Case also expounded the "familiar rule" followed by our courts that in the event of any conflict in computation of time, the provision most favorable to the insured should be applied and the contract of insurance sustained.

Appellant's confusion of "periods of insurance" and "grace period" has led it to repudiate the terms of its own policy. So long as premiums were paid within the grace period there was continuous coverage and no question

could arise on period of insurance. Only if a premium were not paid within the grace period and the policy lapsed, and thereafter claim was made under the policy, would it be necessary to determine if said injury was sustained during the period of insurance. Respondent paid her premium on the thirty-first day. Her policy never lapsed.

II at on October 31st

THE APPELLANT ACCEPTED AND RETAINED THE PREMIUM FOR THE MONTH OF OCTOBER 1951 AND HAS DEMANDED AND ACCEPTED ALL SUBSEQUENT PREMIUMS, THEREBY WAIVING ANY RIGHT IT MIGHT HAVE HAD TO DECLARE THE POLICY FORFEITED AND TERMINATED.

After plaintiff obtained her policy of insurance she made all of her subsequent premium payments during the grace periods. On the payment which immediately preceded the one in question, plaintiff made payment in the afternoon of the 1st day of the succeeding month. Without variance defendant accepted and retained the premium and applied said premium to cover insurance during the grace period. On the

October 1st payment, as well as on the October 31st payment, defendant accepted the premiums unconditionally. Never at any time did defendant tender back the amount of the premium or any part thereof nor demand a new application for insurance or additional evidence of good health, nor did defendant alter the dates of coverage for the policy. In other words, defendant on October 31st accepted the premium payment for the entire month of October just as it had accepted the October 1st payment for the entire month of September and also accepted payment for the entire month of November. Where is the hiatus in coverage? Can defendant now say that it accepted a full month's premium for less than a month's coverage under the policy? Having accepted the premium for October unconditionally, which acceptance it has confirmed by subsequently accepting all monthly premiums thereafter, defendant has waived any right it may have had to declare the policy lapsed and for-

feited. By accepting the October premium and unconditionally, defendant waived late payment (if it was late) and the policy was continuously in force.

In Ellerbeck v. Continental Casualty Company, 63 Utah 530; 227 P 805, our Supreme Court said:

"By the terms of the policy, the plaintiff...had the right to make the annual payments to reinstate the policy so as to afford protection for accidents after the date of payment...It is therefore contended by counsel for defendant that even though a waiver of payment was made by the defendant...such...would not keep the policy in force between the date of payment as fixed in the policy and the date of actual payment. The courts usually do not concur in that construction of similar provisions in insurance policies. As stated the insured had a legal right to reinstate his policy by making the annual payment as stipulated in the policy. His rights upon such payment are fixed by the terms or provisions of the policy. Under the construction of the provision contended for by the defendant's counsel, there would be nothing gained for plaintiff in this case by either a waiver or an extension of credit."

And the court held that a premium paid and accepted some four months late was effective to reinstate the accident and health policy to cover plaintiff for an illness contracted after

the end of the grace period of the policy and before actual premium payment. Defendant was held to have waived prompt payment. It will be noted that this was an accident and health case, and the policy contained the usual provision which is found in the policy of Mrs. Cooper that reinstatement would provide coverage only after payment of premium. This Court held squarely that acceptance of the late premium provided coverage under the policy all the way back to the date when said premium became overdue and delinquent.

Loftis v. Pacific Mutual Life Insurance

Company, 38 Utah 530; 11 4P 134, is an accident insurance policy case. The premium in question was not paid on time. However, defendant continued to demand and later collected the late premium. In the meantime, the insured had been killed during the period when the premium was overdue but unpaid. When defendant learned of the death of the insured it tendered back the premium it had collected late. But the court

held that defendant had waived late payment and could not now defeat its liability:

"But when appellant (defendant) by its acts and conduct apparently elected to keep the policy in force for the purpose of collecting premiums, the law will require it to keep it in force for all purposes."

The Loftis case holds that an accident insurance company cannot continue to collect premiums and at the same time treat a policy as lapsed during periods when premiums were overdue and unpaid. If it does not terminate the policy when it has a right so to do, and it accepts a late premium, then the company waives any right it may have to forfeit the policy and it must pay on its contract.

Sullivan v. Beneficial Life Insurance

Company, 91 Utah 405, 64 P.2d 351, holds that

"If an attempt to collect a premium after forfeiture constitutes a recognition of the contract as being in force, certainly actual payment of past-due premiums and receipt thereof by the insurer without conditions attached must be given the same effect."

In the Sullivan case, the premium was due on October 6th, but was not paid until December

24th. Thereafter, in January defendant refused to accept the next premium saying that the policy had lapsed in October for non-payment of premium. The insured died the following December. The court held that the defendant had waived late payment by accepting the premium on the previous December 24th and that it could not refuse the premium payment in January and consequently the policy was in force.

"The law will not permit an insurance company even though a fraternal mutual to accept dues or premiums from its members as if the insurance was in force and then refuse payment on the ground that the failure to pay promptly forfeited the insurance."

Watkins v. Brotherhood of American
Women (Missouri) 176 SW 326

Barnett v. Grand Lodge Brotherhood
of Railroad Trainmen (Missouri)

176 SW 326

The insurance cases universally hold that it is the policy of the law to keep insurance contracts in force and that whenever the conduct of the insurer indicates that it waives its right to declare a forfeiture the courts will so hold to avert a lapse of insurance. Our

courts, along with the courts of most other states, have consistently followed this policy. See Wittmer v. N. Y. Life Insurance Co. (Cal) 112 P2d 621; Marston v. Marston Life Insurance Co. (Cal) 56 P 773; Huber v. N. Y. Life Insurance Co. 63 P2d 318.

III

BY ITS PRACTICE OF ACCEPTING LATE PREMIUMS AND APPLYING THEM RETROACTIVELY, APPELLANT HAS WAIVED PRESENT PAYMENT OF PREMIUMS

The cases generally hold that if the company has accepted late payment of premiums without declaring a forfeiture of the policy on previous occasions, it cannot later, even if it desires to do so, elect to declare a forfeiture of a policy for late payment. Lof-tis v. Pacific Mutual Life Insurance Company of California, supra; Ballard v. Beneficial Life Insurance Co., 82 Utah 1, 21 P2d 847; Winter v. Sunset Mutual Life Insurance Co. (Cal.) 53 P2d 102; Nelson v. National Guaranty Life Co. (Cal.) 21 P2d 1022; Lincke v. Mutual Benefit Health and Accident Assn. (Cal.) 172

Pa'd 912.

In the Cooper case the premium payment for the month of September was accepted by defendant on the 1st day of October and defendant applied that premium to insurance coverage for the month of September. The insurance policy had a term that ran from the last day of the month to the last day of the succeeding month. When plaintiff failed to pay said premium during September, but did tender the premium in the afternoon of October 1st and defendant at that time accepted and retained the premium and applied it for the month of September, it established a practice of waiving any right which it might have to declare a forfeiture for late payment, and in so doing defendant was following the pattern which it set when it accepted the initial premium at 5:00 P.M. and dated coverage back to noon of March 31. Therefore, having allowed plaintiff to make the October 1st payment late, and, in effect, make the March 31st payment late, de-

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defendant could not refuse to accept the payment on the afternoon of October 31 to cover the month of October. (This is assuming for the purpose of argument that the grace period did terminate at noon on the 31st day of October.) Not only was defendant precluded by its prior practice from rejecting the October 31 payment, but, in fact, defendant made no attempt to refuse the payment. Gladly defendant accepted the October 31 premium and applied it to the October period of coverage, just as it has accepted all subsequent premium payments and applied them to the proper monthly coverage under the original terms of the contract.

So even if it is conceded for the sake of argument that the provision of the policy which limited the insurance period from noon on the last day of a month to noon on the last day of the next month somehow affected and limited the grace period to thirty and one-half (30½) days and, therefore, terminated coverage under the policy at noon on October 31,

still, this policy remained in force because defendant by its practice had created a method of operation which permitted the payment of premiums after noon of the last day without having the policy lapse. It will be remembered that the original contract of insurance was made at about 5:00 P. M. on the 31st day of March, 1951. On that day defendant accepted a premium payment at 5:00 P. M., but wrote a policy of insurance to cover a period beginning at noon on March 31. Again, on October 1, plaintiff made a payment after noon of that date to cover the period of the month of September. Even if we accept the view that the 31 day grace period extended the September coverage to noon of October 1 (since September is a 30 day month,) still, defendant accepted that payment after noon on the 1st day of October, but did not declare the policy lapsed and applied the premium payment for the preceding month. Consequently, when plaintiff tendered her premium for the month of October at about 5:30 P. M. on October 31,

appellant was bound to accept that premium payment in accordance with its practice and could not, if it so desired, declare the policy lapsed. Appellant was bound to accept the premium payment for all of the preceding month. In neither of the instances, where a premium payment was made after noon of 31st day of the insurance period, did appellant require the respondent to fill out a statement as to her present condition of health before it accepted the premium and entered into a contract for an additional month's insurance. Had appellant followed this practice of requiring evidence of insurability and thereby set up a new contract of insurance, we would have had a true lapse of the previous contract and the creation of a new contract. But appellant did not follow this practice. When the company accepted the payment of October 31 without requiring a new statement of health, the company chose to recognize the policy as in continuous force, without any lap-

se. This is further emphasized by the fact that the appellant did not tender back any part of the premium to cover any period when it claimed that the contract was not in force. Instead the appellant accepted the payment unconditionally. Our court has held that an insurer in order to be in a position to declare a policy lapsed for non-payment of premium must, at the time of the tender of the overdue premium, notify the insured that the premium is accepted conditionally upon the filing of proof of insurability by the insured. See Ballard v. Beneficial Life Insurance Company, supra.

In the Ballard case the court held that an insurance company could require an insured to file a new statement of health and thereby create a new contract of insurance running from the date when the policy was reinstated. But that situation is entirely different from the one under consideration. In this case, if the defendant argues (1) that on the 1st

day of October when it accepted payment of a premium in the afternoon to cover the month of September that the policy had lapsed and a new term of insurance was created, then the new term would run from the 1st day of October to the 1st day of November, and there would be no question that respondent was covered when she was injured; but (2) if the appellant accepted the October 1st premium unconditionally and applied it retroactively for the month of September with no lapse in the insurance coverage, then appellant was bound to do the same thing on October 31st when the premium in question was paid. The Louisiana Case of Richardson v. American National Insurance Co., 137 S. 370 relied on by appellant is distinguished in the Lincke case, *supra*.

It is submitted therefore that respondent has been continuously covered by insurance since the 31st day of March, 1951, up to the present date and that there has never been a gap or lapse in that insurance policy. Consequently,

respondent was and is entitled to recover under the terms of the policy to reimburse her for the medical and hospital expenses which she incurred as a result of her injury on the 31st day of October, 1951.

Respectfully submitted,

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