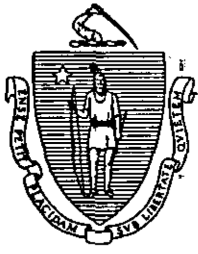
Testimony

- Hearing Testimony Forms
- Letters of support from legislators
- Letters and materials sent by citizens

2B



Massachusetts General Court
Joint Committee on Financial Services
2007-2008

HEARING TESTIMONY FORM

*PLEASE COMPLETE ONE SHEET FOR EACH PIECE OF LEGISLATION YOU INTEND TO TESTIFY ON.

Hearing Date: 10/10/07

If you would like to present oral testimony or be recorded on any legislation, please provide the following information:

Testimony on Bill #: H 1072
S ______

ORAL TESTIMONY: In support of ( ) In opposition to ( )

TO BE RECORDED ONLY: In support of ( ) In opposition to (✓)

WILL YOU BE SUBMITTING ANY WRITTEN TESTIMONY? Yes ( ) No (✓)

NAME (please print): LUKE A. DILLON

ORGANIZATION AND ADDRESS: LIFE INS. ASSOC. OF MASS.

TELEPHONE #: 617-695-0560

Please submit this completed form to committee staff prior to hearing.

Thank you,

Senator Stephen J. Buoniconti, Senate Chair
Representative Ron Mariano, House Chair

1 A

Massachusetts General Court
Joint Committee on Financial Services
2007-2008

HEARING TESTIMONY FORM

*PLEASE COMPLETE ONE SHEET FOR EACH PIECE OF LEGISLATION YOU INTEND TO TESTIFY ON.

Hearing Date: 10/10/07

If you would like to present oral testimony or be recorded on any legislation, please provide the following information:

Testimony on Bill # H__________

S 633

ORAL TESTIMONY: In support of (✓) In opposition to ( )

TO BE RECORDED ONLY: In support of ( ) In opposition to ( )

WILL YOU BE SUBMITTING ANY WRITTEN TESTIMONY? Yes ( ) No (✓)

NAME (please print): ~~B.B.~~ Brendan Bridgeland

ORGANIZATION AND ADDRESS: ~~CIR~~ Center for Insurance Research

TELEPHONE #: __________

Please submit this completed form to committee staff prior to hearing.

Thank you,

Senator Stephen J. Buoniconti, Senate Chair
Representative Ron Mariano, House Chair

Massachusetts General Court
Joint Committee on Financial Services
2007-2008

HEARING TESTIMONY FORM

*PLEASE COMPLETE ONE SHEET FOR EACH PIECE OF LEGISLATION YOU INTEND TO TESTIFY ON.

Hearing Date: 10/10/07

If you would like to present oral testimony or be recorded on any legislation, please provide the following information:

Testimony on Bill # H______

S 633

ORAL TESTIMONY: In support of (✓) In opposition to ( )

TO BE RECORDED ONLY: *In support of ( ) In opposition to ( )*

WILL YOU BE SUBMITTING ANY WRITTEN TESTIMONY? Yes ( ) No (✓)

NAME (please print): Marc Hymovitz

ORGANIZATION AND ADDRESS: American Cancer Society
18 Tremont St · Boston

TELEPHONE #: 617-878-4130

Please submit this completed form to committee staff prior to hearing.

Thank you,

Senator Stephen J. Buoniconti, Senate Chair
Representative Ron Mariano, House Chair

1 A

Massachusetts General Court
Joint Committee on Financial Services
2007-2008

HEARING TESTIMONY FORM

*PLEASE COMPLETE ONE SHEET FOR EACH PIECE OF LEGISLATION YOU INTEND TO TESTIFY ON.

Hearing Date: 1/9/10

If you would like to present oral testimony or be recorded on any legislation, please provide the following information:

Testimony on Bill # H________

S 633

ORAL TESTIMONY: In support of ( ) In opposition to ( )

TO BE RECORDED ONLY: In support of ( ) In opposition to ( )

WILL YOU BE SUBMITTING ANY WRITTEN TESTIMONY? Yes ( ) No ( )

NAME (please print): Sen Spilka and Panel

ORGANIZATION AND ADDRESS: ________

TELEPHONE #: ________

Please submit this completed form to committee staff prior to hearing.

Thank you,

Senator Stephen J. Buoniconti, Senate Chair
Representative Ron Mariano, House Chair

1A

Massachusetts General Court
Joint Committee on Financial Services
2007-2008

HEARING TESTIMONY FORM

*PLEASE COMPLETE ONE SHEET FOR EACH PIECE OF LEGISLATION YOU INTEND TO TESTIFY ON.

Hearing Date: 10/10/2007

If you would like to present oral testimony or be recorded on any legislation, please provide the following information:

Testimony on Bill # H______
S 633

ORAL TESTIMONY: In support of (X) In opposition to ( )

TO BE RECORDED ONLY: In support of ( ) In opposition to ( )

WILL YOU BE SUBMITTING ANY WRITTEN TESTIMONY? Yes ( ) No ( )

NAME (please print): Mr. + Mrs. Geoffrey O'Kiells (Kiells)

ORGANIZATION AND ADDRESS: N/A

TELEPHONE #:

Please submit this completed form to committee staff prior to hearing.

Thank you,

Senator Stephen J. Buoniconti, Senate Chair
Representative Ron Mariano, House Chair

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON 02133-1054

BARRY R. FINEGOLD
STATE REPRESENTATIVE
17TH ESSEX DISTRICT
ROOM 275, STATE HOUSE
TEL. (617) 722-2676
Rep.BarryFinegold@hou.state.ma.us

Committees on:
Ways and Means
Economic Development and Emerging Technologies
Labor and Workforce Development

July 5, 2007

Honorable Stephen J. Buoniconti, Senate Chair
Honorable Ronald Mariano, House Chair
Joint Committee on Financial Services
State House, Room 254
Boston, MA 02133

To the Honorable Chairs & Committee Members;

I am writing in full support of Senate Bill No. 633, *An Act ensuring consumer protection in life insurance contracts*. This legislation is intended to clarify that in court actions where issue arises as to the good health of the insured at the time a life insurance policy was issued, there will be a presumption that good health existed.

This legislation will also requires the insurer to inform the insured or policy applicant if they have or are at risk of a serious health condition.

Current law allows life insurance companies to claim that a policy holder diagnosed after being issued a policy may have not been in good health at the time of issue, even if there is no evidence to this effect. One of my constituents, Jenny Crowley, is an example of this lack of clarity in law has led to unfairness towards her widower, John Crowley.

On September 22, 2004, John and Jenny were issued life insurance. In October of 2004, tests revealed that Jenny suffered from stage four breast cancer. She passed away in October of the following year. In December of 2005, Jenny's life insurance claim was denied on the basis that, although Jenny's medical records prior to September 22, 2004 did not include any symptoms of breast cancer, the insurance company believed that her cancer existed prior to the effective date of the policy based on the evidence of cancer less than one month later. Noted specialists in the field acknowledge that it is possible that Jenny's cancer did not exist prior to September 22, 2004, and agree that no conclusions on when the onset of cancer may have occurred prior to receipt of the biopsy results. The legislation would clarify the law and help to prevent cases such as that of John and Jenny Crowley, and would give the kind of assurance health insurance laws are supposed to give the citizens of Massachusetts.

I offer my full support of this legislation and respectfully request that the Committee give a favorable recommendation and allow the bill to continue in the legislative process. Thank you for your careful consideration of this request. If you have any questions, please do not hesitate to contact my office.

Respectfully,

Barry R. Finegold
Representative

The Commonwealth of Massachusetts
House of Representatives
State House, Boston 02133-1054

GEOFFREY D. HALL
STATE REPRESENTATIVE
2ND MIDDLESEX DISTRICT
CHELMSFORD - PRECINCTS 3, 5, 7
LITTLETON, WESTFORD

Chairman
Committee on Post Audit and Oversight

ROOM 146, STATE HOUSE
TEL. (617) 722-2575
FAX (617) 722-2238

October 18, 2007

Representative Ronald Mariano, Chairman
Joint Committee on Financial Services
Room 254
State House

OCT 2 2 2007

Dear Chairman Mariano:

I am writing in support of S.633, **An Act Ensuring Consumer Protection In Life Insurance Contracts** which was the subject of a public hearing on October 10.

As you know, the current law provides that one must be in good health when they apply for life insurance. Subsequently, when someone is diagnosed with an illness which results in their death, an insurance company may challenge the payment benefit in court on the basis that the deceased individual's death was the result of an illness they had when they acquired their life insurance policy. When such a challenge arises, the individual's beneficiaries must prove in court that the individual was healthy at the time of purchase of the policy. This can be very difficult to prove.

This provision of law was instituted in the 1980's when there was a concern with increasing HIV infection rates and that individuals so infected would subsequently acquire large insurance policies as a result of their diagnoses. In that situation, the provisions may have been warranted. Clearly, the provision is not warranted for present day circumstances.

This proposal would provide that a presumption of good health be the accepted policy notwithstanding any obvious and verifiable pre-existing medical condition that could likely and directly result in an individual's future death.

Chairman Mariano, I urge you and the members of your committee, following your analysis of testimony, to issue a favorable report on this legislation in order that both branches of the legislature may act and forward the bill to the Governor.

Sincerely,

Geoffrey D. Hall
Chairman
Committee on Post Audit & Oversight

Geoffrey O. Hills
33 Brimmer Street
Boston, MA 02108

OFFICE (617) 918 4882

October 10, 2007

Regarding the good health clause in life insurance

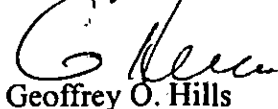
To Whom It May Concern,

Enclosed are some papers relating to the discussion of the good health clause in life insurance. One, titled "Determination of whether insured had been I good health on his policy date", ties into the discussion of the difficulty of proving whether the insured had been in good health, as it is the burden of the insured or his representative to do so. The approach was offered by a Justice of the Supreme Court in the case If Lee v. Prudential, a copy of which is enclosed as well. This ties in very well to Karen Spilka's bill, in which she seems to be attempting to switch the burden by making it the burden of the insurance company to prove otherwise. According to the court in this case, the fact that the insurer issued the policy is evidence that it acknowledged the insured's good health at the time of application, and that absent evidence to the contrary, the insured would have still been in good health on the policy date. In other words, the insurer needs to show evidence that the person was not in the health condition represented in the application, as it has already *determined that the condition represented is one of good health. In other words*, while the burden of proof is on the plaintiff, the issuance of the policy is the first evidence of proof and refuting that would be the burden of the insurer.

Statements were made during the show that SBLI is in the business of paying claims, and that less than 1% of claims made within the first two years (an infinitesimal quantity) are reviewed. Enclosed is a discussion regarding that, starting out "During the radio..." We have the sworn testimony of the members of SBLI's death claim committee that virtually all early death claims (those submitted within two years) are reviewed. The statement made on behalf of SBLI, if not untrue, was certainly misleading. We have an internal email from within SBLI telling us that the company reviews early death claims to search reasons for denying coverage based on the good health clause, even when those reasons were unknown at the time of the policy date. Such as an illness that had not manifested as of the policy date. That they apparently re-underwrite with the benefit if hindsight, and that that is standard practice.

As for the details of my wife's (Elise Larner Hills) case against SBLI, I think it best to not discuss the particulars of the case, beyond that which is public. We know that her late husband who was a friend of mine, was in good health when he took out his policy.

Thanks you.



Geoffrey O. Hills

MASSACHUSETTS
LAWYERS WEEKLY
www.masslawyersweekly.com

Want to jun
your legal re

Wednesday, October 10, 2007

HILLS

v.

SAVINGS BANK LIFE INSURANCE CO. OF MASSACHUSETTS

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPERIOR COURT

No. 04-1590

ELISE HILLS f/k/a

ELISE LARNER

Plaintiff

v.

SAVINGS BANK LIFE INSURANCE COMPANY

OF MASSACHUSETTS

Defendant

MEMORANDUM OF DECISION AND ORDER

ON CROSS MOTIONS FOR SUMMARY JUDGMENT

This is an action seeking payment of proceeds under a life insurance policy issued by the defendant Savings Bank Life Insurance Company of Massachusetts ("SBLI") to Charles Larner, who died on May 1, 2002. The plaintiff Elise Larner (now Elise Hills) is his widow and the named beneficiary under the policy. The case is now before the Court on cross motions for summary judgment. At issue is the interpretation of a "good health" clause in the policy application. For the following reasons, this Court concludes that, as to Count II (alleging breach of contract) the plaintiff's Motion must be ALLOWED, and the defendant's Motion DENIED. As to all remaining Counts, the defendant's Motion is ALLOWED.

The undisputed facts material to these motions can be summarized as follows. In November 2001, Mr. Larner, then 50, applied for term life insurance with SBLI. Part One of the Application was filled out on November 8, 2001 with the assistance of Maureen E. Carney, an insurance agent associated with SBLI. The Application stated that Mr. Larner had been laid off from his job at Polaroid, and was looking to "provide financial security for his wife and children," who were named as the beneficiaries. [1] The amount of insurance applied for was $300,000. In a preprinted box on the second page of Part One of the Application, there appears the following language:

I agree that the insurance applied for shall not be effective until the later of the date that the first full premium is paid or the date the application is approved by SBLI, and only then if each person to be insured is in good health on such date.

(emphasis in original). There was no discussion at the time the Application was filled out concerning the meaning of the reference to "good health." Carney told Mr. Larner only that the policy would become effective once the underwriter approved his application and he paid his first premium. It is undisputed, however, that as far as Mr. Larner or his family knew, he was in fact in good health when he executed this Application on November 21, 2001.

In order to satisfy itself that Mr. Larner was indeed in good health, SBLI did two things. First, it dispatched a paramedic to Mr. Larner's residence to examine him. The paramedic measured his height and weight, took his blood pressure and pulse, and took blood and urine samples. The test results were all normal. The paramedic also asked Mr. Larner a number of questions concerning his health (as well as that of family members), and his responses to these questions were recorded in Part Two of the Application. Mr. Larner reported that he had last seen his physician in October 2001 for a complete physical examination, which was normal. He also stated that he took Prilosec and suffered from seasonal allergies. Otherwise, his responses indicated that he was in good health as far as he knew: he had never smoked, and had never been treated for or had any indication of rheumatism, cancer, bone disease, or any other serious disorder. He had never been advised to reduce his consumption of alcohol nor had he consumed at any time any barbiturates, narcotics, or other habit forming drugs. He did not suffer from any sexually transmitted diseases. He was not overweight.

The next thing that SBLI did was get Mr. Larner's medical records. There was nothing in these medical records to indicate to SBLI that Mr. Larner was not in good health. The records did show that Mr. Larner had a long history of gastroesophageal reflux disease ("GERD"), and that he was taking Prilosec for this, as he had stated in the Application. He had seen his doctor last in the fall 2001, as he reported. The record of that visit (described as "routine") stated that Mr. Larner "looks well," and reported "running two to three miles a day" without difficulty. The physician stated that there were "no major concerns" except for the "ongoing dyspepsia and GERD," which had been treated with Prilosec.

On November 27, 2001, Mr. Larner sent SBLI a check for the policy premium. There is no evidence that anything medically significant occurred for the next six weeks. On January 3, 2002, SBLI approved the Application and the policy issued a few days later. The insurance policy stated that it included the Application and any attached riders as part of the contract.

It also contained a provision stating that SBLI could contest or cancel the policy for any misrepresentation of fact in the Application. There is no claim in this case that Mr. Larner made any misrepresentations to SBLI or in any way gave it untrue information about his health as he perceived it.

On January 16, 2002, Mr. Larner returned to his doctor after experiencing abdominal cramps the night before. Mr. Larner's doctor referred him to Emerson Hospital for diagnostic tests, suspecting a possible kidney stone. An ultrasound instead showed "multiple hepatic lesions consistent with metastatic disease." The next day, Dr. Dubois at Emerson performed a CAT scan which showed multiple lesions on Mr. Larner's liver and a mass in his pancreas.

He was diagnosed with Stage IV pancreatic cancer, which is the highest level of severity and has a prognosis of survival which is less than a year. Mr. Larner died on May 1, 2002.

Mr. Larner's wife Elise (the plaintiff) promptly submitted a claim to SBLI for death benefits. On June 19, 2002, SBLI denied the claim on the grounds that Mr. Larner could not have been in "good health" as of January 3, 2002 when his Application was approved. Citing the "good health" clause in the Application, SBLI took the position that the policy was void.

It issued the plaintiff a check for $827.28, representing the premiums paid as of that date.

This lawsuit ensued.

DISCUSSION

The issue before this Court is whether a beneficiary under a life insurance policy can be denied death benefits under a "good health" clause even where the insured did not know at the time that his application was approved that he was suffering from a disease which would ultimately prove to be fatal. The defendant contends that a long line of Massachusetts cases supports its position that the insured's actual good health is a condition precedent to coverage which, if not satisfied, voids the policy even though the health problem was not known until after the policy issued. The plaintiff argues that the Court should interpret this clause from the perspective of the policy holder: if the insured reasonably believed that he was in good health at the time he applied for insurance, then the insurer should not be able to escape its obligations, particularly where it had satisfied itself as to the state of the insured's health before it approved the application. Recognizing that the defendant has precedent on its side, this Court is nevertheless of the view that, if the Supreme Judicial Court were to confront this issue today, it would take the plaintiff's position. That is, clauses like the instant one must be interpreted based on what the parties knew and reasonably believed at the time the policy issued, and not on what in fact turned out to be the case based on discoveries made sometime later.

This Court begins its analysis with certain principles in mind. The interpretation of an insurance contract is no different from the interpretation of any other contract: if a provision is free from ambiguity, then the Court must give the words their usual and ordinary meaning.

Cody v. Connecticut General Life Insurance Co., 387 Mass. 142, 146 (1982), quoting

MacArthur v. Massachusetts Hospital Service Inc., 343 Mass. 670, 672 (1962). Where there are equally plausible interpretations of the policy language, however, then "the insured is entitled to the benefit of the one that is more favorable to it." Trustees of Tufts University v. Commercial Union Insurance Co., 415 Mass. 844, 849 (1993), quoting Hazen Paper Co. v. United States Fidelity & Guaranty Co., 407 Mass. 689, 700 (1990). This makes particularly good sense since the insurer generally drafts the policy language; it is therefore within its power to make clear its intentions and to alleviate any confusion on the insured's part. Finally, it is appropriate for the Court to consider whether an objectively reasonable insured, reading the relevant policy language, would expect to be covered. Hakim v. Massachusetts Insurer's Solvency Fund,

424 Mass. 275, 282 (1997); see also City Fuel Corp., v. National Fire Insurance Co of Hartford, 446 Mass. 638 (2006). This Court applies these principles in weighing the arguments of the parties.

SBLI contends that Mr. Larner's good health was a condition precedent to the formation of a contract of insurance. As a condition precedent as opposed to a representation, "good health" (it is argued) means actual good health; the insured's state of mind is totally irrelevant. Certainly, there is support for this position in the case law, although most of these decisions date back to the late nineteenth and early twentieth century. See e.g. Fondi v. Boston Mutual Life Insurance Co., 224 Mass. 6, 7 (1916); Barker v. Metropolitan Life Insurance Co., 188 Mass. 542, 546 (1905); Gallant v. Metropolitan Life Insurance Co., 167 Mass. 79 (1896); see also Ansin v. Mutual Life Insurance Co. of New York, 241 Mass. 107, 110 (1922). If the Court were to use this analysis, then SBLI would

prevail: there can be no dispute that Mr. Larner was suffering

from pancreatic cancer as of January 3, 2002, the date the insurance policy issued. [2]

Although SBLI does have Massachusetts precedent on its side, more recent decisions interpreting "good health" clauses are not quite so clearly on point or are readily distinguishable. Thus, in Krause v. Equitable Life Insurance, 333 Mass. 200 (1955), the policy not only required that the insured be in good health at the time the policy issued but contained the further requirement that the insured shall not have received any medical treatment after the insurer's doctor examined him. Following the examination, the insured collapsed from what appeared to be a heart attack and was treated by a doctor – facts he did not disclose to the insurer before his application was approved. In Warren v. Confederate Life Ass'n, 401 F.2d 487 (1st Cir. 1968), the insured warranted in his application that he was "in first class good health and free from all symptoms of disease" when in fact, unknown to the insurer, he had been hospitalized several times for the ingestion of drugs and for seizures. In Connolly v. John Hancock Mutual Life Insurance Co., 322 Mass. 679 (1948), the trial court erred by simply presuming that the insured was in good health because he was alive at the time the policy was to take effect. The question of whether the insured knew or had any reason to know that he was not in good health was not discussed at all. See also Shurdut v. John Hancock Mutual Life Insurance Co., 320 Mass. 728 (1947).

Clearly, these more recent cases are quite different from the case before this Court.

First, the Application does not attempt to define "good health," in contrast, for example, to the clause in Warren ("first class good health" and "free from all symptoms of disease"). Second, in contrast to the facts in Krause, there is no evidence that Mr. Larner received any medical treatment (or even that his physical status changed in some way) between the time he saw the paramedic in November 2001 and the date when he was diagnosed with cancer. There is therefore no basis to find that a change in circumstances occurred which should have been disclosed to SBLI. Finally, is undisputed that Mr. Larner truthfully represented the state of his health as he knew it to be on November 2001 and had no knowledge that he had cancer until after the policy issued. The instant case thus lacks that element of misrepresentation which have moved many courts to enforce the good health clause so as to deny any coverage. See e.g. Pagnotti v. Savings Bank Life Insurance Co. of Massachusetts, C.A. No. 02-00922

(Brockton Superior Court) (Giles, J.)

In attempting to predict what the Supreme Judicial Court would do with this case if confronted with it today, I look to the state of the law in other jurisdictions. As best this Court can determine, the states are almost evenly divided, with approximately twenty adopting the position advocated by SBLI,[3] and around seventeen favoring a position closer to that proposed by the plaintiff.[4] The Massachusetts approach has been pronounced by courts in the latter group to be "harsh." See e.g. *Brubaker v. Beneficial Life Insurance Co.*, 130 Cal. App. 2d 340, 345 (1955) (applying California law). In those states which have upheld coverage even where the insured was not in fact in good health at the time the policy issued, one can discern certain common themes or core facts which moved the court to the decision that was ultimately reached. They include the following.

First, courts have given considerable weight to whether the insurer required the insured to undergo a medical examination. These courts reasoned that, in issuing the policy after such an examination, the insurer had effectively waived the ability to cancel a policy based on a condition which neither the insurer nor the insured detected beforehand. See e.g. Combs v. Equitable Life Ins. Co. of Iowa, 120 F.2d 432, 435 (4th Cir. 1941) (applying Virginia law); see also Wanshura v. State farm Life Ins. Co., 275 N.W.2d 559 (1978) (applying Minnesota law). Where the insurance company determines the nature, scope and extent of the medical examination that the insured must submit to as a condition of coverage, then the insurance company should not be able to take advantage of any shortcomings in such an examination by voiding the policy retroactively under the "good health" clause once a disease which could have been detected eventually manifests itself. Ortega v. North American for Life & Health Ins.

187 Neb. 569, 573 (1971). Under this reasoning, it should not matter whether the examination was conducted by a doctor or a paramedic (as was true in the instant case). The insurance company could have reduced its risk by requiring a more extensive examination. Having settled for less (at a reduced cost to it), it bears the risk if a condition then comes to light which neither the insured nor the insurer were aware of at the time the policy issued.

This approach also makes sense when one considers the situation from the standpoint of the insured. As the Pennsylvania Supreme Court noted, the applicant who "passes" a medical exam "is certainly justified in assuming, in the absence of fraud or misrepresentation on his part, that the company has satisfied itself as to his state of health, and that he can rest confident in the belief that he has obtained a valid policy of insurance upon his life." Prudential Ins. Co. v. Kudoba, 323 Pa. 30, 35 (1936). Absent some evidence that the insured's health status markedly changed after such an examination and prior to the delivery of the policy, the insured should be able to rely on the results of the examination which the insurer essentially held out as the standard by which "good health" would be measured. See Sherman v. Mutual Life Insurance Co., 447 Pa. 442, 449 (1972) (noting that a change in health after the examination could be a reason to deny coverage even after the insured was given a clean bill of health). In the instant case, it is fair to say that Mr. Larner quite reasonably expected that he had been determined by SBLI to be in "good health" once he released his medical records (showing a normal examination by his own doctor), and after no problems surfaced in tests run by the paramedic whom SBLI had hired. Unless his health changed for the worse between the time of the Application and the date the policy issued (and there is no evidence of that), there would be no reason for these expectations to change.

A second rationale for these decisions favoring coverage even in the absence of the insured's actual good health is the inevitable gap in coverage which would result if insurers could void a policy retroactively based on a condition which manifests itself some time after the policy issued. As the court noted in Kudoba, "no one would ever know if he were insured or not, even though he has passed a medical examination and received a policy." 323 Pa. at 35. People buy insurance to protect their family's financial future. If one insurer turn them down, they have the option of applying to another. Where the insurer accepts their money and issues the policy, however, then there is no reason to seek coverage elsewhere. It hardly seems fair to allow the insurance company to go back on that decision when it discovers sometime after delivery of the policy that the risk that the insured sought protection against (namely, his untimely death) can be traced back to some latent condition which no one knew about when the application for insurance was first made. See e.g. Bronx Savings Bank v. Weigandt, 1 N.Y.2d 545, 553 (1956) (stating that it would be unfair to rescind a life insurance policy by interpreting the good health clause in a way which the reasonable insured would not have understood it). See also National Life & Accident Insurance Co, v. Martin, 35 Ga. App.1 (1926); Kudoba, 323 Pa. at 34-35.

Apart from the approach taken in these other states, this Court also finds support for plaintiff's interpretation in the fact record before this Court, including testimony from representatives of SBLI itself. Thus, the insurance broker who sold Mr. Larner the policy testified that she understood the reference to "good health" to mean that Mr. Larner was certifying that he had no knowledge of any medical illness or condition impairing his health.

See Deposition of Maureen E. Carney, at pp. 25-27. SBLI's Director of Brokerage agreed that a reasonable insured could understand "healthy" to mean "free of any known serious illnesses." See Deposition of Dennis Clifford at p. 44. SBLI's underwriter described the issue of "good health" in terms of risk: in deciding whether to approve a policy application, he would review medical records and the medical findings from the examination to determine if the applicant was an "acceptable risk." See Deposition of William Ventola, pp. 55-56;. See also Affidavit of Steven Rudnyai (describing his communications with SBLI concerning the meaning of the "good health" clause). Here, Mr. Larner's application was approved: that is, knowing of his GERD problem, and having the results from both its own examination and that of Mr. Larner's personal physician, SBLI accepted Mr. Larner as he was as of the date the policy issued. He was in effect deemed to be insurable by SBLI's own standards.

Finally, this Court returns to the principles that it cited at the beginning. The term "good health" (notwithstanding SBLI's assertion to the contrary) is not one which is free from ambiguity.

See Friez v. National Old Line Ins. Co., 703 F.2d 1093, 1095 (9th Cir. 1983) (concluding that "good health" could mean either "objective good health" or "apparent good health," and adopting, under *Montana law, that meaning which favored the insured). As the New York Court of Appeals held in* Weigandt, supra, that ambiguity is not eliminated by simply calling "good health" a condition precedent rather than a representation. Although "an insurer is entitled to protect itself against risks it does not wish to take...it must manifest its intent to exclude such risks in clear, unequivocal terms." Weigandt, 1 N.Y.2d at 553. Where it fails to do so, the Court should interpret the term based how the average person in the insured's position would understand it. This is not just a question of contract law but of fairness. To interpret the policy contrary to the reasonable expectations of the insured so as to rescind it at a time when it is too late for the insured to seek insurance elsewhere would be "manifestly unjust." 1 N.Y.2d at 553.

Having accepted the plaintiff's position with regard to the meaning of "good health," all the Court must still consider with regard to the breach of contract count is whether there is any question of fact which would make summary judgment for the plaintiff inappropriate. This Court concludes that no such fact issue exists. As already noted, SBLI concedes that the Mr. Larner did not know that he had cancer until after the policy issued. Furthermore, there is no evidence that he had any reason to know that his health was any different on January 3, 2002 than it was on November 21, 2001: there *is no indication that there was any change in circumstances, or that Mr. Larner came into possession* of information about his health between those dates which he should have disclosed to SBLI. His good faith is not questioned. In opposing the plaintiff's summary judgment motion, SBLI does not argue that there is a material fact issue. Rather, it makes the straightforward argument that plaintiff's interpretation of the good clause is wrong as a matter of law.

Although this Court accepts plaintiff's interpretation of the insurance contract, the plaintiff is not entitled to pursue her claims seeking relief on theories other than breach of contract. [5] In Count VII, plaintiff asserts a violation of G.L.c. 93A and G.L.c. 176D. Where the interpretation of policy language is an issue of first impression, however, there is no violation of 93A. City Fuel Corp., 446 Mass. at 644. Here, this Court is not only striking out into new territory but is diverging from existing precedent. Clearly, SBLI's interpretation of the "good health" clause is not so unreasonable as to constitute an unfair and deceptive practice. Plaintiff will likewise be unable to make out a claim for either intentional infliction of emotional distress (Count IV), since that requires outrageous conduct on the part of the defendant, or of negligent infliction of emotional distress (Count VI), there being no evidence of negligence or of physical harm to the plaintiff manifested by objective symptomalogy. *Payton v. Abbott Labs,*

386 Mass. 540, 555-557 (1982). This is a breach of contract case and nothing more. The defendant is thus entitled to summary judgment on the plaintiff's remaining claims. With a final judgment to enter, the parties are thus free to test this Court's legal conclusions by seeking appellate review.

CONCLUSION AND ORDER

For all the foregoing reasons, the plaintiff's Motion for Partial Summary Judgment on Counts II alleging a breach of contract claim is ALLOWED and the Defendant's Motion for Summary Judgment on that claim is DENIED. As to the remaining counts, the Defendant's Motion is ALLOWED. It is hereby ORDERED that judgment enter for the plaintiff on Count II after a hearing to assess damages on that count, which should be scheduled promptly. Such damages shall be limited to that amount of money which the plaintiff would have received if her claim for death benefits had been honored; it should not include any amount for attorneys' fees or costs. Counts I and III through VII are DISMISSED, with prejudice.

Janet L. Sanders

Justice of the Superior Court

Dated: June 19, 2007

FOOTNOTES:

[1]Mr. Lamer was not alone in seeking life insurance for his family during this period. As his insurance broker testified at her deposition, there was a dramatic surge in the number of people applying for life insurance in the fall of 2001, after September 11.

[2]When the cancer was diagnosed January 16, 2002, it was in an advanced stage. If common sense were not enough to compel the conclusion that this cancer had its onset well before January when the policy issued, the defendant has submitted the affidavit of an oncologist supporting that conclusion. The plaintiff has submitted no opposing affidavit so as to raise a triable issue on this point.

[3]Those states are as follows: Alabama, Arizona, Connecticut, Florida, Indiana, Kansas, Massachusetts, Michigan, Missouri, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, South Carolina, Texas, Tennessee, Vermont, Washington, and Wisconsin. Ball v. National Life & Acc. Ins. Co. Nashville, Tenn., 40 Ala. App. 593 (1960) (reversed on other grounds); Sovereign Camp, W.O.W. v. Daniel, 48 Ariz. 479 (1936); Kelly v. John Hancock Mut. Life Ins. Co., 131 Conn. *106 (1944); Life Ins. Co. of North America v. Cichowlas, 659 So. 2d 1333 (1995); Western &* Southern Life Ins. Co. v. Persinger, 101 Ind. App. 522 (1936); Klein v. Farmers' & Bankers' Life Ins. Co., 132 Kan. 748 (1931); Krause v. Equitable Life Ins. Co. of Iowa, 333 Mass. 200 (1955); Ogilvie v. Inter-Ocean Ins. Co., 12 Mich. App. 652 (1968); Prince v. Metropolitan Life Ins. Co., 235 Mo. App. 168 (1939); Perkins v. John Hancock Mut. Life Ins. Co., 100 N.H. 383 (1956); Barrase v. Metropolitan Life Ins. Co., 12 N.J. Misc. 631 (1934); Huffman v. State Capital Life Ins. Co., 8 N.C. App. 186 (1970); Thompson v. Travelers' Ins. Co., 13 N.D. 444 (1904); Metropolitan Life Ins. Co. v. Howle, 62 Ohio St. 204 (1900); United Ins. Co. of America v. Stanley, 277 S.C. 463 (1982); American Nat. Ins. Co. v. Navarette, 758 S.W. 2d 805 (1988); De Ford v. National Life & Acc. Ins. Co., 185 S.W.2d 617 (1945); Grover v. John Hancock Mut. Life Ins. Co., 119 Vt. 246 (1956); Logan v. New York Life Ins. Co., 107 Wash. 253 (1919); Clark v. Prudential Ins. Co. of America, 219 Wis. 422 (1935); Mutual Trust Life Ins. Co. v. Ossen, 77 F.2d 317 (2nd Cir. 1935) (applying New York law); Assurity Life Ins. Co. v. Grogan, 480 F.3d 743 (5th Cir. 2007) (applying Texas law); Continental Illinois Nat. Bank & Trust Co. of Chicago v. Columbian Nat. Life Ins. Co., 76. F.2d 733 (7th Cir. 1935) (applying Illinois law); Security Ben. Life Ins. Co. v. Jackson, 318 F.2d 846 (8th Cir. 1963) (applying Missouri Law).

[4]Those states are as follows: Arkansas, California, Georgia, Illinois, Iowa, Kentucky, Minnesota, Mississippi, Montana, New York, New Mexico, Nebraska, Oklahoma, Oregon, Pennsylvania, Rhode Island, and Virginia. . Aetna Life Ins. Co. v. Mahaffy, 215 Ark. 892 (1949); Metropolitan Life Ins. Co. *v. Devore, 66 Cal. 2d 129 (1967); Life & Cas. Ins. Co. of Tenn. v. Truett, 112 Ga. App. 338 (1965);* Cox v. Equitable Life Assur. Soc. of U.S., 333 Ill. App. 207 (1948); Mickel v. Mutual Life Ins. Co. of New York, 213 N.W. 765 (1927); Kentucky & Southern Life Ins. Co. v. Downs, 301 Ky. 322 (1946); Wanshura v. State Farm Life Ins. Co., 275 N.W. 2d 559 (1978); Fidelity Mut. Life Ins. Co. v. Elmore, 111 Miss. 137 (1916); Williams v. Union Fidelity Life Ins. Co., 329 Mont. 158 (2005); Ortega v. North Am. Co. for Life & Health Ins., 187 Neb. 569 (1971); Bronx Sav. Bank v. Weigandt, 1 N.Y. 2d. 545 *(1956); Jackson Nat. Life Ins. Co. v. Receconi, 113 N.M. 403 (1992); Mid-Continent Life Ins. Co. v.* House, 156 Okla. 285 (1932); Mutual Life Ins. Co. of New York v. Muckler, 143 Or. 327 (1933); Sherman v. Security Mut. Life Ins. Co. of New York, 447 Pa. 442 (1972); Madsen v. Metropolitan Life Insurance Company, 90 R.I. 176 (1959); Greenwood v. Royal Neighbors of America, 118 Va. 329 (1916); Combs v. Equitable Life Ins. Co. of Iowa, 120 F.2d 432 (4th Cir. 1941) (applying Virginia law); Friez v. National Old Line Ins. Co., 703 F.2d 1093 (9th Cir. 1983) (applying Montana Law).

[5] Count I seeks declaratory relief. The plaintiff's remedy is a legal one in the form of damages, however. Count III alleges a breach of the covenant of good faith and fair dealing. Having already concluded that SBLI breached a contractual term, this court sees this Count as duplicative. There is no Count V in the Complaint.

User Agreement For Subscriber-Only Online Benefits | Help | Our Privacy Policy
Send any questions or comments to comments@lawyersweekly.com

Subscriber Services: 1-800-451-9998 **Technical Support**: 1-800-444-5297 ext. 8156
© Copyright 2007 Lawyers Weekly, Inc. All Rights Reserved

Lawyers Weekly does not use spyware; however, we link to a number of other sites and do not take responsibility for any spyware they i

This site is best viewed with Internet Explorer 6 (click here to download) or Netscape 7 or higher (click here to download)
146.243.4.157/5.93
0 milliseconds

Sylvia Richardson

To: Hills, Geoffrey

Subject: FW:

Geoff,

I sent this on - to our legal department - here is his response

-----Original Message-----
From: Jason Brush
Sent: Wednesday, October 01, 2003 1:58 PM
To: Sylvia Richardson
Subject: RE:

Sylvia

Mr. Hills is correct in his analysis, but that is the standard in the industry. "Good health" is not necessarily based only on things known at the time of the application of insurance. It can also be based on things that are unknown, by either us, him or his doctors. Presumably and hopefully, an applicant discloses all necessary and truthful medical info to us. Thereafter, we hope to receive all related medical records concerning the applicant from providers. Based on the information we receive, we underwrite and we determine risk and whether an application should be approved. However, an applicant may in fact have a brain tumor that he, his doctor, nor we know anything about, that has been developing prior to applying and being issued a policy. If that person were to die within the 2 year contestability period given in their policy (the legal maximum period allowed for contestability), it is possible that a claim for benefits could be denied by us based on the good health clause. As you know, once the 2 year contestability period is up, it does not matter when the tumor was detected, and unfortunately for the industry in MA at this time, it does not matter even if the tumor was known by the applicant and he lied to us.....we would have to pay the claim!

So theoretically, a policy could be issued, and if that person dies in say 5 months after issue, and then we learn that the cause of death was due to a brain tumor (unknown), we do have the right to investigate further to see if that person was in "good health" at the time the application was approved (was the tumor developing before approval). There would not be an automatic denial of any claim made, but we would have the right to investigate the matter. There is precedent case law on the good health clause used by life insurers in MA.

Hope that helps!
Jason

> -----Original Message-----
> **From:** Sylvia Richardson
> **Sent:** Wednesday, October 01, 2003 12:57 PM
> **To:** Jason Brush
> **Subject:** FW:
>
> Jason,
>
> I have forwarded this E-Mail - because I have a client - (currently with an outstanding application) considering applying for insurance with the company - I need a clarification to his answer - can you help me on this?
>
> Sylvia Richardson 901-03520 X5708 10/1/03

To : Jeffrey Hilts

Jeff

Per our conversation today.

When you apply , the insurance company does a paramedic exam which includes a height weight measurement, blood pressure reading , blood and urine sample. The application then goes to the medical department for underwriting approval to determine what class they would offer.They might also write to your doctor to verify information in your medical records.

Once they underwrite, they determine what class to issue your policy at. Ie they determine you are insurable and in good health for the company standards at that class.

They then mail the policy with a premium notice. The offer is valid for 30 days. Once your premium is paid, you are insured.

LEXSEE 203 MASS 299

HELENE M. LEE v. PRUDENTIAL LIFE INSURANCE COMPANY

[NO NUMBER IN ORIGINAL]

Supreme Judicial Court of Massachusetts, Berkshire

203 Mass. 299; 89 N.E. 529; 1909 Mass. LEXIS 933

September 28, 1909
October 19, 1909

DISPOSITION: [**1]

Exceptions sustained.

HEADNOTES:

Insurance, Life. *Evidence*, Presumptions and burden of proof, Admissions, Declarations of deceased persons. *Practice, Civil*, Exceptions.

COUNSEL:

P. J. Ashe, for the plaintiff, submitted a brief.

E. D. Duffield (of New Jersey), (*E. A. McClintock* with him,) for the defendant.

JUDGES:

Present: KNOWLTON, C.J., MORTON, HAMMOND, LORING, & SHELDON, JJ.

OPINIONBY:

KNOWLTON

OPINION:

[*300] This is an action upon a policy of life insurance in which the plaintiff is named as the beneficiary. The policy states that a part of the consideration for the agreement of the insurance company is "the application for this policy, which is hereby made a part of this contract." The application itself, which was annexed to the policy, was signed by George H. Lee, the insured, and it contained a statement that the application should "become a part of the contract for insurance hereby applied for." The policy and the application together constitute the contract between the parties, and both alike are to be considered in determining their rights. In the application the insured made this agreement: "It is agreed that the policy . . . shall not take effect [**2] until the same shall be issued and delivered by the said company, and the first premium paid thereon in full, while my health is in the same condition as [*301] described in this application." The condition described was that of "good health."

The defendant contended that payment of the premium while the insured was in good health was a condition precedent to the policy's taking effect, and that, as the burden was upon the plaintiff to show that there was a contract which became binding upon the defendant, it was incumbent upon her to prove not only that the policy was delivered, but that the first premium was paid while the insured was in good health. The judge so ruled and the plaintiff excepted. This ruling was correct. It was in accordance with the plain import of the language; and the language of a contract of insurance is as binding upon both parties as that of any other contract. It was also in accordance with decisions in this and other States. *Gallant v. Metropolitan Ins. Co. 167 Mass. 79. Barker v. Metropolitan Ins. Co. 188 Mass. 542. Packard v. Metropolitan Ins. Co. 72 N.H. 1. McClave v. Mutual Reserve Fund Life Association, 26* [**3] *Vroom, 187. Langstaff v. Metropolitan Ins. Co. 40 Vroom, 54. Anders v. Life Insurance Clearing Co. 62 Neb. 585. Reese v. Fidelity Mutual Life Association, 111 Ga. 482. Ormond v. Fidelity Life Association, 96 N.C. 158. Volker v. Metropolitan Ins. Co. 21 N.Y. Supp. 456.* 25 Cyc. 719.

The ruling went further, to the effect that there was no evidence to submit to the jury on this point, and a verdict for the defendant was directed, subject to the plaintiff's exception. The evidence seems very convincing in favor of the defendant, and it is not to be supposed that, upon the testimony reported, a jury would have found for the plaintiff. But the testimony which seems to present the facts clearly on this point came almost entirely from witnesses called by the defendant. The question of law before us relates, not to the weight of the evidence, but to the existence or non-existence of evidence which, taken by itself alone, would warrant an inference that the plaintiff was in good health at the time of the payment. On this question the plaintiff is entitled to have the case con-

sidered as it was before the defendant's witnesses were called. Was there [**4] anything before the jury which would warrant a finding for the plaintiff if no credit was given to the witnesses called by the defendant?

[*302] The policy contains a promise to pay the plaintiff, in consideration of the application, "and of the payment, in the manner specified, of the premium herein stated." This must mean the manner specified in the contract, including the application, if the application contains any specification as to the manner of payment. There are different specifications as to the payment of the premium. By the terms of the policy it is to be paid quarter-annually in exchange for the company's receipt, and the time is to be on the delivery of the policy, and on or before the twenty-ninth day of March, June, September and December in every year during the continuance of the policy. The place of payment is the home office of the company. By the terms of the application, in order to give the policy effect, the first premium is to be paid while the insured is in good health. It is a matter not free from doubt whether all, and if not all, how many of these particulars are referred to by the language "in the manner specified." It may be argued that this [**5] last requirement relates to the manner of payment, within the meaning of the contract, and it may be argued that it does not. It was proved that the policy was delivered. As the first premium was to be paid at the time of the delivery, it was perhaps a fair matter of inference from the language of the policy as to the consideration, that the defendant's premium had been paid. There was ground for a contention that the delivery of the policy containing this recital is evidence in the nature of an admission, not binding, of course, that this premium had been paid "in the manner specified," and that "in the manner specified" meant while the insured was in good health. We appreciate that there might be force in a contention to the contrary. Neither party referred to this subject in argument, and we do not find it necessary to consider it further; for we are of opinion that there were other facts before the jury which, if we disregard the testimony introduced by the defendant, would warrant an inference in favor of the plaintiff. Not only was the policy delivered, but it was delivered by an agent of the defendant, who, to a certain extent, was charged with the duty of ascertaining [**6] whether it ought to be delivered, and ought to take effect, and whether the company ought to receive the payment of the premium upon it. There was evidence that he made inquiry in regard to this matter on [*303] the day of the payment of the premium, and was told by the plaintiff that her father, the insured, was out on the street. "Before he delivered the policy he asked the plaintiff how her father was and she said he was all right." From this testimony the jury might find that the defendant's agent made investigation to this extent, and that he was satisfied that the insured was then in good health. Perhaps he relied in part upon his previous knowledge and in part upon his opinion that the plaintiff's statement was trustworthy. This was evidence against the defendant, although not strong evidence, that the insured was in good health.

If we go further back it appears that the company saw fit to write this policy after such investigation as it chose to make in regard to the health of the applicant. It is a matter of common knowledge that life insurance companies do not issue such policies until they have received what they regard as satisfactory evidence that the person [**7] to be insured is in good health. The application annexed to the policy shows that questions were put and answers taken, with a view to determine the state of the applicant's health. The writing of the policy by the company, under these circumstances, was some evidence in the nature of an admission that he was in good health when the application was made, and it might be inferred, in the absence of anything to show the contrary, that he remained in the same condition until the premium was paid.

Neither party has referred to the fact that the application, which seems to have been put in evidence by both the plaintiff and the defendant, contains a declaration made by a person who died before the trial, expressly stating that he was in good health. There is ground for a contention that this is evidence to be considered by the jury under the R.L. c. 175, § 66. This declaration was in evidence without objection, and no request for a ruling was made in regard to it. Although it was contained in a contract which was competent and important evidence, perhaps the judge, if requested, might have instructed the jury not to consider it as evidence, on the ground that he was not satisfied [**8] that it was made in good faith. This subject, too, was not referred to by either party in argument, and we do not find it necessary to pass upon it. On other grounds already referred [*304] to, we are of opinion that inferences of fact might be drawn, sufficient to warrant a finding in favor of the plaintiff, in the absence of any more definite evidence as to the condition of the insured when the premium was paid. It follows that the case should have been submitted to the jury.