The Truth, The Whole Truth, & Nothing But the Truth - Misrepresentations in Policy Applications

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I. Introduction

II. A. Differences in Applications

B. Misrepresentation

Insurers must look to the statutory insurance law of a jurisdiction governing the effect of misrepresentations on the voidability of insurance contracts. These statutes differ as to exactly what types of misrepresentations will void a contract:

Misrepresentations can be generally classified into one of the following categories:

1. **INNOCENT**

2. **WITH KNOWLEDGE**

3. **WITH SPECIFIC INTENT TO DECEIVE**

1. **Innocent**

  - i.e., “any” misrepresentation

  - “Whether the applicant intended to mislead or knew of the falsity is irrelevant. False representations concerning a material fact, which mislead, will avoid an insurance contract, like any other contract, regardless of whether the misrepresentation was innocent or made with a fraudulent design.” *Omni Ins. Group v. Poage*, 966 N.E.2d 750, 754 (Ind. Ct. App. 2012).

• Under Mississippi law, “the insurer is not required to prove that the misrepresentation was intentional, and even misrepresentations caused by negligence or mistake can result in rescission.” N. Wind Fabrication, Inc. v. Pruco Life Ins. Co., Case No. 1:09CV682-LG-RHW, 2010 WL 4007315, at *3 (S.D. Miss. Oct. 12, 2010).

• “Under New York law, the insurer need not show that the misrepresentation was knowingly made since even an innocent misrepresentation is sufficient to allow a rescission of the contract.” Cohen v. Mut. Ben. Life Ins. Co., 638 F. Supp. 695, 698 (E.D.N.Y. 1986).

• “An insurer may void an insurance policy based on a misrepresentation in the insurance application, even if the misrepresentation was unintentional.” Amerson v. Gardner, 681 So. 2d 570, 572–73 (Ala. Civ. App. 1996), as modified on denial of reh'g (June 21, 1996).

2. With Knowledge

- i.e., misrepresentations that are “knowingly false”

- Includes concealment, or knowingly failing to disclose a matter that is material to the risk about which the insurer did not inquire.
• Under Minnesota law, “All that is required is that the insured have full knowledge of the facts that are concealed and that the concealed facts probably would have precluded issuance of the policy if known to the insurance company.” Ser Yang v. W. S. Life Assur. Co., 713 F.3d 429, 433 (8th Cir. 2013) (quoting Ellis v. Great–West Life Assur. Co., 43 F.3d 382, 387 (8th Cir.1994)).

• Under Nevada law, knowledge of the misrepresentation is all that is required. “Inserting an intent to defraud requirement into the policy would run counter to Nevada law, because it would impermissibly rewrite an unambiguous contract provision that only contains a ‘knowingly’ requirement.” Siefers v. PacifiCare Life Assur. Co., 461 Fed. Appx. 652, 654 (9th Cir. 2011).

• “Under Pennsylvania law, an insurance company may rescind a policy if (1) the application contained a misrepresentation, (2) the misrepresentation was material to the risk being insured, and (3) the insured knew that the representation was false when made, or the insured made the representation in bad faith.” Jung v. Nationwide Mut. Fire Ins. Co., 949 F. Supp. 353, 356 (E.D. Pa. 1997).
3. Specific Intent to Deceive
- i.e., knowingly false misrepresentations or omissions made to intentionally defraud the company

- Under Illinois law, a material misrepresentation “will void an insurance contract regardless of whether the misrepresentation was made innocently or with an intent to deceive.” Kieszkowksi v. PersonalCare Ins. of Illinois, Inc., 2011 WL 3584324, at *4 (N.D. Ill. Aug. 12, 2011).

- Under the law of the State of Utah, “it is enough if an insurance company proves that it relied on a material misrepresentation by an applicant. It does not need to prove intent if the misrepresentation is material.” Chowdhury v. United of Omaha Ins. Co., Case No. 1:07-CV-00095 CW, 2009 WL 1851005, at *3 (D. Utah June 26, 2009).

- “Where a statement of fact in an application is only a representation, its mere falsity is not sufficient to avoid the policy, its materiality and the good faith of the applicant in making it being important considerations. Under the issues made in the case at bar, it would be necessary for the defendant to show that the statements in the application relied on to defeat the policy were untrue, that their falsity was known to the applicant, that they were material to the risk and relied on by the insurer, and that they were made with intent to deceive and defraud the company.” Metro. Life Ins. Co. v. Bates, 213 S.C. 269, 278–79, 49 S.E.2d 201, 205 (1948).
TWO ADDITIONAL CATEGORIES OF MISREPRESENTATIONS THAT INVOLVE MISREPRESENTATIONS FROM THE CATEGORIES ABOVE:

A. THE “OR” STANDARD:

- i.e., a misrepresentation that involves either:
  1) a specific intent to deceive OR;
  2) a material misrepresentation without specific intent to deceive; OR
  3) a misrepresentation and increased risk of loss

- Note, misrepresentations in the Innocent category (i.e. without specific intent or knowledge) may also be material, and therefore fall into the material misrepresentation and increased risk of loss categories.

- “[I]f the misrepresentation 'shall have been made with actual intent to deceive or materially affects either the acceptance of the risk or the hazard assumed by the company.’” Methodist Med. Ctr. of Illinois v. Am. Med. Sec. Inc., 38 F.3d 316, 319 (7th Cir. 1994) (quoting 215 ILCS 5/154)).

- The Florida Insurance Code “provides that a misrepresentation, omission, concealment of fact, or incorrect statement may prevent recovery under the contract or policy only if any of the following apply: (1) the misrepresentation, omission, concealment, or statement is fraudulent or is material either to the acceptance of the risk or to the
hazard assumed by the insurer; or (2) if the true facts had been known to the insurer pursuant to a policy requirement or other requirement, the insurer in good faith would not have issued the policy or contract, would not have issued it at the same premium rate, would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss." § 627.409(1), Fla. Stat.

B. THE “AND” STANDARD:

-i.e., a misrepresentation that involves:

1) Specific intent to deceive AND
2) A material misrepresentation or increased risk of loss

- Under Oklahoma Law, “an insurer properly may rescind an insurance policy when the application contains a misrepresentation that (1) is fraudulent; (2) is material to the insurance company's acceptance of the risk; or (3) induced the insurer to issue the policy where it would not have done so had it known the true facts. However, Enterprise concedes that 'section 3609 requires a finding of intent to deceive before an insurer can avoid the policy.... [A] statement made without intent to deceive is not a misrepresentation at all, and thus does not

C. Criteria for Rescission

1. Within the contestability period?
2. Was misrepresentation material?
3. Would underwriting have issued the policy anyway?
4. What’s the definition of misrepresentation in the applicable state?
5. What’s the judicial climate in that state?

CASE EXAMPLE #1


Mr. Clarence Williams purchased a new pickup truck and credit life insurance to protect the car loan. He signed the insurance application representing that “he was in good health and not under treatment for, or receiving medical advice for any illness, disease, or physical or mental impairment.” The application did not include any questions for treating doctors or provide space for detailed medical information. In fact, Mr. Williams had been diagnosed with stage four renal cell cancer and was told further treatments were of no value. He died 9 months later.
UFLIC rescinded the policy based on the ground Mr. Williams clearly misrepresented his medical history when he signed the application. This lawsuit, seeking policy benefits and extra-contractual (including punitive) damages, attorney’s fees and costs was filed. The case was tried to a jury and a defense verdict was rendered. However, the Montana Supreme Court reversed, and ordered a new trial. Ms. Williams argued the application was ambiguous and didn’t define “good health.” Nor did it require any disclosure of health information. Thus, an objective standard of what Mr. Williams’ medical condition was on the date of application was the wrong standard to use.

The Court stated the application’s general language sought only the best of the applicant’s knowledge and belief as to his health at the time he signed the application. This means a subjective standard for reviewing the insured’s “good health” representation applies. Here, medical information disclosed that several months prior to the vehicle purchase, radiation treatments had shrunk the tumor and, according to Ms. Williams, her husband thought the cancer had been neutralized. The question on retrial is what did Mr. Williams subjectively believe his health condition was on the date he signed the application. With that standard, would it ever be possible for the carrier to win?

The case later settled at mediation.
CASE EXAMPLE #2

B. Joe College applied for a $100,000 20-year life policy naming his mother and father as beneficiaries. At the time of application, Joe was a 20-year old single male and attended community college. His parents were not married and he lived with each parent, part-time, at each parent’s respective home. An Application and Temporary Insurance Agreement were electronically signed on September 20.

On the Application, Joe College answered “No” to a lifestyle question on the application asking whether he had been convicted of a moving traffic violation. Joe also answered “No” to all health questions, including questions about whether he had been told by a member of the medical profession that he had, or been diagnosed or treated for, asthma, attention deficit hyperactivity disorder (ADHD) or mental health disorder. He also answered “No” to the question whether he had within the past five years had a “checkup, consultation, illness, injury or surgery…”

On the Temporary Insurance Agreement, Joe answered “No” to the question whether in the past five years he had received treatment for or been advised to seek treatment for or been diagnosed by a licensed medical professional as having “chest pain.”

No current medications – prescriptions or non-prescription – were revealed on
either the Application or TIA.

Joe also answered “0” to Existing and Pending Insurance, indicating this application as the only application for life insurance, pending or in force.

The Temporary Insurance Agreement (“TIA”) contained a contestability for misrepresentation provision which allowed the insurer to void the TIA for incorrect, untrue, incomplete or omitted statements or any other material misrepresentation for any answers in the TIA or Application.

Unfortunately, Joe College died in a motor vehicle accident on October 8 during the contestable period, eighteen days after signing the Application.

After an insurance claim was presented, the insurer noted several inconsistencies with Joe’s health questions. Research received from the examiner concerning previous providers and prescribed medications. The insurer’s investigation revealed the following:

- Joe College had been treated for asthma and ADHD for most of his life. A record from a doctor dated the May before the Application noted chronic diagnoses of asthma and ADHD and indicate the reason for the visit was a follow-up to an ER visit for chest pain. Prescription records from that same date indicate multiple prescriptions filled as well as medications dating back to 2012.
• Joe’s mother purchased a $25,000 life policy on him approximately three years prior. Search results revealed that Joe himself applied for life insurance in July and August prior to this Application.

• Joe pled guilty to a seat belt violation the prior April. When questioned, both of Joe’s parents indicated that they remember their son being cited for a traffic violation but thought it had been dismissed.

• Joe’s father had contacted the agent as he was obtaining life insurance for four of his children. The agent met with Joe College “on an occasion.”

1. In the state where the policy was written, false statements on an application of insurance do not bar an insured from recovering unless the statements are made with actual intent to deceive and they materially affect the acceptance of risk by the insurer.

2. Can the insurer deny the claim for benefits under the Temporary Insurance Agreement? Why or why not?

3. What if mom, not Joe, actually provided the answers to the Health Questions? Does that change your conclusion?
CASE EXAMPLE #3

C. Mrs. Trucker sought life insurance on the application. She indicated her annual income was $250,000. She was also asked whether she had any other life insurance policies. She responded “none.” The woman died during the contestability period. It turned out she had two other life insurance policies from another carrier and her last available tax return indicated a total income of $25,000, but noted that her business had gross income of $500,000. It turned out she did not work for the business at all, but it was her husband’s trucking business and the income was completely his.

1. In the state where this policy was written, the applicant must “knowingly” make a false statement for the insurer to avoid payment.

2. The carrier had an underwriting guideline that precluded the issuance of life insurance policies to individuals for more than 15 times their annual income. Here, since the applicant has no income, the carrier would not have issued the policy on her life. At best, her husband had a $25,000 income which was a mere fraction of the $1 million policy.
3. The carrier also had an underwriting guideline to preclude issuing life insurance to individuals where life is already insured unless they agree to cancel the other policies.

4. Can the carrier avoid the life insurance contract? If not, why not?
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The Devil Is in the Details: Establishing an Insured’s Intent to Deceive in Life and Health Insurance Rescission Cases†

Gary Schuman

I. INTRODUCTION

Life, health and disability insurance companies, especially those selling coverage to individuals and small groups, are not required to issue coverage to any applicant for insurance. Rather, they are permitted to select the risks they will insure and to deny or limit coverage through a process known as “underwriting.”

Underwriting ensures that each applicant receives fair and consistent evaluation and, if accepted, is charged an appropriate premium for the coverage offered. One of the basic principles of insurance is that each individual accepted for coverage should pay a premium that is proportionate to the amount of risk the company assumes for that person. Otherwise many people seeking to purchase insurance in the individual and small group markets would pay considerably higher premiums.

† Submitted by the author on behalf of the FDCC Life, Health and Disability Section.


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With some variations depending on the type of insurance coverage sought, insurers primarily base underwriting decisions on an applicant’s responses to questions regarding the applicant’s medical history, employment record, social activities and earnings history. The prospective insured has a duty to provide truthful and complete answers to the questions posed so the insurer can properly evaluate the risk it is contracting to insure. This is so because the insurer is in an unequal position vis-à-vis the applicant when it comes to obtaining the needed information to properly assess the applicant’s health and other risk factors.


People with certain health conditions or who engage in dangerous occupations or social activities may be required to pay higher premiums, may be subject to policy exclusions or, in cases of excessive risk, may be denied coverage altogether. As a consequence, some individuals may fail to disclose adverse conditions or activities on the application so they may either obtain insurance not otherwise available or pay premiums lower than justified had they disclosed the true facts.⁶

The insurer often discovers false information on an application only after a claim is submitted.⁷ The insurer may then seek to rescind the policy if it determines that had the applicant correctly disclosed all of the requested material facts it would have declined to issue coverage, would have limited the type of coverage issued or would have charged a higher premium.⁸

Many legal issues arise when an insured challenges the insurer’s decision to rescind. Some of the most important of these include whether there actually was a “misrepresentation” based on the application questions presented; whether the misrepresentation was “material”; and, in those states that impose such a requirement, whether the misrepresentation was “intentional.”

States requiring the insurer to present evidence of the insured’s intent to deceive have adopted a variety of standards to determine “intent.” As a result, insurers often have a difficult time determining whether this critical requirement has been satisfied. This Article first addresses how various states define what constitutes a “knowing” misrepresentation and under what circumstances an insured’s failure to disclose requested information constitutes

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⁸ The Patient Protection and Affordable Care Act (“PPACA”) was enacted on March 23, 2010 (Pub. L. No. 111-148, 124 Stat. 119). PPACA prohibits insurers from rescinding medical insurance coverage in the absence of fraud. PPCA also calls for “Guarantee Issue,” preventing insurers from rescinding on the basis of any misrepresentation involving the insured’s health or medical history. This law will limit, but certainly not eliminate, an insurer’s ability to rescind for a variety of insurance products such as health and accident, life, disability and supplemental coverage.
an intentional act of deception. It then suggests ways insurers can protect themselves from contract and bad faith challenges by the insured or beneficiary when coverage is rescinded.

II.

THE APPLICATION PROCESS

Insurers typically require an applicant to complete an application that, depending on the type of coverage sought, includes questions about the applicant’s medical history (including physicians seen, prescriptions taken and other similar information); employment history; and social activities (such as the use of alcohol, tobacco products or recreational drugs). In signing the application, the applicant generally attests to the accuracy and completeness of the information provided.

A. Application Questions

Questions on the application should seek to obtain all the information the insurer needs to make an informed underwriting decision. The insured has an affirmative duty to know and understand the content of the application and will be bound by the representations made in his or her answers. However, an insured has no duty to volunteer information. Thus, an insured is obligated to disclose only that information specifically and unambiguously sought in the application.

Application questions are either objective or subjective. In the context of rescission, this distinction is especially important in proving whether the application contains a misrepresentation and, in jurisdictions requiring intent, whether the misrepresentation was intentional.

1. Objective Questions

Objective questions provide the most protection to an insurer. Such questions are typically specific and easily understandable, and seek disclosure of information readily within the applicant’s knowledge, such as the names of doctors or other medical professionals who have seen or treated the applicant; medications prescribed for the applicant, including

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10 See, e.g., Adam v. Stonebridge Life Ins. Co., 612 F.3d 967, 972 (8th Cir. 2010).
narcotics or other controlled substances; the applicant’s alcohol, tobacco or recreational drug use; or any specific medical conditions considered important by the insurer.\textsuperscript{14} Objective inquiries may also include questions regarding an applicant’s income and net worth, previous purchase or cancellation of insurance coverage, previous suspension or revocation of a driver’s license, and conviction of a misdemeanor or felony.\textsuperscript{15}

An insured may also be required to disclose information in response to questions that are not so specific. For example, in response to a question asking whether the insured has “any disease of the nervous system,” the insured must disclose a history of epilepsy.\textsuperscript{16} So, too, a question inquiring generally about “any other disease or injury” requires the disclosure of vascular hypertension.\textsuperscript{17} And a question seeking information about the applicant’s “last physician visit” requires the disclosure of the applicant’s visit to a gynecologist, even though this medical specialty is not listed on the application.\textsuperscript{18}

These types of questions are considered to be objective because their accuracy may be proven by direct evidence, giving rise to a presumption that the matter is material to the insurer’s ability to properly underwrite the risk.\textsuperscript{19} The applicant’s personal belief regarding the seriousness of a health condition is irrelevant.\textsuperscript{20} The insurer, not the applicant, determines what issues are important in deciding whether the applicant is an acceptable risk and, if so, on what terms.\textsuperscript{21}


\textsuperscript{17} Id. (citing Robinson v. Occidental Life Ins. Co. of Calif., 281 P.2d 39, 41 (Cal. Dist. Ct. App. 1955)).

\textsuperscript{18} Hagan, 2011 WL 6820396, at *3.

\textsuperscript{19} Id. at *11. See also Tudor Ins. Co. v. Hellickson Real Estate, 810 F. Supp. 2d 1211, 1217 (W.D. Wash. 2011).

\textsuperscript{20} See Salkin v. USAA Life Ins. Co., 544 F. App’x 713, 714 (9th Cir. 2013).

2. Subjective Questions

Insurance applications may also include questions that are considerably more subjective. These questions are subject to interpretation and seek the applicant’s subjective belief or judgment as to the state of the applicant’s health—e.g., questions asking whether the applicant is “in good health” or “free from any physical or mental disorder.” Because such subjective questions inquire into the applicant’s state of mind, they are inherently more ambiguous.

Courts are more lenient when reviewing responses to subjective questions for possible misrepresentations. Courts have interpreted such questions to mean that the insurer is interested only in “serious” medical conditions as understood from the point of view of a layman, not from that of a medical professional. The failure to mention minor or temporary indispositions is not considered to be material to the risk. Thus, application questions inquiring about an individual’s overall health will not hold an applicant to the literal truth. Such questions—e.g., is the applicant “free from disease?”—require only that the applicant has a good faith belief, or is justified in believing, that his or her response is truthful. For such a representation to be actionable, the insurer must demonstrate not only that the answer is false, but also that the insured knew it was false. So long as the response is true in the broader sense that it is honest, sincere and not fraudulent, there is no misrepresentation.

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25 See United Nat’l Ins. Co. v. Granoff, Walker & Forlenza, 598 F. Supp. 2d 540, 547 (S.D.N.Y. 2009); see also Fireman’s Fund Ins. Co. v. DeNiro, No. B208336, 2009 WL 1652971, at *10 (Cal. Ct. App. June 15, 2009); West Coast Ins. Co. v. Hoar, 558 F.3d 1151, 1157 (10th Cir. 2009) (“in the context of answering an insurance application question which calls for a value judgment, ‘[a] particular misrepresentation . . . must be such that a [r]easonable person would, under the circumstances, have understood that the question calls for disclosure of specific information’”) (citation omitted; alteration in original).
26 Courts have interpreted subjective questions to mean that the insured must disclose only “serious” medical conditions as understood from the standpoint of the ordinary person. DeNiro, 2009 WL 1652971, at *10.
27 See Williams, 123 P.3d at 222; see also Mitchell, 2011 WL 5878378, at *5.
For example, in *Wetherspoon v. Columbus Life Insurance Co.*, the insured applied for, and was issued, a life insurance policy. In response to questions on the application, the insured stated she had not previously consulted a medical practitioner for a disorder of the stomach, that she was not under any treatment or observation and that she was not taking any medication. Just prior to signing the application, however, the insured had been evaluated twice at a hospital emergency room for abdominal pain, was prescribed medication for acid reflux and underwent a CT scan. Soon after the insured completed the application, the radiologist read the CT scan and found a potentially cancerous stomach mass, which ultimately was confirmed as cancer. Three months later, the insured died. The insurer rescinded coverage.

The court denied summary judgment to the insurer. First, there was a triable issue whether the insured had a stomach disorder within the meaning of the application. According to the court, being treated twice for indigestion and abdominal pain and being prescribed medication for acid reflux may not constitute a “disorder.” The application did not define “disorder,” so its meaning in the application was not known. Objectively, the insured could have reasonably believed her condition did not constitute a stomach disorder.

Likewise, the insured’s statement that she was not under treatment or observation was not actionable. A layperson’s understanding of “treatment or observation” may differ from that of a medical professional.

Finally, although the insured had been prescribed medication, her daughter testified the insured never took the medication. Thus, there was a disputed issue whether the insured was “taking medication” when she completed the application.

Similarly, in *Barry v. United States Life*, John Barry applied for a life insurance policy on December 26, 2006. He completed an application representing that he had no “disease or disorder” of his liver, but stated he was being treated for hypertension. The policy was issued on January 15, 2007, and he died one month later.

During its investigation, the insurer learned that Barry’s doctor advised him to have an ultrasound based on an abnormal blood test regarding his liver function. U.S. Life argued that Barry’s failure to reveal this information justified rescinding coverage. Barry sued, and the insurer sought summary judgment, which the district court denied.

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31 Id. at *2.
32 Id. at *1.
33 Id.
34 Id. at *5.
35 Id. at *4.
36 Id.
37 Id.
39 Id. at *1
The “one crucial and material fact” before the court was whether Barry actually knew the state of his health in December 2006 and what he thought the application was asking regarding his health.  

Barry argued, and the court agreed, that the question regarding liver disease or disorder was a subjective question and would thus be considered false only if Barry actually knew he had a liver “disease” or “disorder.”

Although there was no question that Barry was “a gravely ill man,” it was not clear that he knew he was sick. The recommended test was presumably to assist the doctor in making that determination. The fact that Barry did not have the ultrasound test ordered by his doctor eight months earlier actually supported his contention he did not believe he had any disease or disorder. Nor was there anything to show Barry’s abnormal blood test results were conveyed to him in such a manner as to indicate he knew or understood the seriousness of these results.

B. Insurer’s Duty to Investigate

A very important element of the insurer’s underwriting evaluation is trust. An insurer is entitled to receive honest and complete answers from applicants for insurance. An applicant who is aware of any medical condition, symptom or treatment thus has a duty to disclose this information if asked.

The law permits insurers to rely on the information contained in an insured’s application. When the insured’s answers are complete on their face, the insurer has no independent obligation to investigate their accuracy. This rule is premised on the fact that only the applicant has the requisite knowledge of his or her health and other issues. An insurer has a

40 Id. at *2.
41 Id. at *1, 3.
42 Id.
43 Id. at *3.
44 Id.
47 Shipley v. Ark. Blue Cross & Blue Shield, 333 F.3d 898, 904 (8th Cir. 2003).
duty to investigate representations on an application only if there is information that would put a reasonably prudent insurer on notice of a possible misrepresentation.\footnote{Harper v. Fid. & Guar. Life Ins. Co., 234 P.3d 1121, 1218 (Wyo. 2010); Silver v. Colo. Cas. Ins. Co., 219 P.3d 324, 331-32 (Colo. App. 2009); Allianz, 2012 WL 714686, at *8.}

Relying on these legal principles, insurers may utilize simplified underwriting procedures to approve or reject applications for coverage. Courts have upheld the use of these types of applications against challenges that a more through investigation prior to coverage would have disclosed the insured’s medical problems.

For example, in \textit{Adam v. Stonebridge Life Insurance Co.}, the insured applied for a $75,000 term life insurance policy, listing his occupation as “Laborer—Part time Social Security.”\footnote{612 F.3d 967, 969 (8th Cir. 2010).} The application asked a number of specific questions, including whether the applicant had ever received treatment or medical advice or been hospitalized for any nervous or mental disorder within the past five years. He replied “no.”\footnote{Id.} In fact, the insured had been diagnosed with bipolar disorder and was receiving treatment from a psychiatrist.

The application responses were reviewed by computer. Under the insurer’s system, any affirmative response to a health question resulted in automatic rejection of the application. Conversely, if all health questions were answered “no,” the insurance would immediately be approved. Should a misrepresentation be discovered later, the policy would be rescinded.\footnote{Id.} Because the insured answered “no” to all questions, the insurer issued coverage without undertaking any investigation to determine why a 45 year old person was receiving Social Security benefits.\footnote{Id. at 970.}

Less than four months later, the insured was killed in an automobile accident.\footnote{Id.} The subsequent investigation uncovered the insured’s misrepresentations, and coverage was rescinded.

The beneficiary sued, alleging in part that the insurer did not reasonably rely on the insured’s representations because the insured’s disclosure that he was receiving Social Security benefits triggered an obligation to investigate further before issuing coverage.\footnote{Id. at 973.} According to the insurer, however, it justifiably relied on the insured’s representations because its simplified underwriting process was commonly used in the industry and it had no reason to doubt the insured’s negative responses to the health questions. The court agreed, noting that the application specifically stated the insurer would rely on the applicant’s responses in issuing coverage.\footnote{Id.} The fact that the insured referred to receiving Social Security benefits...
did not change that result. An individual may be receiving Social Security benefits and still not have received medical treatment or advice within the previous five years. Thus, it was not obvious the insured was lying.\textsuperscript{59}

Similarly, in \textit{Harper v. Fidelity & Guaranty Life Insurance Co.},\textsuperscript{60} Joseph Harper purchased a life insurance policy. The application contained questions regarding the applicant’s current and past health history.\textsuperscript{61} Harper denied receiving medical treatment or advice for a number of medical conditions, acknowledging only that he was taking medication for high blood pressure and high cholesterol.

The insurance applied for was considered by the insurer to be a “simplified underwritten product” whereby the underwriter simply reviewed the application and obtained information from the Medical Information Bureau (“MIB”).\textsuperscript{62} Based on this investigation, the underwriter learned Harper’s weight was slightly higher than represented but assumed Harper’s weight had been lower on the date of the application.\textsuperscript{63} Nor was the underwriter concerned that Harper had received treatment for depression treatment 10 years earlier, since Harper stated he had made a “complete recovery.”\textsuperscript{64} The underwriter also assumed Harper’s blood pressure and cholesterol were most likely under control because he was taking medication for these conditions. Coverage was approved.\textsuperscript{65}

Harper died two months later from cardiac problems. At that point, the insurer learned for the first time that Harper had failed to disclose treatment for a “probable transient and ischemic attack,” alcohol abuse and liver problems, and chest pains. It also learned Harper’s weight was significantly higher than stated on the application and MIB report. Accordingly, coverage was rescinded. The beneficiary sued, and the insurer obtained summary judgment.\textsuperscript{66}

The beneficiary argued the insurer should have investigated further based on the application and MIB responses. The beneficiary contended there were “red flags” which the underwriter ignored.\textsuperscript{67} The court rejected these arguments, noting that the underwriter adequately explained why no further investigation was undertaken: “In the simplified underwriting process that was used [here], the underwriter is to rely on the health questionnaire and the MIB, which is what happened in this instance. Furthermore, Mr. Harper represented in his

\textsuperscript{59} Id. at 973-74.
\textsuperscript{60} 234 P.3d 1211 (Wyo. 2010).
\textsuperscript{61} Id. at 1214.
\textsuperscript{62} Id. at 1219.
\textsuperscript{63} Id.
\textsuperscript{64} Id. at 1215.
\textsuperscript{65} Id.
\textsuperscript{66} Id.
\textsuperscript{67} Id. at 1219.
application that ‘[t]he statements made in this application are complete, true and correctly recorded.’” An insurer is not obligated to further investigate unless it is placed on notice that the application responses are inaccurate. That was not the case here, and rescission was therefore proper.

III.

Rescinding Coverage

A. Insurer’s Right to Rescind

It is a basic principle of contract law that if one party to a contract has been led to enter into the agreement by the misrepresentation of the other party, the contract is voidable at the option of the innocent party. Accordingly, rescission is available to an insurer when an insurance policy is obtained based on incorrect information communicated by the insured that was material to the formation of the contract. In many states, in order for an insurer to rescind coverage, the application must clearly and unambiguously state that a misstatement by the insured will void the policy ab initio.

The ordinary result of the rescission of a policy is that the contract is void from the outset (i.e., ab initio). The policy is treated as if it never existed, and the parties are restored to the position they were in before the contract was created.

Rescission requires notice to the insured and a tender of all premiums paid. In addition to giving direct notice to the insured, an insurer can satisfy the notice requirement by

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68 Id.
69 Id. at 1218.
suing for declaratory judgment\textsuperscript{75} or by asserting rescission as an affirmative defense to an insured’s lawsuit on the policy\textsuperscript{76}

When an insurer learns of a material misrepresentation, it must act promptly to rescind, regardless of whether a loss has occurred.\textsuperscript{77} This includes attempting to return all premiums to the insured or making a reasonable effort to do so within a reasonable time after learning there is a basis to rescind.\textsuperscript{78} An insurer’s failure to act promptly may result in a waiver of the defense, especially when the insurer continues to accept premiums with knowledge of the true facts.\textsuperscript{79}

The question whether an insurer has unreasonably delayed in seeking rescission arises only when the insurer learns of facts that \textit{actually} justify rescission—not merely facts that raise the \textit{potential} for rescission.\textsuperscript{80} Determining what constitutes a reasonable time period depends on more than merely the length of time elapsed because insurers risk bad faith actions should they act too soon.\textsuperscript{81} Courts must provide insurers with an adequate time period to make a good faith investigation to determine whether there is an adequate basis to rescind.\textsuperscript{82}


\textsuperscript{78} See Faye Keith Jolly Irrevocable Life Ins. Trust, 466 F. App’x at 902; DeRose, 2012 WL 910085, at *1; Dodd, 956 N.E.2d 769, 774.


B. Elements Required for Rescinding Coverage

1. State Law

Each state has its own statutory framework and case law standards an insurer must satisfy before it can rescind a policy. This has resulted in a variety of requirements which determine whether an insurer can properly rescind a life, health or disability insurance policy.

Rescission generally requires four elements: (1) a misrepresentation by the applicant that is (2) material to the risk to be assumed by the insurer, (3) knowingly false, fraudulent or made with a total disregard for its truthfulness, and (4) reasonably relied on by the insurer. A few states further require that, for certain types of coverage, the insurer must establish a causal connection between the claim being denied and the information requested on the application. In addition, several states require the insurer to seek a judicial determination that the rescission is valid, either by filing an action seeking rescission or pleading the right to rescind as part of the insurer’s defense to a lawsuit filed to enforce a policy.

The insurer has the burden to establish each required element. In some states, the elements must be established by clear and convincing evidence. This standard requires more than the “preponderance of evidence” test normally applied in civil cases, but less than

certainty “beyond a reasonable doubt” as required in the criminal context. “Clear and convincing evidence” is evidence sufficient to produce in the mind of the trier of fact a firm belief or conviction as to the facts sought to be established. 88 Other states permit rescission when the requirements are satisfied by a preponderance of the evidence. 89 Still others require some level of proof in between. 90 When the application states that answers provided by the applicant are correct to the best of the applicant’s knowledge and belief, the burden on the insurer increases to clear proof that the answer is knowingly false. 91 This standard of proof is a heightened one, but is not as exacting as the clear and convincing standard required in certain fraud cases. 92

(a) Misrepresentation/Concealment

A misrepresentation is a false statement of fact or a failure to disclose a fact in response to a specific question.93 An individual’s failure to communicate that which he or she knows is a “concealment.”94 The failure to properly disclose information on the application prevents the insurer from inquiring about these facts so that a proper risk evaluation can be undertaken.95

(b) Materiality

An insurer is not entitled to rescind a policy unless the information misrepresented or concealed is material.96 Materiality is determined from the insurer’s perspective.97 A misrepresentation is material if a reasonable insurer would have considered the information

92 Noel, 861 F. Supp. 2d at 711; Ocean’s 11 Bar & Grill Inc. v. Indem. Ins. Corp. of D.C., 522 F. App’x 696, 698 (11th Cir. 2013) (heightened standard).
95 Zaucha, 2011 WL 3584766, at *3.
important in determining whether or not to insure the applicant. An applicant’s prior medical history is naturally and logically the most material matter to a life or health insurance company when it underwrites a risk. Materiality is determined not by the actual loss but only by the probable and reasonable influence of the facts upon the insurer at the time the application is underwritten.

To prove materiality the insurer must establish that its underwriting practices with respect to applicants with similar conditions would reasonably influence the underwriter’s judgment in issuing a policy, in estimating the degree or character of the risk or in deciding what premium to charge. The fact an insurer has asked a specific questions in an application is usually sufficient in itself to establish materiality as a matter of law.

Questions arise whether the insurer routinely followed or ignored its own underwriting procedures and whether the requested information was actually important to the company’s underwriting decisions with respect to similarly situated applicants. Courts often rely on the testimony of insurance company personnel to prove that truthful answers on the application would have affected the insurer’s decision to issue coverage and, if issued, the premium charged. However, an underwriter’s affidavit may be insufficient if the underwriter’s statements are conclusory. In addition to direct testimony, the insurer should produce an underwriting manual that establishes that the insurer would have analyzed the insured’s application differently had it known the insured had a certain medical condition or occupation or engaged in certain social behaviors.

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104 Johnson, 880 N.Y.S.2d at 847-49; Salkin, 835 F. Supp. 2d at 831.
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Depending on the state, materiality is considered to be either an objective or a subjective standard of conduct of a prudent insurer.\textsuperscript{106} While materiality is generally a mixed question of law and fact, a court may decide the issue as a matter of law utilizing the insurer’s practice regarding similar risks, underwriting manuals and testimony by a qualified employee.\textsuperscript{107}

c. Intent to Deceive

(1) Introduction

The most difficult issue facing insurers in rescission cases is establishing, when required, the requisite knowledge or intent to deceive by the insured. This is so because what constitutes a knowing misrepresentation and intent to deceive varies significantly from state to state.

There is a distinction between misrepresentation and fraud. Misrepresentation is but one element of fraud.\textsuperscript{108} This distinction is particularly important when dealing with insurance applications.

A number of states do not require an insurer to establish an actual intent to deceive on the part of an insured to rescind coverage; in these states, a material misrepresentation, even if innocently made, will suffice.\textsuperscript{109} The insured’s good faith in completing the application is not material.\textsuperscript{110} In these situations “whether the applicant intended to mislead or knew of the falsity is irrelevant. False representations concerning a material fact, which mislead, will avoid an insurance contract, like any other contract, regardless of whether the misrepresentation was innocent or made with fraudulent design.”\textsuperscript{111}


\textsuperscript{107} Noel, 861 F. Supp. 2d at 712; Jordan, 2011 WL 1770435, at *6; Johnson, 880 N.Y.S.2d at 846.


\textsuperscript{111} Omni Ins. Grp., 966 N.E.2d at 754 n.4.
Other states require an insurer seeking to rescind to establish either that the false statement was made with an actual intent to deceive or that it materially affected either the acceptance of the risk or the degree of hazard assumed by the insurer. Still other states say that a misrepresentation is one that is known by the insured to be false when made, though not necessarily with a conscious intent to defraud.

Applying the most stringent test, some states require the insurer to prove that the applicant made the false statement knowingly or knowingly concealed the true facts with an intent to deceive. When an insured has made a misrepresentation regarding material facts particularly within his or her knowledge, the finder of fact may, from the mere occurrence of the misrepresentation, determine that it was knowingly made with the requisite intent to deceive.

Fraud occurs when “someone knowingly makes a materially false representation or recklessly makes a materially false representation without regard to its veracity with the intent that the statement be relied on by another party and that other party suffers an injury.” A “reckless disregard for the truth” occurs when “the applicant entertains serious doubts as to the truth” of the statements made. Courts set a high bar for the insurer to establish a knowing, intentional deception.

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(2) Legal Fraud

Those states mandating proof of actual or legal fraud as a prerequisite to rescission require the insurer to establish a material misrepresentation of a presently existing or past fact made by the insured with knowledge it is untrue and with the intent to deceive so the insurer relies to its detriment on the misrepresentation. The key element is that the misrepresentation must be knowingly made. The applicant must be reasonably chargeable with knowledge that the facts omitted or misrepresented were within the scope of the questions asked on the application. Fraud is never presumed; rather, it must be proven by clear and convincing evidence. Because subjective intent is rarely subject to summary judgment, the issue of intent to deceive is usually a question for the trier of fact.

Courts acknowledge that there are inherent difficulties in proving intent, so strict proof of fraud is not always required. Intent often is determined from all the attending circumstances which indicate the insured’s knowledge of the falsity of the representation made in the application. For example, evidence of the severity of the insured’s undisclosed health problems strongly indicates that the application representations were knowingly false.

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123 Benson, 2012 WL 6585123, at *3; but see Bennett v. Am. Hallmark Ins. Co., No. 5:10-1600-MBS, 2011 WL 2936003, at *4 (D.S.C. July 18, 2011) (noting that, if there is only one inference, intent to deceive can be decided as a matter of law).


Similarly, when an insured makes representations he or she knows to be false, courts presume intent to deceive.\textsuperscript{126} This presumption is not overcome by the insured’s unsupported denial of fraudulent intent.\textsuperscript{127}

Innocent misrepresentations—i.e., those made due to ignorance, mistake or negligence—are not sufficient. An applicant’s failure to disclose a specific medical condition of which he or she was ignorant will not justify rescission.\textsuperscript{128} A layman is excused if he or she failed to understand the meaning of certain medical terms and for that reason failed to disclose some fact in the requested medical history. The rationale is that because laypersons lack the same level of knowledge or understanding as that possessed by doctors and other experts, it is unfair to permit rescission based on information the applicant did not know or did not fully understand.\textsuperscript{129} In those situations, the applicant does not know that the information he is providing is false.\textsuperscript{130}

This does not, however, excuse an applicant who fails to read the application prior to signing it. An individual is required not only to respond accurately and fully to all questions but also to use reasonable diligence to be sure that the responses are correctly written.\textsuperscript{131} Signing the application without reading it is evidence of a reckless disregard for the truth of the representations set forth in the application.\textsuperscript{132} This duty is not strictly enforced when the insurer’s agent completes the application and either knowingly enters false information or fails to ask the applicant for all requested information. In that case, the insurer cannot rescind coverage,\textsuperscript{133} even if the applicant could have discovered the misrepresentation by reading the application.\textsuperscript{134}


\textsuperscript{129}Shokrian, 2009 WL 2488881, at *7. Questions on an application are viewed from a layperson’s point of view. La Plant, 2013 WL 3341054, at *2.

\textsuperscript{130}Shokrian, 2009 WL 2488881, at *7.


(3) Equitable Fraud

New Jersey law draws a distinction between legal and equitable fraud. Equitable fraud requires the insurer to establish the material misrepresentation of a presently existing fact, the applicant’s intent that the insurer rely on it and detrimental reliance.\(^{135}\)

An insurer may rescind for equitable fraud where the false statements on the application materially affected either the acceptance of the risk or the hazard assumed by the insurer.\(^ {136}\) No actual intent to deceive is required. Even innocent misrepresentations may constitute equitable fraud.\(^ {137}\) New Jersey requires that proof of equitable fraud be established by clear and convincing evidence.\(^ {138}\) A subjective misrepresentation can be considered to be equitable fraud only if it was knowingly false.\(^ {139}\) This rule has two qualifications. First, it does not apply to persons capable of appreciating the significance of the misrepresented or omitted facts.\(^ {140}\) Second, in misrepresenting or omitting material facts, the applicant must have acted in good faith.\(^ {141}\)

2. ERISA

Group coverage, such as that provided by employers, is in most instances issued without the necessity of underwriting and rescission is not an issue. But not all policies subject to the Employee Retirement Income Security Act (ERISA) waive the individual’s requirement to qualify medically.\(^ {142}\) ERISA, unlike state laws, is silent on the issue of rescission. Because there is no statutory provision governing rescission in response to misrepresentations in a life or health insurance application, federal common law controls.\(^ {143}\) Courts applying federal common law permit equitable rescission of an ERISA-governed insurance policy obtained through material misrepresentations or omissions.\(^ {144}\)


\(^{139}\) Id.


\(^{141}\) Id.


\(^{143}\) Shipley v. Ark. Blue Cross & Blue Shield, 333 F.3d 898, 902 (8th Cir. 2003).

\(^{144}\) Id.; Sec. Life Ins. Co. of Am. v. Meyling, 146 F.3d 1184, 1191 (9th Cir. 1998).
When developing federal common law, courts may look to state law for guidance. The issue regarding which law applies—federal or state—is important because of the various state requirements. A particular state’s law governing rescission does not automatically control. It must be consistent with the federal common law approach. Under ERISA, knowing misstatements or omissions are material and support rescission where knowledge of the true facts would have influenced the insurer’s decision to accept the risk or its assessment of the premium amount. In Shipley v. Arkansas Blue Cross & Blue Shield, the court acknowledged that some states require proof of fraudulent intent or bad faith on the part of the insured, but noted that the majority of states permit rescission merely on the basis of a misrepresentation of material facts made knowingly in an application for an ERISA-governed insurance policy.

This point is illustrated in Van Anderson v. Life Insurance Co. of North America. There, the insurer sought to rescind an ERISA-governed voluntary supplemental life insurance policy. The health application requested information regarding diagnosis or treatment within the previous five years for any condition affecting the stomach or pancreas and regarding anxiety and alcohol or drug abuse. The insured, prior to applying for coverage, had undergone a battery of medical tests, had a history of alcohol abuse, and suffered from acute pancreatitis. He also had a history of gastroesophageal reflux and heartburn, and was taking prescription medication for anxiety. None of these conditions was disclosed on the application.

Under Virginia law, which the court found to be consistent with federal common law, an insurer need not prove the insured had an actual intent to deceive in order to rescind the policy. The insurer must show only that the applicant was or should have been aware of the facts in question based on the circumstances. A knowing misrepresentation is established by showing that the insured was aware he needed medical care because he sought that care, received a diagnosis from a medical professional, and was prescribed medication thereafter. It was obvious the insured knew about the true condition of his health. His physicians had advised him of his medical conditions, and he knew he was taking medication for anxiety.

145 Shipley, 333 F.3d at 902.
146 Id. at 903; Kieszkowski v. Personal Care Ins. of Ill., Inc., No. 09 C 01936, 2011 WL 3584324, at *4 (N.D. Ill. Aug. 12, 2011).
147 Gabrielian & Assocs., 2012 WL 6618268, at *5.
148 Shipley, 333 F.3d at 903.
150 Id. at *6.
151 Id. at *3.
152 Id. at *9.
153 Id. at *11.
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and undergoing numerous medical tests. The court found it “fairly clear that [the insured’s] misrepresentations were made knowingly.”\textsuperscript{154} Rescission was permitted.\textsuperscript{155}

3. Application Questions

The more specific the application question and the more serious the medical condition not disclosed, the easier it is for the insurer to establish fraud. When the application asks clear and straightforward questions, the applicant is required to provide equally clear and straightforward responses.\textsuperscript{156} The misrepresentation should concern objective facts about doctor visits, hospital confinements and concrete diagnoses of which the insured was undoubtedly aware and that were not reasonably open to interpretation.\textsuperscript{157}

An insured’s failure to disclose conditions specifically asked about on the application supports a finding that the insured did so with knowledge of the falsity of the information provided.\textsuperscript{158} So too, the fact the insured does not merely fail to provide any specific medical history, but also mentions a specific insignificant injury or minor illness and specific dates of treatment, is evidence that the failure to disclose a more serious medical condition was intentional or at least done with reckless disregard for the truth.\textsuperscript{159} Similarly, multiple false statements on an application establish that the statements were made with the deliberate and fraudulent intent to deceive.\textsuperscript{160}

Once such a showing is made, the burden shifts to the insured to establish an honest motive or an innocent intent.\textsuperscript{161} The insured’s bare assertion that he or she did not intend to deceive the insurer is not sufficient evidence of good faith, and the presumption supports a finding for the insurer.\textsuperscript{162}

\textsuperscript{154} Id.

\textsuperscript{155} Id.

\textsuperscript{156} United of Omaha Life Ins. Co. v. Halsell, 2010 WL 376428, at *3 (W.D. Tex. 2010).

\textsuperscript{157} See Kutlenios v. UnumProvident Corp., 475 F. App’x 550, 553 (6th Cir. 2012); Kennedy v. North Am. Co. for Life & Health Ins., No. 08-2175-JWL, 2009 WL 1374270, at *7 (D. Kan. May 15, 2009). For example, longstanding and serious medical conditions such as cirrhosis, liver failure, hepatitis, diabetes and hypertension may support the insurer’s argument that the insured’s failure to disclose these conditions was done with knowledge of their falsity. See Johnson v. Metro. Life Ins. Co., 880 N.Y.S.2d 842, 845, 850 (Sup. Ct. 2009); see also Wilton Reassur. Life Co. v. Lister, No. 08-CV-085-TCK-PJC, 2009 WL 483197, at *2 (N.D. Okla. Feb. 25, 2009) (same re metastatic esophageal cancer).


\textsuperscript{159} Kennedy, 2009 WL 1374270, at *7 (D. Kan. May 15, 2009).


These points are illustrated in *Sadal v. Berkshire Life Insurance Co. of America*. The insured, a licensed pharmacist, began treatment in 2002 with a licensed clinical social worker for abusing opiates (Percocet, Oxycontin, Vicodin, Lorcl, Xanax and Soma). He attended individual and group sessions for a substance abuse disorder.

In 2005, the insured purchased disability coverage, responding “no” to application inquiries regarding the use of stimulants, hallucinogens, narcotics or other controlled substances; counseling or treatment for alcohol or drug abuse; and treatment, consultation or counseling for anxiety, depression, nervousness, stress, mental or nervous disorder or other emotional disorder.

The insured was injured during an armed robbery in one of his pharmacies, resulting in the amputation of the three middle fingers of his left hand and injury to the two remaining fingers. When taken to a hospital for treatment, he disclosed that he had a history of taking “unprescribed” narcotics. He thereafter resumed individual therapy (along with his ongoing group therapy) for post-traumatic stress disorder. During the first session, the social worker noted in her chart that the insured told her he lied about his drug treatment on his insurance application.

The insurer sought to rescind on March 27, 2009, relying on the policy’s contestability fraud exception since more than two years had elapsed since the policy’s issuance. In this circumstance, the insurer was required to prove facts justifying rescission by clear and convincing evidence.

The insurer satisfied these requirements. The company’s underwriting guidelines stated that coverage would not be issued to anyone who abused controlled substances within five years preceding the application date, a policy that was confirmed by an underwriter in deposition.

The insured alleged he did not really notice these questions when he “breezed though” the application and that he was “embarrassed” because of the stigma associated with the conduct in question. However, the insured had signed the application attesting that his

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164 Id. at *2.
165 Id. at *3.
166 Id. at *5.
167 Id. at *7.
168 Id. at *10.
169 Id. at *9.
170 Id. at *2.
responses were correct and also met with a medical examiner during the application process where he again denied drug use or treatment. Consequently, these court rejected the insured’s explanations.\footnote{171}{Id. at *10.}

These application questions were straightforward, and the insured knowingly answered them falsely.\footnote{172}{Id. at *8.} Moreover, the evidence established numerous individual and group therapy sessions for drug dependency and stress,\footnote{173}{Id.} and the plaintiff admitted the falsity of his representations.\footnote{174}{Id. at *9.} On the basis of this evidence, the district court judge ruled as a matter of law these statements had been fraudulently made.\footnote{175}{Id. at *10.}

In \textit{American General Life Insurance Co. v. Bolden},\footnote{176}{No. 10 Civ.712 (LTS) (GWG), 2011 WL 3278910 (S.D.N.Y. July 27, 2011).} the insurer filed a declaratory judgment action seeking to void a $500,000 life insurance policy. The policy was issued at the “preferred plus” rate, the best rate offered by American General.\footnote{177}{Id. at *1.} The insured died one year later from renal cancer.

The application asked “in the past 10 years, has the Proposed Insured . . . been advised to have any diagnostic test, hospitalization, or treatment that was NOT completed?”\footnote{178}{Id.} The insured said “no.”\footnote{179}{Id.} However, two months before completing the application, the insured had sought treatment from a urologist for gross hematuria (visible blood in the urine), and the doctor had ordered further testing and told the insured to return for another visit.\footnote{180}{Id.} Additionally, the insured’s internist had ordered additional tests, including cytology, which is an element of cancer screening. The insured never completed these tests.

The insurer’s underwriting guidelines stated that hematuria “present[s] a significant underwriting challenge,” and recommended a “thorough assessment” of the applicant before accepting him or her as a preferred policyholder.\footnote{181}{Id.} American General would not have issued the policy without additional follow-up testing had it known about the uncompleted diagnostic test.
The application also asked whether “the Proposed Insured ever . . . sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs?”182 The insured responded “no.”183 However, the insured’s doctor had told him to stop drinking alcohol. The insurer’s underwriting guidelines stated that such medical instructions “would have raised red flags” requiring additional information.184

The court found the cytology test to be material and that American General would not have issued the policy without further testing. So, too, the failure to disclose alcohol counseling was material: Had the insured disclosed his doctor’s instruction to stop drinking alcohol, American General would not have offered the policy without the insured’s completing an additional questionnaire. Based on these material misrepresentations, American General was entitled to rescind as a matter of law.185

However, the more open-ended the application question, the more difficult it becomes to establish the insured knowingly made a false statement. Rescission cannot be based on responses to ambiguous application questions.186 “A question is ambiguous when it is susceptible to two reasonable interpretations, one in which a negative response would be correct and one in which an affirmative response would be correct.”187 The interpretation of questions in an insurance application is a question of law for the court’s determination.188 Ambiguity is construed against the insurer.189

For example in *Weekes v. Ohio National Life Assurance Corp.*,190 the insured stated on the application that the current policy was to replace a prior policy. However, when the insured died a few months later, the prior policy was still in force.191 The insurer sought to rescind on the basis that it expected the prior policy to have been cancelled, and the insured’s failure to do so constituted a misrepresentation. The court disagreed.192 If the insurer wanted

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182 Id. at *1.
183 Id.
184 Id. at 2.
185 Id.
191 Id. at *2.
192 Id. at *4.
to predicate issuance of its policy on the actual termination of the prior policy, it could have specifically asked that question. “Replacement” of the old policy did not necessarily mean simultaneous replacement.  

In another case, Loza v. American Heritage Life Insurance Co., plaintiff Loza applied for a for a cancer insurance policy, responding “no” to the question “[i]s any person to be insured currently undergoing any diagnostic test for, now being treated for, or ever been treated for, cancer . . . ?” Prior to completing the application, Loza had visited his doctor for urinary problems. In addition, he had a past history of an enlarged prostate and his father had been diagnosed with prostate cancer.  

Loza’s doctor determined that Loza’s prostate was enlarged and ordered a PSA (prostate specific antigen) test. Although considered a routine screening test in men, a PSA test is also used to indicate a number of prostate and urinary tract infections. Loza’s PSA was elevated, and he was referred to a urologist.  

Several months after the policy was issued, Loza was diagnosed with prostate cancer. The insurer conducted an investigation and, based on the negative response to the application question quoted above, rescinded coverage. The insurer considered the PSA test to be a diagnostic test for cancer.  

The question before the court was whether a PSA test constituted a “diagnostic test” within the meaning of the application. The term was not defined in the policy. The insurer argued that the term should be defined as any test that is part of the diagnostic process used to identify cancer. The court noted that, although a PSA test is a diagnostic test, it does not directly diagnose cancer. The relevant question was not whether the PSA test generally can be described as diagnostic test, but “how the language of the policy applies to the specific facts of the case.”  

The PSA is used as a screening test in conjunction with other examination results to evaluate whether a biopsy of the prostate is needed. In fact, this test is recommended for all men of a certain age, regardless of symptoms. Here, the insured’s physical symptoms and medical history indicated a heightened potential for prostate cancer but his doctor did not tell him he was being tested for cancer, and the insured stated he did not know what the test was for. Under Arizona law, the insurer must establish that the insured made a

\[\text{193 Id.}\]
\[\text{194 Id. at *1.}\]
\[\text{195 Id.}\]
\[\text{196 Id.}\]
\[\text{197 Id. at *3.}\]
\[\text{198 Id. (quoting Emp’rs Mut. Cas. Co. v. DGG & CAR, Inc., 183 P.3d 513, 515 (Ariz. 2008)).}\]
\[\text{199 434 F. App’x at 689.}\]
\[\text{200 Id. at 690.}\]
\[\text{201 Id.}\]
misrepresentation in the application. Because both the insured’s and insurer’s arguments were reasonable, the policy was ambiguous and construed against the insurer.

In Brondon v. Prudential Insurance Co. of America, the insurer denied benefits under a $50,000 ERISA-governed life insurance policy due to alleged misrepresentations on the application. According to the insured, “I have never been diagnosed with, or taken medication for, any of the following: heart trouble . . . .” Medical records indicated the insured suffered from “mild aortic sclerosis and mitral valve prolapse with mild mitral insufficiency.”

The court found the term “heart trouble” to be ambiguous. “Heart trouble” is not a recognized diagnosis in the medical field, and the question did not ask whether the applicant suffered from a specific disorder or disease (such as high blood pressure, cancer, diabetes, etc.). The insured’s denial of “heart trouble” therefore not be used to support a misrepresentation regarding the insured’s health.

[O]nly Prudential would be allowed to define what constitutes “heart trouble”; would be allowed to do so after the claim is made; and would be allowed to change and amend the definition on a case by case basis for the purpose of contesting and rescinding any policy in circumstances where there is retroactive evidence of any heart abnormality, no matter how common or benign, that the applicant may have known of. Such a holding would be manifestly unjust, and would defeat the purpose of protecting a beneficiary’s right to a fair consideration of his or her claim for benefits.

Moreover, the court noted, mitral valve prolapse is often harmless and treatment is not required. Here, there was nothing to show that the insured’s heart conditions affected her heart function; and, according to her doctor, these conditions were of “no clinical significance.” The insured did not take any medication, nor were her daily activities restricted.

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4. Medical Testimony

Finally, testimony by the insured’s treating physician can be very important when an insurer must prove intent to deceive. When an insured represents on the application that he or she has not been diagnosed or treated for a particular medical condition, testimony that the treating physician told the insured about the diagnosis can establish that the insured acted knowingly and with the requisite intent or reckless disregard.\(^{214}\)

In *Kennedy v. North American Co. for Life & Health Insurance*, for example, the insured, Kennedy, applied for and was issued a term life insurance policy.\(^{215}\) He allowed the policy to lapse and then applied for reinstatement.\(^{216}\) In both the original and subsequent application, Kennedy stated that he had had only a routine physical with no adverse findings. He also answered “no” to the question whether he had been diagnosed with or treated by a medical professional for, among other conditions, a stroke or cancer.\(^{217}\) In fact, Kennedy had been diagnosed and treated for a stroke, and his doctor testified that Kennedy was well aware of this diagnosis.\(^{218}\) Accordingly, Kennedy’s misrepresentations on the application were not made in good faith, but knowingly and with the required intent or reckless disregard.\(^{219}\) The court granted the insurer’s summary judgment motion seeking to affirm its rescission.\(^{220}\)

The court reached the opposite conclusion in *Neiman v. American International Group, Inc.*\(^{221}\) In that case, the insured died of lung cancer within the two year contestable period.\(^{222}\) Prior to the insured’s applying for coverage, his treating physician had told him he might have chronic bronchitis or pneumonia due to chronic coughing; the physician also stated that she wanted the insured to have a chest x-ray but did not explain why.\(^{223}\) An x-ray taken six days prior to completing the application was positive for a lung tumor.\(^{224}\) Once again, the doctor did not recall what she told the insured other than she wanted a CT Scan. According to the court, you “can’t use the word cancer until you have that definitive diagnosis,” and the insured did not receive a definitive diagnosis of cancer until after the application was completed.\(^{225}\)


\(^{215}\) *Id.* at *1.

\(^{216}\) *Id.*

\(^{217}\) *Id.*

\(^{218}\) *Id.* at *2.

\(^{219}\) *Id.* at *6.

\(^{220}\) *Id.* at *8.

\(^{221}\) No. 1:CV-08-1535, 2009 WL 37640273 (M.D. Pa. Nov. 9, 2009).

\(^{222}\) See *supra* note 7.

\(^{223}\) *Neiman*, 2009 WL 37640273, at *4.

\(^{224}\) *Id.*

\(^{225}\) *Id.* at *4-5.*
In support of its motion for summary judgment, the insurer argued that the temporal proximity of the insured’s application to his medical treatment, diagnostic testing and lung cancer diagnosis established knowledge or bad faith justifying rescission of the insured’s life insurance policy.\footnote{226} The issue of intent, however, involved an inquiry into the state of mind of the applicant—a particularly difficult task when the applicant is dead.\footnote{227} The court noted that a jury could conclude that the insured knew he had a serious medical condition at the time of application and did not disclose the critical facts, including the chest x-ray only six days prior to application and a CT Scan only eight days prior to the Paramedical Supplement.\footnote{228} Although this timing could support an inference that the insured purchased insurance because he was afraid he had lung cancer, there was also evidence he did not knowingly make false statements or act in bad faith.\footnote{229} Summary judgment was therefore denied.

Similarly, in \textit{Zell-Brier v. Independent Order of Foresters},\footnote{230} the insured completed a medical application for life insurance and answered “no” to the question whether he had “[i]n the past 10 years, been diagnosed by a licensed medical practitioner or provider as having, or received treatment for: (g) Chronic . . . bleeding . . . [or] (j) Depression . . . ?”\footnote{231} After the insured’s death, the insurer’s investigation resulted in rescission of coverage.\footnote{232}

Two physicians stated they had never diagnosed the insured with these conditions.\footnote{233} One doctor consulted the insured by phone during which the insured reported he “often” had blood in his stool if he ate badly or ate sugar, that he had some depression in the past two years due to his financial condition and lots of stress.\footnote{234} The doctor did not consider these conditions to be a diagnosis or clinically significant.\footnote{235}

Rescission was not appropriate because the insured did not misrepresent the facts. A doctor “diagnoses” a patient as having a “condition” based on the individual’s signs and symptoms; by contrast, simply considering someone’s self-reported symptoms is not a...
“diagnosis.” Similarly, “chronic” requires a problem to be of a long duration or frequent recurrence. “Depression” refers to a depression in the sense of a medical disorder. Summary judgment was therefore granted to the beneficiary.

IV. CONCLUSION

Rescinding an insurance policy is necessary when the insured fails to honestly disclose requested information on the application. Otherwise, insureds can obtain coverage to which they are not entitled, and the general public suffers through higher premiums. However, rescission is a drastic remedy, denying the insured not only the promised policy benefits but also the policy coverage from the day it was issued. Judges and juries critically review rescission and often punish the insurer for an incorrect decision. Accordingly, it is necessary for the insurer to fully understand the rescission laws of the applicable jurisdiction and to carefully review all the evidence to be certain each required element for rescission is documented.

236 Id. at *3.
237 Id.
238 Id. at *4.
239 Id.
The Federation of Insurance Counsel was organized in 1936 for the purpose of bringing together insurance attorneys and company representatives in order to assist in establishing a standard efficiency and competency in rendering legal service to insurance companies, and to disseminate information on insurance legal topics to its membership. In 1985, the name was changed to Federation of Insurance and Corporate Counsel, thereby reflecting the changing character of the law practice of its members and the increased role of corporate counsel in the defense of claims. In 2001, the name was again changed to Federation of Defense & Corporate Counsel to further reflect changes in the character of the law practice of its members.
Coverage Risks

The “Nuts and Bolts” of Life & Health Insurance Policy Rescissions

Life, health and disability insurance companies, especially those selling coverage to individuals and small groups, which are not affected by the Affordable Care Act, are not required to issue coverage to any applicant seeking insurance. Rather, they are permitted to select the risks they will insure and to deny or limit coverage through a process known as “underwriting.” One of the basic principles of insurance is that each individual accepted for coverage should pay a premium that is proportionate to the amount of risk the company assumes for that person. Otherwise, many people seeking to purchase insurance in the individual and small group markets would pay considerably higher premiums. Nourachi v. First Am. Title Ins. Co., 44 So. 3d 602, 610 (Fla. App. 2010).

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Insurers primarily base underwriting decisions on an applicant's responses to questions contained in an application regarding the applicant's medical history, employment record, social activities, and earnings history. A prospective insured has a duty to provide truthful and complete answers to the questions posed so the insurer can properly evaluate the risk it is contracting to insure. *Mulrooney v. Life Ins. Co. of the Southwest*, No. N11 C-04-192 JAP, 2014 Del. Super. LEXIS 450 at *25–26 (Super. Ct., Sept 3, 2014). The insurer is in an unequal position vis-à-vis the applicant information so it can properly assess the applicant's health and other risk factors. People with adverse health conditions or who engage in dangerous occupations or social activities may fail to disclose adverse conditions or activities on the application so they may either obtain insurance not otherwise available or pay premiums lower than justified had they disclosed the true facts, may be required to pay higher premiums, may be subject to policy exclusions or, in cases of excessive risk, may be denied coverage altogether.

Too often, the insurer learns of this false information only at claim time. The insurer, if it determines that had the applicant correctly disclosed all of the requested material facts it would have not have issued the policy as applied for, may then seek to rescind the policy based on the insured's misrepresentations.

A variety of legal issues arise when an insured challenges the insurer's decision to rescind. Some of the most important of these include whether there actually was a "misrepresentation" based on the application questions presented; whether the misrepresentation was "material"; and, in those states that impose such a requirement, whether the misrepresentation was "intentional." States requiring the insurer to present evidence of the insured's intent to deceive have adopted a variety of standards to determine "intent." As a result, insurers often have a difficult time determining whether this critical requirement has been satisfied.

The Application Process

**Application Questions**

Insurers typically require an applicant to complete an application. Questions on the application should seek to obtain all the information the insurer needs to make an informed underwriting decision. These questions, depending on the type of coverage sought, seek information about the applicant's medical history (including physicians seen, prescriptions taken, and other similar information); employment history; and social activities (such as the use of alcohol, tobacco products, or recreational drugs). The applicant, when signing the application, generally attests to the accuracy and completeness of the information provided. *Goar v. Federated Life Ins. Co.*, No. 1:13-cv-00919-JMS-DKL, 2015 U.S. Dist. LEXIS 46960 at *32 (S.D. Ind. April 10, 2015).

The insured has an affirmative duty to know and understand the content of the application and will be bound by the representations made in his or her answers. However, an insured has no duty to volunteer information and is obligated to disclose only that information specifically and unambiguously sought in the application.

Application questions are either objective or subjective. In the context of rescission, this distinction is especially important in proving whether the application contains a misrepresentation and, in jurisdictions requiring intent, whether the misrepresentation was intentional.

**Objective Questions**

Objective questions that are typically specific and easily understandable provide the most protection to an insurer. They request information readily within the applicant's knowledge, such as the names of doctors or other medical professionals who have seen or treated the applicant; medications prescribed for the applicant, including narcotics or other controlled substances; the applicant's alcohol, tobacco, or recreational drug use; or any specific medical conditions considered important by the insurer. *Hawkins v. Globe Life Ins. Co.*, 2015 U.S. Dist. LEXIS 62443 at *3 (D.N.J., May 13, 2015). Objective inquiries may also include questions regarding an applicant's income and net worth, *PHL Variable Ins. Co. v. 2008 Christa Joseph Trust*, 2015 U.S. App. LEXIS 5724 at *17 (8th Cir., April 19, 2015), previous purchase or cancellation of insurance coverage, previous suspension or revocation of a driver's license, and conviction of a misdemeanor or felony. *Hawkins*, 2015 U.S. Dist. LEXIS 62443 at *35.

These types of questions are considered to be objective because their accuracy may be proven by direct evidence. There is a presumption that the information sought is material to the insurer's ability to properly evaluate the applicant based on the type of coverage sought. The applicant's personal belief regarding the seriousness of a health condition is irrelevant. The insurer, not the applicant, determines which issues are important in deciding whether the applicant is an acceptable risk and, if so, on what terms.

**Subjective Questions**

Insurance applications may also include questions that are considerably more subjective. These questions seek the applicant's subjective belief or judgment as to the state of the applicant's health. These include questions asking whether the applicant is "in good health" or "free from any physical or mental disorder." Because such subjective questions inquire into the applicant's state of mind, they are inherently more ambiguous. *Williams v. Union Fidelity Life Ins. Co.*, 123 P. 3d 213, 222 (Mont. 2005); *Bishop's Property v. Protective Life Ins. Co.*, 597 F. Supp. 2d 1354, 1362 (M.D. Ga. 2009).

Courts are more lenient when reviewing responses to subjective questions. Judges have interpreted such questions to mean that the insurer is interested only in "serious" medical conditions as understood from the point of view of a layman, not from that of a medical professional. *West Coast Ins. Co. v. Hoar*, 558 F. 3d 1151, 1157 (10th Cir. 2009). The insured's failure to disclose minor or temporary medical problems are not considered to be material. Thus, application questions inquiring about an individual's overall health
will not hold an applicant to the literal truth. Such questions—e.g., is the applicant “free from disease”—require only that the applicant has a good faith belief, or is justified in believing, that his or her response is truthful. For example, “alcohol use” doesn’t mean “alcoholism” and “drug use” doesn’t mean “drug abuse.” Mead v. Am. Nat. Ins. Co., 2014 U.S. Dist. LEXIS 97157 at *12–14 (D. Minn. July 17, 2014). So too, “annual income” is ambiguous. Mega Life and Health Ins. Co. v. Pieniozek, 505 F. 3d 199, 1406 (11th Cir. 2009). For such representations to be actionable, the insurer must demonstrate not only that the answer is false, but also that the insured knew it was false. So long as the response is true in the broader sense that it is honest, sincere, and not fraudulent, there is no misrepresentation.

For example, in Barry v. United States Life, 2011 U.S. Dist. LEXIS 51419 (D. NJ May 13, 2011). John Barry applied for a life insurance policy on December 26, 2006. He completed an application representing that he had no “disease or disorder” of his liver, but stated he was being treated for hypertension. The policy was issued on January 15, 2007; and he died one month later.

During its investigation, the insurer learned that Barry’s doctor advised him to have an ultrasound based on an abnormal blood test regarding his liver function. U.S. Life argued that Barry’s failure to reveal this information justified rescission coverage. Barry’s widow sued, and the insurer sought summary judgment, which the district court denied.

The “one crucial and material fact” before the court was whether Barry actually knew he had a disease of his health in December 2006 and what he thought the application was asking regarding his health. The plaintiff argued, and the court agreed, that the question regarding liver disease or disorder was a subjective question and would thus be considered false only if Barry actually knew he had a liver “disease” or “disorder.”

Although there was no question that Barry was “a gravely ill man,” it was not clear that he knew he was sick. The recommended test was presumably to assist the doctor in making that determination. The fact that Barry did not have the ultrasound test ordered by his doctor eight months earlier actually supported his contention he did not believe he had any disease or disorder. Nor was there anything to show Barry’s abnormal blood test results were conveyed to him in such a manner as to indicate he knew or understood the seriousness of these results.

The insurer only has a duty to investigate representations on an application if there is information that would put a reasonably prudent insurer on notice of a possible misrepresentation.

Insurer’s Duty to Investigate
An insurer is entitled to receive honest and complete answers from applicants for insurance. A very important element of the insurer’s underwriting evaluation is trust. An applicant who is aware of any medical condition, symptom, or treatment thus has a duty to disclose this information if asked.

The courts consistently have permitted insurers to rely on the information contained in an insured’s application. When the insured’s answers are complete on their face, the insurer has no independent obligation to investigate their accuracy. Goer, 2015 U.S. Dist. LEXIS 46960 at *41. This rule is based on the fact that only the applicant has the necessary knowledge of his or her health and other issues. The insurer only has a duty to investigate representations on an application if there is information that would put a reasonably prudent insurer on notice of a possible misrepresentation.


Relying on these legal principles, insurers may utilize simplified underwriting procedures to approve or reject applications for coverage. Courts have upheld the use of these types of applications against challenges that a more thorough investigation prior to coverage would have disclosed the insured’s medical problems.

In Harper v. Fidelity & Guaranty Life Insurance Co., 234 P 3d 1121 (Wyo. 2010), Joseph Harper purchased a life insurance policy. The application contained questions regarding the applicant’s current and past health history. Harper denied receiving medical treatment or advice for a number of medical conditions, acknowledging only that he was taking medication for high blood pressure and high cholesterol.

The insurance applied for was considered by the insurer to be a “simplified underwritten product” whereby the underwriter simply reviewed the application and obtained information from the Medical Information Bureau (“MIB”). Based on this investigation, the underwriter learned Harper’s weight was slightly higher than represented but assumed Harper’s weight had been lower on the date of the application. Nor was the underwriter concerned that Harper had received treatment for depression 10 years earlier, since Harper stated he had made a “complete recovery.”

The underwriter also assumed Harper’s blood pressure and cholesterol were most likely under control because he was taking medication for these conditions. Coverage was approved.

Harper died two months later from cardiac problems. At that point, the insurer learned for the first time that Harper had failed to disclose treatment for a “probable transient ischemic attack,” alcohol abuse and liver problems, and chest pains. It also learned Harper’s weight was significantly higher than stated on the application and MIB report. Accordingly, coverage was rescinded. The beneficiary sued, and the insurer obtained summary judgment.

The insurer argued the insurer should have investigated further based on the application and MIB responses.
The beneficiary contended there were "red flags" which the underwriter ignored. The court rejected these arguments, noting that the underwriter adequately explained why no further investigation was undertaken: "In the simplified underwriting process that was used [here], the underwriter is to rely on the health questionnaire and the MIB, which is what happened in this instance. Furthermore, Mr. Harper represented in his application that '[t]he statements made in this application are complete, true and correctly recorded.'" An insurer is not obligated to further investigate unless it is placed on notice that the application responses are inaccurate. That was not the case here, and rescission was therefore proper.

Rescinding Coverage

Insurer's Right to Rescind

It is a basic principle of contract law that if one party to a contract has been led to enter into the agreement by the misrepresentation of the other party, the contract is voidable at the option of the innocent party. Accordingly, rescission is available to an insurer when an insurance policy is obtained based on incorrect information communicated by the insured that was material to the formation of the contract. In many states, in order for an insurer to rescind coverage, the application must clearly and unambiguously state that a misstatement by the insured will void the policy ab initio. Ark. March 20, 2015). This is so regardless of whether a loss has occurred. An insurer's failure to act promptly may result in a waiver of the defense. Dubek, 2015 Cal. App. LEXIS 203 at *19. The question whether an insurer has unreasonably delayed in seeking rescission arises only when the insurer learns of facts that actually justify rescission—not merely facts that raise the potential for rescission. Determining what constitutes a reasonable time period depends on more than merely the length of time elapsed because insurers risk bad faith actions should they act too soon. Courts must provide insurers with an adequate time period to make a good faith investigation to determine whether there is an adequate basis to rescind.

Elements Required for Rescinding Coverage

State Law

Each state has its own statutes and case law that an insurer must satisfy before it can rescind a policy. This has resulted in a variety of requirements which determine whether an insurer can properly rescind a life, health or disability insurance policy.

Generally Speaking, rescission requires three elements: (1) a misrepresentation by the applicant that is (2) material to the risk to be assumed by the insurer and (3) reasonably relied on by the insurer. Some states include a fourth requirement that the misrepresentation must be either knowingly false or is made with a total disregard for its truthfulness.


In addition, a number of states require the insurer to seek a judicial determination that the rescission is valid, either by filing an action seeking rescission or pleading the right to rescind as part of the insurer's defense to a lawsuit filed to enforce a policy. Mut. of Omaha Life Ins. Co. v. Costello, 420 S.W.3d 873 (Tex. App. 2014); Protective Life Ins. Co. v. Sullivan, 682 N.E.2d 624 (Mass. 1997).

The insurer has the burden to establish each element required by the particular state where the insured resides or the policy was sold. Mulrooney v. Life Ins. Co., of the Southwest, 2014 Del. Super LEXIS 450 at *20 (Super. Ct. Sept. 3, 2014). In some states, the elements must be established by a preponderance of evidence. Settlemeyer v. Farmers New World Life Ins. Co., 2014 U.S. Dist. LEXIS 155961 at *14 (D. Oregon, Nov. 3, 2014). Other states require clear and convincing evidence. Midland Nat. Life Ins. Co. v. Gavin, 2014 U.S. Dist. LEXIS 179227 at *9 (N.D. Ohio, Dec 31, 2014). This latter standard requires more than the "preponderance of evidence" test normally applied in civil cases, but less than certainty "beyond a reasonable doubt" as required in the criminal context. Still other states require some level of proof in between.

When the application states that answers provided by the applicant are correct to the best of the applicant's knowledge and belief, the burden on the insurer increases to clear proof that the answer is knowingly false. Kominsky v. Pyro Life Ins. Co., 2015 U.S. Dist. LEXIS 61664 at *14 N.D. Ala. May
Misrepresentation/Concealment
A misrepresentation is a false statement of fact or the failure to disclose a fact in response to a specific question. An individual’s failure to communicate that which he or she knows is a “concealment.” Benson v. Leaders Life Ins. Co., 339 P.3d 843, 845 (Okla. 2012). The failure to properly disclose information on the application prevents the insurer from inquiring about these facts so that a proper risk evaluation can be undertaken.

Materiality
The information misrepresented or concealed also must be material. A misrepresentation alone is not sufficient to support rescission. Materiality is determined from the insurer’s perspective. A misrepresentation is material if a reasonable insurer would have considered the information important in determining whether or not to insure the applicant. Kaminsky v. Pruro Life Ins. Co., 2015 U.S. Dist. LEXIS 61664 at *11 (N.D. Ala. May 11, 2015). Materiality in the vast majority of the states is determined not by the actual loss but only by the probable and reasonable influence of the facts upon the insurer at the time the application is underwritten. Oregon Mut. Ins. Co. v. Victorville Speedwash, Inc., 2015 U.S. Dist. LEXIS 88109 at *16 (C.D. Cal. July 6, 2015).

To prove materiality the insurer must establish that its underwriting practices with respect to applicants with similar conditions would reasonably influence the underwriter in issuing a policy, attaching a limiting or exclusionary rider for certain medical conditions, or activities or in determining what premium to charge. Many courts have ruled that the fact an insurer asked specific questions in an application is usually sufficient in itself to establish materiality as a matter of law. Oregon Mut. Ins. Co., 2015 U.S. Dist. LEXIS 88109 at *15; Reliastar Life Ins. Co. v. Laschkitsch, 2014 U.S. Dist. LEXIS 72558 at *14 (E.D. N.C. May 28, 2014).

Issues arise whether the insurer routinely followed or ignored its own underwriting procedures and whether the requested information was actually important to the company’s underwriting decisions with respect to similarly situated applicants. Courts often rely on the testimony of insurance company personnel to prove that truthful answers on the application would have affected the insurer’s decision to issue coverage and, if issued, the premium charged. Reliastar, 2014 U.S. Dist. LEXIS 72558 at *17-18. However, an underwriter’s testimony may be insufficient if the underwriter’s statements are conclusory. Accordingly, in addition to direct testimony, the insurer also should produce the company’s underwriting manual establishing that the insurer would have analyzed the insured’s application differently had it known the insured had a certain medical condition or occupation or engaged in certain social behaviors. Oregon Mut. Ins. Co., 2015 U.S. Dist. LEXIS 88109 at *16. While materiality is generally a mixed question of law and fact and thus a jury question, Mitchell v. Modern Woodman of Am., 2014 U.S. Dist. LEXIS 170695 at *29 (N.D. Ala., Dec. 10, 2014), a court may decide the issue as a matter of law utilizing the insurer’s practice regarding similar risks, underwriting manuals, and testimony by a qualified employee.

Intent to Deceive
Introduction
A number of states do not require an insurer to establish an actual intent to deceive on the part of an insured to rescind coverage; in these states, a material misrepresentation, even if innocently made, will suffice. The insured’s good faith in completing the application is not material. Oregon Mut. Ins. Co., 2015 U.S. Dist. LEXIS 88109 at *14; George v. Pukin Life Ins. Co., 2015 Ind. App. Unpub. LEXIS 619 at *5 (Ct. of App. June 4, 2015).

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Other states require an insurer to establish either that the false statement was made with an actual intent to deceive or that it materially affected either the acceptance of the risk or the degree of hazard assumed by the insurer. American General Life Ins. Co. v. Underwood, 2015 U.S. Dist. LEXIS 2311 at *14–15 (E.D. Tenn. Jan. 9, 2015). Still other states say that a misrepresentation is one that is known by the insured to be false when made, though not necessarily with a conscious intent to defraud. Ramsey v. Penn Mut. Life Ins. Co., 2015 U.S. App. LEXIS 9019 at *18 (6th Cir. June 1, 2015).

The most challenging issue facing insurers is establishing, when required, the requisite knowledge or intent to deceive by the insured. What constitutes a knowing misrepresentation and intent to deceive varies significantly from state to state. There is a distinction between misrepresentation and fraud. Misrepresentation is but one element of fraud. This distinction is particularly important when dealing with insurance applications.

Fraud occurs when “someone knowingly makes a materially false representation or recklessly makes a materially false representation without regard to its veracity with the intent that the statement be relied on by another party and that other party suffers an injury.” Kutilenis v. Union Provident Corp., 475 F. Appx. 550, 553 (6th Cir. 2012). A “reckless disregard for the truth” occurs when “the applicant entertains serious doubts as to the truth” of the statements made. Chism v. Protective Life Ins. Co., 234 P. 3d 780, 791–92 (Kan. 2010). Courts set a high bar for the insurer to establish a knowing, intentional deception.

Some states require the insurer to prove that the applicant made the false statement knowingly or knowingly concealed the true facts with an intent to deceive, Benson, 339 P3d at 845. When an insured has made a misrepresentation regarding material facts, determine it was knowingly made with the requisite intent to deceive.

Legal Fraud
Those states requiring proof of actual or legal fraud as an element in establishing a right to rescind require the insurer to establish a material misrepresentation of a presently existing or past fact made by the insured with knowledge it is untrue and with the intent to deceive so the insurer relies to its detriment on the misrepresentation. Importantly, the misrepresentation must be knowingly made. Goar v. Federated Life Ins. Co., 2015 U.S. Dist. LEXIS 46960 at *29 (S.D. Ind., April 10, 2015).

The applicant must be reasonably chargeable with knowledge that the facts omitted or misrepresented were within the scope of the questions asked on the application. Fraud is never presumed; rather, it must be proven by clear and convincing evidence. Evergreen Recycle v. Indiana Lumbermens Mut. Ins. Co., 2015 Kan. App. LEXIS 34 at *26 (May 1, 2015). Subjective intent is rarely subject to summary judgment, so the issue of intent to deceive is usually a question for the trier of fact.

Courts acknowledge that there are inherent difficulties in proving intent, so strict proof of fraud is not always required. Intent is often determined from all the attending circumstances which indicate the insured’s knowledge of the falsity of the representation made in the application. Warkentin, 2015 U.S. Dist. LEXIS 64108 at *17. For example, evidence of the severity of the insured’s undisclosed health problems strongly indicates that the application representations were knowingly false. Similarly, when an insured makes representations he or she knows to be false, courts presume intent to deceive.


Innocent misrepresentations, such as those made due to ignorance, mistake, or negligence, are not sufficient. Nor will an applicant’s failure to disclose a specific medical condition of which he or she was ignorant will not justify rescission. Ramsey, 2015 U.S. App. LEXIS 9019 at *18 (6th Cir. 2015). A layman is excused if he or she failed to understand the meaning of certain medical terms and for that reason failed to disclose some fact in the requested medical history. The rationale is that because laypersons lack the same level of knowledge or understanding as that possessed by doctors and other experts, it is unfair to permit rescission based on information the applicant did not know or did not fully understand. In those situations, the applicant does not know that the information he is providing is false.

This does not, however, excuse an applicant who fails to read the application prior to signing it. An individual is required not only to respond accurately and fully to all questions but also to use reasonable diligence to be sure that the responses are correctly written. Warkentin, 2015 U.S. Dist. LEXIS 64108 at *19–20. Signing the application without reading it is evidence of a reckless disregard for the truth of the representations set forth in the application. Alfa Ins. Co. v. Reese, 2015 Ala. LEXIS 92 at *29 (Ala., June 30, 2015). This duty, however, is not always enforced when the insurer’s agent completes the application and either knowingly enters false information or fails to ask the applicant for all requested information. In that case, the insurer cannot rescind coverage, even if the applicant could have discovered the misrepresentation by reading the application. Patel v. New York Life Ins. Co., No., U.S. Dist. LEXIS 34963 at *8–9 (W.D. Ark., March 20, 2015).

Application Questions
The more specific the application question and the more serious the medical condition not disclosed, the easier it is for the insurer to establish fraud. When the application asks clear and straightfor-
ward questions, the applicant is required to provide equally clear and straightforward responses. The misrepresentation should concern objective facts about doctor visits, hospital confinements and concrete diagnoses of which the insured was undoubtedly aware and that were not reasonably open to interpretation.

An insured’s failure to disclose conditions specifically asked about on the application supports a finding that the insured did so with knowledge of the falsity of the information provided. *Miguel v. Metro Life Ins. Co.,* 200 F. Appx. 961, 967 (11th Cir. 2006). So too, the fact the insured does not merely fail to provide any specific medical history, but also mentions a specific insignificant injury or minor illness and specific dates of treatment, is evidence that the failure to disclose a more serious medical condition was intentional or at least done with reckless disregard for the truth. Similarly, multiple false statements on an application establish that the statements were made with the deliberate and fraudulent intent to deceive.

Once such a showing is made, the burden shifts to the insured to establish an honest motive or an innocent intent. The insured’s bare assertion that he or she did not intend to deceive the insurer is not sufficient evidence of good faith, and the presumption supports a finding for the insurer.


In 2005, the insured purchased disability coverage, responding “no” to application inquiries regarding the use of stimulants, hallucinogens, narcotics, or other controlled substances; counseling or treatment for alcohol or drug abuse; and treatment, consultation, or counseling for anxiety, depression, nervousness, stress, mental, or nervous disorder or other emotional disorder.

The insured was injured during an armed robbery in one of his pharmacies, resulting in the amputation of the three middle fingers of his left hand and injury to the two remaining fingers. When taken to a hospital for treatment, he disclosed that he had a history of taking “unprescribed” narcotics. He thereafter resumed individual therapy (along with his ongoing group therapy) for post-traumatic stress disorder.

Intent often is determined from all the attending circumstances which indicate the insured’s knowledge of the falsity of the representation made in the application.

During the first session, the social worker noted in her chart that the insured told her he lied about his drug treatment on his insurance application.

The insured then submitted a disability claim. The claims adjuster obtained medical records and learned the insured had participated in about 57 individual and 78 group therapy sessions between 2002 and the date the application was signed on January 18, 2005. The insurer sought to rescind on March 27, 2009, relying on the policy’s contestability fraud exception since more than two years had elapsed since the policy’s issuance. In this circumstance, the insurer was required to prove facts justifying rescission by clear and convincing evidence.

The insurer satisfied these requirements. The company’s underwriting guidelines stated that coverage would not be issued to anyone who abused controlled substances within five years preceding the application date, a policy that was confirmed by an underwriter in deposition.

The insured alleged he did not really notice these questions when he “breezed through” the application and that he was “embarrassed” because of the stigma associated with the conduct in question. However, the insured had signed the application attesting that his responses were correct and also met with a medical examiner during the application process where he again denied drug use or treatment. Consequently, the court rejected the insured’s explanations.

These application questions were straightforward, and the insured knowingly answered them falsely. Moreover, the evidence established numerous individual and group therapy sessions for drug dependency and stress, and the plaintiff admitted the falsity of his representations. On the basis of this evidence, the district court judge ruled as a matter of law these statements had been fraudulently made.

In *American General Life Insurance Co. v. Bolden,* 2011 U.S. Dist. LEXIS 82527 (S.D. NY, July 27, 2011), the insurer filed a declaratory judgment action seeking to void a $500,000 life insurance policy. The policy was issued at the “preferred plus” rate, the best rate offered by American General. The insured died one year later from renal cancer.

The application asked “in the past 10 years, has the Proposed Insured… been advised to have any diagnostic test, hospitalization, or treatment that was NOT completed?” The insured said “no.” However, two months before completing the application, the insured had sought treatment from a urologist for gross hematuria (visible blood in the urine), and the doctor had ordered further testing and told the insured to return for another visit. Additionally, the insured’s internist had ordered additional tests, including cytology, which is an element of cancer screening. The insured never completed these tests.

The insurer’s underwriting guidelines stated that hematuria “present[s] a significant underwriting challenge,” and recommended a “thorough assessment” of the applicant before accepting him or her as a preferred policyholder. American General would not have issued the policy without additional follow-up testing had it known about the uncompleted diagnostic test.

The application also asked whether “the Proposed Insured ever… sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs.” The insured responded “no.” However, the insured’s doctor had told him to
stop drinking alcohol. The insurer's underwriting guidelines stated that such medical instructions "would have raised red flags" requiring additional information.

The court found the cytology test to be material and that American General would not have issued the policy without further testing. So, too, the failure to disclose alcohol counseling was material: Had the insured disclosed his doctor's instruction to stop drinking alcohol, American General would not have offered the policy without the insured's completing an additional questionnaire. Based on these material misrepresentations, American General was entitled to rescind as a matter of law.

However, the more open-ended the application question, the more difficult it becomes to establish the insured knowingly made a false statement. Rescission cannot be based on responses to ambiguous application questions. "A question is ambiguous when it is susceptible to two reasonable interpretations, one in which a negative response would be correct and one in which an affirmative response would be correct." The interpretation of questions in an insurance application is a question of law for the court's determination. Ambiguity is construed against the insurer.

In Loza v. American Heritage Life Insurance Co., 434 F. Appx. 687 (9th Cir. 2011), plaintiff Loza applied for a life insurance policy, responding "no" to the question "[i]s any person to be insured currently undergoing any diagnostic test for, now being treated for, or ever been treated for, cancer?" Prior to completing the application, Loza had visited his doctor for urinary problems. In addition, he had a past history of an enlarged prostate and his father had been diagnosed with prostate cancer.

Loza's doctor determined that Loza's prostate was enlarged and ordered a PSA (prostate specific antigen) test. Although considered a routine screening test in men, a PSA test is also used to indicate a number of prostate and urinary tract infections. Loza's PSA was elevated, and he was referred to a urologist.

Several months after the policy was issued, Loza was diagnosed with prostate cancer. The insurer conducted an investigation and, based on the negative response to the application question quoted above, rescinded coverage. The insurer considered the PSA test to be a diagnostic test for cancer.

The question before the court was whether a PSA test constituted a "diagnostic test" within the meaning of the application. The term was not defined in the policy. The insurer argued that the term should be defined as any test that is part of the diagnostic process used to identify cancer. The court noted that, although a PSA test is a diagnostic test, it does not directly diagnose cancer. The relevant question was not whether the PSA test generally can be described as a diagnostic test, but "how the language of the policy applies to the specific facts of the case."

The PSA is used as a screening test in conjunction with other examination results to evaluate whether a biopsy of the prostate is needed. In fact, this test is recommended for all men of a certain age, regardless of symptoms. Here, the insured's physical symptoms and medical history indicated a heightened potential for prostate cancer, but his doctor did not tell him he was being tested for cancer, and the insured stated he did not know what the test was for. Under Arizona law, the insurer must establish that the insured made a misrepresentation in the application. Because both the insured's and insurer's arguments were reasonable, the policy was ambiguous and construed against the insurer.

In Brandon v. Prudential Insurance Co. of America, 2010 U.S. Dist. LEXIS 119113 (S.D. N.Y., Nov. 9, 2010) the insurer denied benefits under a $50,000 ERISA-governed life insurance policy due to alleged misrepresentations on the application. According to the insured, "I have never been diagnosed with, or taken medication for, any of the following: heart trouble,..." Medical records indicated the insured suffered from "mild aortic sclerosis and mitral valve prolapse with mild mitral insufficiency."

The court found the term "heart trouble" to be ambiguous. "Heart trouble" is not a recognized diagnosis in the medical field and the question did not ask whether the applicant suffered from a specific disorder or disease (such as high blood pressure, cancer, diabetes, etc.). The insured's denial of "heart trouble" therefore may not be used to support a misrepresentation regarding the insured's health.

[0]nly Prudential would be allowed to define what constitutes "heart trouble"; would be allowed to do so after the claim is made; and would be allowed to change and amend the definition on a case by case basis for the purpose of contesting and rescinding any policy in circumstances where there is retroactive evidence of any heart abnormality, no matter how common or benign, that the applicant may have known of. Such a holding would be manifestly unjust, and would defeat the purpose of protecting a beneficiary's right to a fair consideration of his or her claim for benefits.

Id.

Moreover, the court noted, mitral valve prolapse is often harmless and treatment is not required. Here, there was nothing to show that the insured's heart conditions affected her heart function, and, according to her doctor, these conditions were of "no clinical significance." The insured did not take any medication, nor were her daily activities restricted.

Medical Testimony

Finally, testimony by the insured's treating physician can be very important when
an insurer must prove intent to deceive. When an insured represents on the application that he or she has not been diagnosed or treated for a particular medical condition, testimony that the treating physician told the insured about the diagnosis can establish that the insured acted knowingly and with the requisite intent or reckless disregard.

In *Kennedy v. North American Co. for Life & Health Insurance*, 2009 U.S. Dist. LEXIS 41678 (D. Kan. May 15, 2009) for example, the insured, Kennedy, applied for and was issued a term life insurance policy. He allowed the policy to lapse and then applied for reinstatement. In both the original and subsequent application, Kennedy stated that he had had only a routine physical with no adverse findings. He also answered "no" to the question whether he had been diagnosed with or treated by a medical professional for, among other conditions, a stroke or cancer. In fact, Kennedy had been diagnosed and treated for a stroke, and his doctor testified that Kennedy was well aware of this diagnosis. Accordingly, Kennedy's misrepresentations on the application were not made in good faith, but knowingly and with the required intent or reckless disregard. The court granted the insurer's summary judgment motion seeking to affirm its rescission.

The court reached the opposite conclusion in *Neiman v. American International Group, Inc.* 2009 U.S. Dist. LEXIS 113483 (M.D. Pa., Dec. 7, 2009). In that case, the insured died of lung cancer within the two-year contestable period. Prior to the insured's applying for coverage, his treating physician had told him he might have chronic bronchitis or pneumonia due to chronic coughing; the physician also stated that she wanted the insured to have a chest x-ray but did not explain why. An x-ray taken six days prior to completing the application was positive for a lung tumor. Once again, the doctor did not recall what she told the insured other than she wanted a CT scan. According to the court, you "can't use the word cancer unless you have that definitive diagnosis," and the insured did not receive a definitive diagnosis of cancer until after the application was completed.

In support of its motion for summary judgment, the insurer argued that the temporal proximity of the insured's application to his medical treatment, diagnostic test-

**Save the Date**

**Insurance Coverage and Claims Institute**

By Max J. Cohen

The DRI Insurance Law Committee will host its annual Insurance Coverage and Claims Institute ("ICCI"), April 6-8, 2016, at the Loews Chicago Hotel in Chicago, Illinois. We invite you to join us and see why ICCI is DRI's flagship seminar for coverage counsel, defense counsel, and claims professionals!

A world class learning opportunity…

Insurance law is constantly changing. ICCI equips its attendees to appreciate the law's ever-evolving nuances. Nationally recognized attorneys and insurance industry professionals, ICCI's speakers not only offer real-world insights on developments in foundational concepts, but also explore hot topic issues impacting the insurance law landscape. This year's topics will include:

- The role of independent counsel;
- Principles of subrogation and the made-whole doctrine;
- Settlement agreements and the duty to indemnify;
- The erosion of the attorney-client privilege and work product doctrine;
- Third party conditions presented in handling claims;
- and
- First party coverage for cyber- and computer-related claims.

This year's ICCI will feature, for the first time, a special Wednesday afternoon program geared solely toward in-house and claims professionals to delve into those issues facing insurers: managing primary-excess relationships, overseeing counsel reporting and expense management, hiring monitoring counsel, and more.

And a world class networking opportunity…

ICCI is much more than an educational conference. It brings insurance law practitioners and claims executives from around the country together. From receptions and breakfasts, to refreshment breaks and dine-arounds, ICCI offers attendees an unparalleled opportunity to expand their network circles, reconnect with colleagues, and launch new, career-spanning friendships.

In a world class city …

Breathtaking architecture, world-renowned museums, zoos, planetariums and aquariums, and critically acclaimed restaurants, all along the shores of Lake Michigan. Chicago offers ICCI attendees limitless opportunities to tailor make a Windy City experience that is second to none.

April will be here before you know it. So save the date and be on the lookout for the registration information that will be coming your way. We look forward to seeing you!


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ing and lung cancer diagnosis established knowledge or bad faith justifying rescission of the insured’s life insurance policy. The issue of intent, however, involved an inquiry into the state of mind of the applicant—a particularly difficult task when the applicant is dead.

The court noted that a jury could conclude that the insured knew he had a serious medical condition at the time of application and did not disclose the critical facts, including the chest x-ray only six days prior to application and a CT Scan only eight days prior to the Paramedical Supplement. Although this timing could support an inference that the insured purchased insurance because he was afraid he had lung cancer, there was also evidence he did not knowingly make false statements or act in bad faith. Summary judgment was therefore denied.

Equitable Fraud

New Jersey law draws a distinction between legal and equitable fraud. Equitable fraud requires the insurer to establish the material misrepresentation of a presently existing fact, the applicant’s intent that the insurer rely on it and detrimental reliance. An insurer may rescind for equitable fraud where the false statements on the application materially affected either the acceptance of the risk or the hazard assumed by the insurer. No actual intent to deceive is required. Even innocent misrepresentations may constitute equitable fraud. New Jersey requires that proof of equitable fraud be established by clear and convincing evidence.

ERISA

Group coverage, such as that provided by employers, is in most instances issued without the necessity of underwriting and rescission is not an issue. But not all policies subject to the Employee Retirement Income Security Act (ERISA) waive the individual’s requirement to qualify medically. ERISA, unlike state laws, is silent on the issue of rescission. Because there is no statutory provision governing rescission in response to misrepresentations in a life or health insurance application, federal common law controls. Courts applying federal common law permit equitable rescission of an ERISA-governed insurance policy obtained through material misrepresentations or omissions. Marshburn v. Unum Life Ins. Co. of Am., 2015 U.S. Dist. LEXIS 4497 at *35 (C.D. Cal. Jan. 5, 2015). This is true even when the insurance policy doesn’t contain any language permitting rescission. Marshburn, 2015 U.S. Dist LEXIS 4497 at *36.

Courts applying federal common law permit equitable rescission of an ERISA-governed insurance policy obtained through material misrepresentations or omissions.

When developing federal common law, courts may look to state law for guidance. The issue regarding which law applies—federal or state—is important because of the various state requirements. However, a particular state’s law governing rescission does not automatically control. It must be consistent with the federal common law approach. In Shiple v. Arkansas Blue Cross & Blue Shield, 333 F. 3d 898 (8th Cir. 2003), the court acknowledged that some states require proof of fraudulent intent or bad faith on the part of the insurer, but noted that the majority of states permit rescission merely on the basis of a misrepresentation of material facts made knowingly in an application for an ERISA-governed insurance policy. Salvatore v. Blue Cross, 2014 U.S. Dist. LEXIS 130212 at *15 (M.D. Pa., Sept. 15, 2014).

This point is illustrated in Van Anderson v. Life Insurance Co. of North America 2012 U.S. Dist. LEXIS 44109 (W.D. Va., March 3, 2012). There, the insurer sought to rescind an ERISA-governed voluntary supplemental life insurance policy. The health application requested information regarding diagnosis or treatment within the previous five years for any condition affecting the stomach or pancreas and regarding anxiety and alcohol or drug abuse. The insured, prior to applying for coverage, had undergone a battery of medical tests, had a history of alcohol abuse, and suffered from acute pancreatitis. He also had a history of gastroesophageal reflux and heartburn, and was taking prescription medication for anxiety. None of these conditions was disclosed on the application.

Under Virginia law, which the court found to be consistent with federal common law, an insurer need not prove the insured had an actual intent to deceive in order to rescind the policy. The insurer must show only that the applicant was or should have been aware of the facts in question based on the circumstances. A knowing misrepresentation is established by showing that the insured was aware he needed medical care because he sought that care, received a diagnosis from a medical professional, and was prescribed medication thereafter. It was obvious the insured knew about the true condition of his health. His physicians had advised him of his medical conditions, and he knew he was taking medication for anxiety and undergoing numerous medical tests. The court found it “fairly clear that [the insured’s] misrepresentations were made knowingly.” Rescission was permitted.

Conclusion

Rescinding an insurance policy is necessary when the insured fails to honestly disclose requested information on the application. Otherwise, insureds can obtain coverage to which they are not entitled, and the general public suffers through higher premiums. However, rescission is a drastic remedy, denying the insured not only the promised policy benefits but also the policy coverage from the day it was issued. Judges and juries critically review rescission and often punish the insurer for an incorrect decision. Accordingly, it is necessary for the insurer to fully understand the rescission laws of the applicable jurisdiction and to carefully review all the evidence to be certain each required element for rescission is documented.