1966

Ruth Marks v. Continental Casualty Co. : Brief of Appellant

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TEXTS

STATUTES

IN THE SUPREME COURT
of the
STATE OF UTAH

RUTH MARKS,
Plaintiff-Respondent,

vs.

CONTINENTAL CASUALTY CO.,
Defendant-Appellant.

Case No. 9785

BRIEF OF APPELLANT

STATEMENT OF NATURE OF CASE

The appellant, Continental Casualty Company, appeals from a decision of the District Court of Salt Lake County, Stewart H. Hanson, Judge, granting to respondent a judgment in the sum of $1,783.70 on a claim that she was covered by hospitalization and surgical insurance policies issued by the appellant.

DISPOSITION IN LOWER COURT

The respondent filed suit against appellant on November 13, 1964 contending that she was entitled to compensation under two policies issued by appel-

lant covering medical expenses she incurred for a lumbar disc fusion of her back. The appellant denied coverage on the grounds of misrepresentation in the insurance application on each policy and on the grounds the operations arose as the result of a pre-insuring condition. Trial was held without jury on March 30, 1966 before the Honorable Stewart M. Hanson, Judge. Judgment was rendered for respondent. A motion for a new trial was made and denied and appellant prosecuted this appeal.

RELIEF SOUGHT ON APPEAL

Appellant contends that the decision of the trial court should be reversed and judgment entered dismissing the respondent's action.

STATEMENT OF FACTS

The appellant submits the following statement of facts .

Respondent in her complaint alleged that the appellant had issued to her two insurance policies (nos. 31381609, 31381610) entitling her to insurance benefits as a result of back surgery she had on April 5, 1964. (R. 1) Appellant admitted the issuance of the policies and the surgery that respondent, Mrs. Ruth Marks, had had performed but denied the coverage of the policies and alleged misrepresentation on her part and a pre-existing condition. (R. 2, 3-4)

Mrs. Marks testified that she resided in Salt Lake City and that the policies in question had been paid for by her former husband. (R. 25) Exhibits P-1 and P-2 are two insurance policies issued by the appellant to the respondent. P-1 covered medical and surgical expense and P-2 hospitalization. Both policies were issued effective May 27, 1963.

Mrs. Marks testified on direct examination that the information on the application accompanying exhibit P-1 indicating she nor her dependents had ever been treated for "arthritis, rheumatism, back, spine, bone, joint or muscle disorder" was a correct answer. The same answer was made with reference to a similar application accompanying exhibit P-2. It was admitted that the policies were in effect on April 4, 1964 at the time respondent underwent surgery for her back. Mrs. Marks did sustain medical expense as a result of the surgery in the sum $1,614.21. (R. 28, Exh. P-4)

The respondent had also refunded the premium checks given for the policies and rejected Mrs. Marks claim. (R. 28)

Mrs. Marks testified that she did not fill out the application for the policies, that this was apparently done by her brother-in-law, Mr. Borofsky. (R. 29) She stated Borofsky was an agent working for the Harry Magoon Agency, in Tulsa, Oklahoma. (R. 30) The policies were placed with the Magoon Agency. She testified that she signed only one ap-

plication and it was signed in blank. (R. 29) At the time of trial the applications accompanying exhibits P-1 and P-2 were received in evidence and they were filled out and a signature purporting to be that of Mrs. Marks was on each application. Respondent denied the signature on one application was hers (Exh. P-1, R. 33) and assumed it was Borofsky who signed her name. She claimed she did not authorize him to sign her name. (R. 45, 46) She did admit signing the application P-2 which she said was sent to her, and was the only application she received. (R. 33) She also denied receiving a letter from the Magoon Agency asking her to fill out the two applications and a doctor's authorization statement. (R. 34) Exhibit D-6 was received and was a letter addressed to Mrs. Marks from Harry B. Magoon purporting to forward two applications and doctor's statement. The letter admonished respondent to give careful attention to the questions in the applications, and return the documents. The letter expressly stated:

> If there has been any medical history on your children, please specify the doctors name on the 'Physicians Form.' (Exhibit D-6)

Mrs. Marks testified that on receipt of the policies she did not examine the applications which were attached to the policies. (R. 34, 35)

Mrs. Marks, on cross-examination, admitted that, prior to the applications and the effective date of the policies, in 1958, she had been in an auto-

mobile accident which "severed nerves" in her arm and she had no control of her wrist. (R. 36) Sections 10 B of both policies had negative indications as to paralysis and 10 F was also negative as to joint and bone disorders. (Exh. P-1, 2) She went into the hospital in 1958 for treatment of the injury. (R. 37) Exhibit D-7 was admitted which was a surgical report made to the Utah State Industrial Commission. In section 2 of the report on the nature and extent of the injuries the following was noted:

> Crushing injury to left arm, mid portion with puncture wound, hematoma formation and partial nerve paralysis of median, ulnar and radial nerves.

Mrs. Marks also admitted on cross-examination that in 1954 she underwent a coccygectomy and her coccyx was removed. (R. 30) She testified she wrote a letter to Borofsky in which she disclosed the coccygectomy in 1954. (R. 30) She did not have a copy of the letter and none was produced at trial. She also admitted sustaining a "severe fall" in 1955 for which she was treated for radiating pain down both legs. (R. 38) She testified she was treated by Drs. Lamb and Chapman. She remembered seeing Dr. Lamb and telling him she had pain in the lower back and both legs. (R. 40).

Respondent on her admission to the hospital in April, 1964, gave her medical history to an intern. (R. 40) She told the intern she had intermit-

tent low back pain for the past nine years. (R. 40-41 Exh. 1 medical records) She had been treated in 1955 by Dr. Lamb and Dr. Chapman.

On redirect examination Mrs. Marks testified she had no back disorder when she applied for the policy and hadn't had any subsequent to her hospitalization in 1957 as a result of the automobile accident. She testified that she could not recall if she had low back pain when she saw Dr. Chapman in July, 1955, but felt the only pain she had was in the area of where the coccyx had been.

The depositions of Mr. Harry B. Magoon and Dr. Robert Lamb were published and received.(1) Mr. Magoon testified that he was an independent general insurance agent doing business as Magoon Associates Inc. and represented several companies. (M 3) His offices were in Tulsa, Oklahoma. One of the companies he represents is the defendant. (M 4) He indicated applications were sent to Mrs. Marks on a suggestion from Jerry Borofsky, Mrs. Marks' brother-in-law. (M 4,5) The arrangements for payment premiums and initial suggestions for insurance were apparently made by Mrs. Marks' former husband. Mr. Magoon never talked to him. He indicated he sent a letter to Mrs. Marks (Exh. D-6) along with the applications and an attending doctor's statement. (M 6) He believed Mrs. Marks

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(1) The record of the Magoon deposition will be referred to as (M—). The Lamb record of the deposition will be referred to as (L—).

returned the applications. He said a signature on the applications was absolutely necessary to issuance of the policy as was completion of the applications. He indicated that if there had been any indication of a medical problem he would not have processed the applications with the doctor's statement. (M 10) He was under an assumption Mrs. Marks had signed both applications, he had not seen the application after return when it was not completed. The signature on both policy applications is almot identical, and it is doubtful if anyone but an expert could tell the difference if in fact the signature was not Mrs. Marks. No other correspondence was received from Mrs. Marks. (M 16).

All checkmarks in the application column were marked "no." Mr. Magoon said if back trouble had been marked it would have been a "red flag." (M 19) He stated a back disorder would have to have been checked out before the policies would have been sent to the company. (M 20) The home office issued all policies. (M 20) Mr. Magoon knew of no correspondence betwen Borofsky and Mrs. Marks. Borofsky was not a licensed agent at the time, but had applied. No special consideration was given to relatives (M 35), and he knew Borofsky and Mrs. Marks were related. (M 33) Mr. Magoon was of the opinion that Borofsky was not to be trusted. (M 39)

Applications are examined by the company's underwriting department before being issued. (M 38) The issuance of the policy under these circumstances would have violated company rules. (M 41)

Dr. Robert Lamb testified that he was an orthopedic surgeon and first saw Mrs. Marks on July 26, 1955. Dr. Chapman saw her July 21, 1955. (L 2,3) The medical records on Mrs. Marks showed she was treated for low back pain radiating into both legs. He diagnosed her condition as evidencing definite nerve root pressure. (L 5) He did not see Mrs. Marks until 1964 when he did a myelogram and determined to operate. (L 7) The operation disclosed a protruding disc, and a pathological examination disclosed a degenerated fibrocartilage. (L 7) Dr. Lamb was of the opinion, based on the medical history, that there was a *probable* connection between the 1955 fall and treatment and the 1964 operation, especially in view of the intermittent back pain. (L 7, 8) He also was of the opinion the fall in 1955 probably had a causative relationship. (L 11, 12)

Mrs. Marks had indicated the operation was a consumation of the fall nine years prior. She stated in response to the following question:

> Question: You subsequently went to the hospital for an operation to correct a defect in the lumbar spinal column or the lower part of your back?
>
> Answer: Nine years later, I guess.

Based on the above evidence the court found for Mrs. Marks, and found no intention on the part of the plaintiff to deceive or defraud, that there was no connection between the 1955 fall and treatment and the 1964 operation. The court further found the 1955 treatment and injury and the 1954 operation were not incidents that increased the hazard "for which defndant issued its policies." (R 10)

Judgment was rendered for respondent.

ARGUMENT

POINT I

THE TRIAL COURT ERRED IN NOT FINDING THAT PLAINTIFF DEFRAUDED THE DEFENDANT IN OBTAINING INSURANCE COVERAGE.

The appellant submits the trial court committed error in failing to determine that plaintiff obtained insurance coverage by material misrepresentation. In urging its position on appeal appellant is aware of the necessity of viewing the evidence in a light most favorable to the trial court's decision. Even so, appellant submits the evidence overwhelmingly demonstrates that respondent should have been denied recovery.

In *Castagno v. Occidental Life Insurance Co.*, 151 F. Supp. 781 (D.C. Utah 1957) Judge Christensen, applying Utah law in a similar case observed:

> Verdicts may not be permitted to rest upon mere conjecture and where proven facts give

equal support to each of two inconsistent inferences, judgment as a matter of law must go against the party having the burden of proof (citing case). There is a presumption of intent to deceive from the knowing concealment of material facts unless such presumption is overthrown by substantial evidence. *Zolintakis v. Equitable Life Assur. Soc. of United States*, 10 Cir., 1938, 97 F.2d 583, see also Id., 10 Cir., 108 F.2d 902. The burden is upon the plaintiff to prove lack of an intent to deceive on the part of the insured.

31-19-8, U.C.A., 1953 relating to representations in applications for insurance now reads:

> (1) All statements and descriptions in any application for an insurance policy or annuity contract, or for the reinstatement or renewal thereof, by or in behalf of the insured or annuitant, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless:
>
> (a) fraudulent; or
>
> (b) material either to the acceptance of the risk, or to the hazard assumed by the insurer; or
>
> (c) the insurer in good faith either would not have issued the policy or contract, or would not have issued, reinstated or renewed it at the same premium rate, or would not have issued, reinstated, or renewed a policy or contract in as large an amount, or would not have

provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise.

(2) If, in any action to rescind any policy or contract or to recover thereon, any misrepresentation with respect to a medical impairment is proved by the insurer, and the insured or any other person having or claiming a right under the contract shall prevent full disclosure and proof of the nature of the medical impairment, the misrepresentation shall be presumed to have been material.

Thus any material misrepresentation relating should be presumed to have been material. The requirement of fraud is similar to the same requirement existing under prior laws, *Laws of Utah 1947*, Ch. 63, Sec. 2; *Chadwick v. Ben. Life Ins. Co.*, 54 Utah 443, 181 Pac. 448. The present statute became effective July 1, 1963. Thus, the above section became effective subsequent to the issuance of the policies in question. The statute in effect before (*Laws of Utah 1947*, Ch. 63, Sec. 2) read:

(1) Except as provided in subsection (2), no oral or written misrepresentation or warranty made in the negotiation of an insurance contract, by the insured or in his behalf, shall be deemed material or defeat or avoid the contract or prevent it attaching, unless such misrepresentation or warranty is made with the intent to deceive.

> The insured shall have the burden of proof that such misrepresentation or warranty was not made with intent to deceive.
>
> (2) In any application for life or disability insurance made in writing by the insured, all statements therein made by the insured shall, in the absence of fraud, be deemed representations and not warranties. The falsity of any such statement shall not bar the right to recovery under the contract unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Appellant submits from a substantive point of view it is relatively immaterial which statute applies, but submits respondent still has the burden to prove lack of an intent to deceive.

The facts in this case show two applications for insurance. Both bear the purported signatures of Mrs. Marks. Although she testified she only signed one of the applications, the signatures rather appear to be of the same hand. Both applications indicated that the respondent had never suffered or sustained any back injury, or had any back trouble. The evidence clearly showed Mrs. Marks had a coccygectomy in 1954, sustained a severe fall in 1955, and had intermittent back pain subsequently. The failure to disclose this matter in the applications was obviously an intentional misrepresentation amounting to fraud. Although Mrs. Marks testified that she signed the application in blank,

the more probable truth is that there was a scheme between herself and her brother-in-law, Borofsky, not to disclose the prior problem. Mrs. Marks said she sent a letter to Borofsky, which was not produced at trial, in which she disclosed the prior operation. However, she did not testify that the letter disclosed the fall and treatment, nor the intermittent pain, nor finally the paralysis to her wrist as a result of the automobile accident in 1957. The latter failure to disclose also indicates an intent to deceive because of the negative markings in the appropriate area on the policy applications.

The affirmative evidence on the part of appellant showed a letter was sent to Mrs. Marks expressly directing her to fill out the applications, note medical histories, and return the applications with the doctor's statement. It is submitted the evidence before the trial court did not overcome the presumption of the intent to deceive nor sustain her burden of proof.

In *Castagno v. Occidental Life Ins. Co.*, supra, the court overturned a jury verdict for plaintiff. The case shows facts indistinguishable in principle from those of the instant case. The deceased had failed to properly disclose material health problems in an insurance application. There had been some disclosure to the selling agent but not to the physician (cit. p. 783). The court held this was insufficient to sustain the burden and granted a judgment notwithstanding the verdict.

In Appleman, *Insurance Law and Practice*, Vol. 1 Sec. 248 it is stated:

> The failure of the insured to fill in any blank demanding information as to medical attendance amounts to a positive statement that none have been rendered, and concealment of any treatments of consequence is held fraudulent.

And further, Sec. 254

> It has frequently happened that the applicant mentions certain treatments which have been rendered him but fails to include certain others, or that he gives the name of certain attending physicians but fails to give the names of others.
>
> In such event where the insured denies having received medical attention from other than certain named physicians, such a representation is usually deemed material to the risk, so as to avoid liability on the part of the insurer.

Appelman would seem to clearly support a conclusion that even if Mrs. Marks disclosed her operation the failure to disclose other medical problems would preclude recovery.

Further, Mrs. Marks can gain nothing by her claim that she signed one application in blank. In so doing she was aware of her aiding a non-disclosure and obviously intended the application to be filled in in any manner Borofsky felt proper. In

Theros v. Metropolitan Life Ins. Co., 17 Utah 2d 205, 407 P.2d 685 (1965) this court observed:

> Upon the record, and plaintiff does not contend otherwise, it appears that the answers contained in the application were untrue; they were material to the risk; the defendant believed and relied upon them; and the defendant, being deceived by them, would not have issued the policy had it known the truth — at least, not without a medical examination.

The appellant's contention was that the proper answers had been given by the insured but not properly recorded by the agent. The applicant had signed the policy. The court went on to observe:

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

fundamental contract law. While courts generally are inclined to treat insurance contracts as special and do not always vigorously apply all the principles of contract law, that tendency should not be allowed to overrun the bounds of legitimate exception.

The facts here presented provide absolutely no basis for applying any exception to the basic contract law. The record is devoid of any facts or circumstances that would indicate or imply that Theros was by fraud, accident, misrepresentation, imposition, illiteracy, artifice or device reasonably prevented from reading the application before signing it. Therefore, he is, by law, conclusively presumed to have read the application and his beneficiary is bound by the contents thereof. It therefore follows that the lower court should be affirmed.

Apart from the trial court's memorandum decision rejecting the application of the above case, the logic of the case seems controlling and decisive of this appeal.

The case of *Wootton v. Combined Ins. Co. of America*, 16 Utah 2d 52, 395 P.2d 724 (1964) found controlling by the trial court is not precedent to sustain the trial court's award. In that case the answers on the application were not directly false as they are in the instant case. A direct disclosure of the full condition of deceased was made, not so in this case. The only issue in Wootton was intent, and the court observed:

The failure of respondent to volunteer the information that her husband had re-

> signed his job in July because with the added work his weak leg was being adversely affected cannot reasonably be considered as sufficient evidence upon which to base a finding of intent to defraud. Appellant had sufficient knowledge of the physical disability of respondent's husband to ascertain all the facts it needed as to its extent, if it had deemed it important, by either asking further questions or conducting an investigation; and it cannot blind itself from ascertaining the truth and then claim wilful misrepresentation of the truth on which it relied in order to avoid payment under a policy. This would appear to be especially applicable in the instant case where the accidental death of respondent's husband was not in any way related to his physical defect.

A reading of the case discloses its inapplicability to the instant appeal. The *Wootton* case is similar to *New York Life Ins. v. Grow*, 103 Utah, 285, 135 P.2d 130 (1943) where this court sustained a jury's verdict for the insured, finding the answers in the application ambiguous and, therefore, capable of being found not to have been made with an intent to deceive. In this case the answers were unambiguous and false.

In *Zolintakis v. Equitable Life Assur.*, 97 F.2d 583 (10th Cir. 1938), the court had a life insurance claim, which required the application of Utah law. The court said:

> A misrepresentation will not constitute a defense to an action on a policy of insur-

ance unless it was intentionally untrue or made with a reckless disregard for its truth or falsity. Where an insured knowingly makes a material misrepresentation, proof of an actual, conscious purpose to deceive is not necessary.

This language was approved by the Utah Supreme Court in the *Grow* case. In the subsequent *Zolintakis v. Equitable Life Asur.* case, 108 F.2d 902 (10th Cir. 1940), the 10th Cir. approved the following language from the second *Chadwick* case, 56 Utah 480, 191 Pac. 240:

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

The second *Zolintakis* case then concludes:

> By this decision Utah is committed to the liberal doctrine that before misrepresentations of material facts will void a policy of insurance it must be established that they were not only knowingly made but also wilfully and intentionally, with intent to deceive and defraud.
>
> * * *

The court then goes on to explain:

> One cannot knowingly conceal or misrepresent facts which one knows would in-

fluence the risk or the issuance of the policy, and then be heard to say that he did not intend to deceive or defraud.

The above cases support judgment for the appellant since respondent lent herself to at least a constructive misrepresentation and did so intentionally.

The trial court's finding that if there was any failure to disclose it did not increase the hazard is equally erroneous. First, the only testimony on the issue, except an objectionable opinion from Mrs. Mars, was Mr. Magoon's testimony that back problems are "red flag." Second, the finding is immaterial since that issue was of no consequence under the law in existence at the time the policies were issued. Finally, 31-19-8, U.C.A., 1953 presumes a failure to disclose medical information in policies like those in question is material. Consequently, the court's findings do not sustain the judgment. This court should reverse.

POINT II

THE TRIAL COURT ERRED IN NOT FINDING THAT MRS. MARKS' MEDICAL PROBLEM COMMENCED PRIOR TO THIRTY DAYS FROM THE EFFECTIVE DATE OF THE POLICY.

The two policies issued by the appellant to Mrs. Marks both contained provisions to the effect that no sickness or injury was covered which commenced prior to thirty days after the policy had

been in force (Exh. P-1, P-2). Consequently, if Mrs. Marks was operated on for a condition that had its inception prior to the 30 day period subsequent to the effective date of the policy, the defendant should have prevailed.

Appellant realizes that in appraising the evidence on appeal it must be viewed in a light most favorable to the jury's verdict. Appellant submits, however, that even when the evidence is so examined there is no reasonable basis for the judgment in favor of the respondent.

The effective date of the policies was May 27, 1963. It was undisputed that respondent underwent a coccygectomy in 1954. It was equally undisputed that Mrs. Marks sustained a "severe fall" in 1955 and sought orthopedic assistance. Medical records of the treating physicians showed low back pain radiating into both legs. Sensitivity was noticed in the lumbosacral region and the sacrum. Diagnosis on the last visit in 1955 was of for "consideration of excision of protruded intervertebral disc and a fusion." Mrs. Marks never went back for further treatment. On admittance to the hospital for the operation giving rise to the instant case, she advised the intern who took her history that nine years prior she had a severe fall landing on her buttocks. The intern noted, "Since that time she has intermittent low back pain, sometimes so severe she cannot get out of bed." The correctness of the in-

formation given the intern was verified at trial except she denied she hadn't been able to get out of bed for 4½ months before the operation. (R. 42).

On redirect examination by her attorney she said she had no pain in her back after 1957. She also testified that the location of the pain was in the area of where the coccyx had been (R. 55).

Dr. Lamb gave his opinion as follows:

> If I might stipulate a little further, that in view of the fact that she stated that she had had continued symptoms since that time, there would possibly, probably be a connection between that and her present condition insofar as her symptoms had been recurrent intermittently since then.

Dr. Lamb also testified that the operation showed a degenerated fibrocartilage condition (L 8).

It is submitted on the basis of this evidence the standard of probability set out in *Moore v. D. & R. G. W. R. R. Co.*, 4 Utah 2d 255, 292 P.2d 849 (1956), the only believable evidence and the only expert, scientific evidence offered showed the operation was performed as a result of a pre-existing condition. The history given to the intern is much more objective evidence of Mrs. Marks' true condition than her testimony at trial. It is interesting to note how clearly that evidence coincides with the traditional degenerative disc condition. In Haynes,

The Diagnosis of Disc Injuries, 1 Lawyers Medical Journal 1, 5 (1965) it is observed:

> The history given by the patient with a suspected protruded intervertebral lumbar disc is one of the more important factors in determining the accuracy of a diagnosis of disc injury.
>
> Usually, there has been a rather mild or minimal injury. This injury need not be confined to the spine itself. It can be no more violent than stepping off a curb, a mistimed golf swing, the picking up of a light or heavy object, or a fit of coughing. There is, however, usually a fairly long history prior to the patient seeing the neurosurgeon of, at least, *intermittent* low back ache with many episodes of low back pain with or without radiation of pain down either leg. Usually the preliminary history of low back pain is not diagnostic of anything beyond the fact that there are occasional bouts of muscle spasm and usually without radiation.

It is of course recognized that there is normally no absolute obligation on the part of the court or jury to accept as conclusive the testimony of an expert. However, in the instant case the expert testimony is direct and corroborated by other objective evidence, some coming from the respondent herself. Additionally, the respondent's testimony first support appellant's position then on redirect examination it was changed. Her testimony was inconsistent, thus undermining its relative value. This in the face of strong counter evidence of experts, independent-

ly corroborated, discloses the trial court erred in reaching the conclusion it did. Finally, respondent's unguarded statement at a point when the trial had not directly focused on the issue, that the operation was the result of an accident nine years before requires finding that the "back" condition for which respondent underwent surgery in April of 1964, predated the effective period of policy coverage.

CONCLUSION

The facts of the instant case show that respondent was not entitled to judgment. The policies under which Mrs. Marks sought to sustain her right to recover against appellant were obtained under fraudulent circumstances, and respondent did not sustain her burden to the contrary. Finally, the evidence relating to a pre-existing condition overwhelmingly supports the conclusion that Mrs. Marks' condition existed prior to the inception of the policies and, therefore, was excluded from their coverage. The judgment should be reversed.

Respectfully submitted,

HANSON & BALDWIN and
REX J. HANSON
Attorneys for Appellant
909 Kearns Building
Salt Lake City, Utah