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Cheryl Hardy v. The Prudential Insurance Company of America : Brief of Appellant

Utah Supreme Court

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20582

IN THE SUPREME COURT OF THE STATE OF UTAH

CHERYL HARDY, Plaintiff-Appellant, vs. THE PRUDENTIAL INSURANCE COMPANY OF AMERICA; WAYNE L. RIGBY, Insurance Agent, Defendants-Respondents.	:	Docket No. 20582

BRIEF OF APPELLANT

Appeal from a Judgment of the Third
Judicial District Court of Salt Lake County,
Judge Dean E. Conder

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vs.	:	
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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes and Rules

Other Authorities

STATEMENT OF ISSUES PRESENTED ON APPEAL

I. Are there genuine issues of material fact precluding summary judgment on the basis of misrepresentation in the insurance application?

A. Misrepresentation: 1. Did Lynn Hardy inform Prudential's agent of his 1974 heart attack? 2. Did Prudential's agent represent to Lynn Hardy that the old heart attack need not be disclosed in the application?

B. Intent to Deceive: Did Lynn Hardy intend to deceive Prudential?

C. Materiality: 1. Was the omitted information material to Prudential's risk? 2. Does Prudential's rule of disregarding medical history beyond five years old render the omitted history immaterial? 3. Does Prudential's waiver of a rating on the disclosed information render immaterial the omitted information?

D. Reasonable Reliance: Did Prudential rely on the omission and was that reliance reasonable?

II. Was Prudential on "inquiry notice" so as to equitably estop it from asserting the defense of misrepresentation?

A. Was Prudential on notice to conduct a further inquiry?

B. Did Prudential conduct a reasonably thorough inquiry prior to issuing the policy?

III. Did the trial court err in granting rescission on the basis of claimed misrepresentations outside of the insurance application?

IV. Is Prudential precluded from obtaining rescission by its own discriminatory and bad faith handling of the claim and by the inequitable result that rescission would produce?

A. Did Prudential unfairly discriminate against Mrs. Hardy in denying the insurance proceeds in violation of the Utah Insurance Code?

B. Did Prudential violate its duty of good faith and fair dealing in handling Mrs. Hardy's claim?

STATEMENT OF THE CASE

This is an action to recover the proceeds due under a life insurance policy issued by the Prudential Insurance Company of America on Lynn Hardy, the plaintiff's deceased husband. Prudential counterclaimed for rescission of the policy on the basis of misrepresentation in the insurance application. Third District Judge Dean E. Conder granted defendants' motion for summary judgment rescinding the policy. (Record pp. 1041-43; Addendum pp. 1-3.) Plaintiff filed a motion to reconsider under Rule 60(b), U.R.C.P., on the grounds of material misrepresentation of facts by opposing counsel. The court reexamined the file and reaffirmed its prior decision. (Rec. p. 1146.)

STATEMENT OF FACTS

A. Application and Underwriting

Lynn Hardy was a truckdriver by vocation. In 1977 he married the plaintiff, Cheryl Hardy, and together they started their own trucking business. They built the business up over time until they had acquired on contract five trucks and eight trailers. (Hardy Dep. pp. 5-7.) About that time, Prudential's agent, defendant Wayne Rigby, contacted the Hardys and interested them in some mortgage life insurance on Lynn to cover the debt on the trucking business if he died. (Frankel Dep., Ex. 1, hereinafter referred to as FDE-1, p. 142; Hardy Dep. pp. 35-36, 38-39; Rigby Dep. pp. 36-37.)

Agent Rigby brought a life insurance application form to the Hardy home on August 4, 1981. Rigby completed the answers to Part 1 of the form as Lynn responded to the written questions. (Hardy Dep. pp. 41, 43-44.) The amount of coverage applied for, based on the approximate amount of the business debts, was $300,000. The named beneficiary was Lynn's wife, Cheryl, and Lynn was to pay the monthly premium of $161.65. (FDE-1 pp. 81-82, Add. pp. 4-7.) During the completion of Part 1, Lynn told Agent Rigby that he had a heart attack in 1974, seven years earlier. (Hardy Dep. pp. 47-48, 60, 62, 73, 128.)[1] Rigby responded that the heart attack would not affect issuance of the policy and that the information need not be included in the application because Prudential disregards medical history beyond five years old. (Hardy Dep. pp. 63, 48-49, 59-63, 65-66, 71-73; see also Aff'ts of Jan Hardy and Mark Ith, Rec. pp. 1012-15, Add. pp. 30-33.)

Part 2 of the application consisted of questions regarding medical history and a physical examination. Agent Rigby arranged for Part 2 to be completed by Launa Perry (now Noble), a paramedic, on August 7, 1981. In reliance upon Agent Rigby's assurance that the old heart attack need not be listed in the application, Lynn did

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[1]On January 5, 1974, Lynn suffered a sudden inferior wall myocardial infarction, (FDE-1 pp. 59-60, 68), which is an insufficiency of circulation to the inferior wall of the middle layer of the heart muscle. Stedman's Medical Dictionary pp. 630-31, 820 (3d Lawyers' Ed. 1972).

not disclose the heart attack to Ms. Perry. However, Lynn did disclose that his father and two brothers had died prematurely from heart attacks, that he smoked cigarettes, and that he had received a Department of Transportation physical from Dr. G.W. Taylor in 1979. Ms. Perry's physical examination consisted of little more than an electrocardiogram (ECG). She did not complete the sections of the exam pertaining to cardiovascular and circulatory condition. Lynn signed the Part 2, authorizing Prudential to obtain his medical records from any physician listed. (Hardy Dep., Ex. C, Add. pp. 8-9.)

Prudential's underwriting department in California received Lynn's application on August 11 and was required to make a final determination by October 5, sixty days from the application. (FDE-1 pp. 207A, 225, 284.) As part of its routine underwriting review, Prudential requested a background and financial inspection by Equifax Services, an independent information service, and an attending physician's statement (APS) from Dr. Taylor, who was listed on the Part 2. (FDE-1 pp. 207, 214; see also Wiczek Dep. pp. 6-7; Reed Dep. pp. 51-55 and Ex. 6.) The Equifax report confirmed Lynn's two-pack-per-day smoking habit; disclosed the name of another attending physician, Dr. Peterson; and revealed that another of Lynn's brothers, still living, also had "heart problems." (FDE-1 pp. 208-10, Add. pp. 34-36.) The APS from Dr. Taylor revealed no cardiovascular information. (FDE-1 p. 215.) Meanwhile, the underwriting department received the result of the ECG performed by

Ms. Perry, showing a first-degree atrioventricular (AV) heart block.[2] (FDE-1 p. 211, Add. p. 37.)

On August 14 the underwriting department discovered that Part 2 of Lynn's application had mistakenly been completed by a paramedic rather than by a physician, as required by the policy amount. (Rec. p. 82; Reed Dep. p. 56 and Ex. 7; FDE-1 p. 283.) As a result, a second Part 2 was completed by Dr. Joseph R. Evans on August 25. Reference to Lynn's prior heart problem was omitted in continuing reliance on Agent Rigby's prior instruction that it need not be listed. However, Lynn confirmed that he had smoked for 20 years and disclosed the additional information that he had rheumatic fever as a child; that he received a Department of Transportation physical every two years, including a recent exam by Dr. Jay Capener; and that he had previously been treated by Dr. Val Sundwall at Cottonwood Hospital, the same physician and hospital that treated Lynn for his 1974 heart attack. (See Rec. p. 1059, Add. p. 38.) Dr. Evans' physical examination of Lynn reported no current cardio-vascular disorder. Lynn also signed this Part 2, again authorizing Prudential to obtain his medical records from any of the named sources. (Hardy Dep., Ex. D, Add. pp. 10-11.)

Based on Lynn's medical information, his heart block and family history of heart disorders in particular, underwriter Tom

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[2]Obstruction causing impairment or prolongation of normal conduction time (P-R interval) between atria and ventricles of the heart. Stedman's Medical Dictionary p. 162 (3d Lawyers' Ed. 1972).

Shaw recommended issuing the policy with a special class 1 rating to account for the higher risk.[3] (FDE-1 p. 217, Add. p. 39.) However, Prudential's medical department waived the rating, stating that Lynn was "standard physically." (Id.) Shaw's supervisor, Marilyn Reed, then discovered that another mistake had been made. According to underwriting rules governing applications with three known cases of early coronary death, Shaw should have requested Dr. Evans to obtain a chest X-ray at the time he completed the Part 2 on Lynn. (FDE-1 p. 218, Add. p. 40; Reed Dep. p. 66 and Ex. 5, p. VII-1.) A chest X-ray was then ordered, but before the result was received on October 7, the deadline for final action had passed and no further underwriting investigation was undertaken. (FDE-1 pp. 285, 223, 225, 290.) Notice that the policy had been approved standard was mailed the next day, but the policy was back-dated to take effect as of September 17, 1981. (FDE-1 p. 286, Add. p. 41; Id. p. 229, Add. p. 12.)

B. Review and Denial of Claim

Lynn Hardy died suddenly and unexpectedly of a myocardial infarction on December 4, 1982, fourteen months after the policy was issued, and within the two-year contestability period. (FDE-1 p.

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[3] A policy may be issued "standard," if the insured has no ratable physical impairment, or "rated," according to the degree of physical impairments. A special class rating is determined by assigning "debits" for each impairment, totaling the debits, and then classifying the policy according to the corresponding debit total in the given table. A rated policy requires charging a correspondingly higher premium. (See Reed Dep., Ex. 5.)

204; Add. p. 17.) Lynn's widow and beneficiary, Cheryl, submitted her "Claim for Insurance Contract Benefits" on December 15. (FDE-1 p. 200.) Prudential's claims department immediately sent Lynn's file to its home office investigator, Richard Stelzner, requesting him to conduct a "contestable investigation." (Id. pp. 188-89; Stelzner Dep. pp. 21-22.) Stelzner reviewed Lynn's application for medical leads and conducted his investigation on January 6, 1983. (FDE-1 p. 140, Add. p. 42.) He confirmed with Mrs. Hardy that Lynn's physician was Dr. Val Sundwall. Stelzner then visited Dr. Sundwall's office and obtained a lead to the University Medical Center. At the University Medical Center, Mr. Stelzner obtained the records of Lynn's 1974 post-heart attack tests and a lead to the Cottonwood Hospital. At the Cottonwood Hospital, Stelzner obtained the records of Lynn's 1974 heart attack. (Add. pp. 42-45.)

Following Stelzner's report of Lynn's 1974 heart attack, Prudential's claims department deliberated for the next month and a half over whether they could deny the claim despite their rule to disregard medical history beyond five years prior to the application. (See Frankel Dep., Ex. 2, p. 9, Add. p. 46; FDE-1 p. 123-24, Add. pp. 47-48.) The question was finally referred to Prudential's corporate headquarters in New Jersey, and senior claim consultant Jan Drosendahl (LeRoux) ruled that an exception to the five-year rule should be made in this case. (FDE-1 pp. 117-18, Add. pp. 49-50.) Ms. Drosendahl also acknowledged the rule of law that bars rescission for misrepresentation if the insurer was "on notice" to conduct an inquiry that would have revealed the truth. She conceded that "the underwriters were concerned about Mr. Hardy's cardiovascular status," but claimed that they "thoroughly investigated all given possible leads to information." Therefore, she concluded that the claim should be denied for nondisclosure of the 1974 heart attack. (Id.) The claim was formally denied for that reason, and Mrs. Hardy was informed of the denial on February 22, 1983, over two months after the claim was submitted. (FDE-1 pp. 116, 113-14; Rigby Dep. pp. 47-48; FDE-1 p. 102.)

C. Facts Subsequent to Denial of Claim

Following Prudential's denial of the claim, Mrs. Hardy filed a written complaint with the Utah Insurance Department. (FDE-1 p. 76, Add. p. 51.) The Insurance Department reviewed the matter and concluded that Prudential should reconsider its decision for possible error:

> It appears an error may have occurred in the underwriting department . . . . If [the application] questions had been reviewed more thoroughly the policy may not have been issued; but the policy was issued and the insured and beneficiary believed they would be protected if a loss did occur.

(FDE-1 p. 75, Add. p. 52, emphasis added.) The Insurance Department requested that Prudential perform an "independent review" of the claim, but Prudential's Vice President and Counsel, Ernest A. Long, responded by sending a copy of his "informal analysis," previously sent to plaintiff's counsel. (Long Dep., Ex. 2.) The Insurance Department took no further action.

Mrs. Hardy subsequently filed this action against Prudential and Agent Rigby alleging (1) breach of the insurance contract, resulting in denial of the policy proceeds and loss of the

Hardy trucking business; (2) bad faith denial of the insurance claim, justifying an award of consequential damages for emotional suffering, punitive damages and attorney fees; and (3) intentional infliction of emotional distress. (Rec. pp. 613-17.) Defendants answered, (Rec. pp. 627-32), and Prudential counterclaimed for rescission of the policy, alleging fraudulent concealment of Lynn's prior heart problem, (Rec. pp. 44-46). Mrs. Hardy filed a Reply denying misrepresentation and alleging (1) that Lynn's prior heart problem was disclosed to Agent Rigby and omitted from the application at his suggestion; and (2) that Prudential is equitably estopped from asserting the misrepresentation defense because it was on notice to conduct an inquiry that reasonably would have revealed the omitted history and it failed to conduct such an inquiry. (Rec. pp. 619-21.)

Defendants moved for summary judgment. (Rec. pp. 472, 664.) Plaintiff opposed the motion, detailing and documenting several material factual issues, including whether Prudential's agent was informed of the prior heart problem. (Rec. pp. 992-1015.) Plaintiff also filed a cross-motion for summary judgment on the counterclaim for rescission on the alternative ground that even if there were a misrepresentation, it was not sufficiently material to justify rescission of the contract because Prudential conceded it still would have issued the policy, but at a higher premium. (Rec. pp. 975-87.)

The trial court granted defendants' motion for summary judgment and rescinded the policy. The court found that Lynn <u>and</u>

Cheryl failed to disclose the prior heart attack and supposed medication and treatment for heart disease. (Rec. pp. 1041-43, Add pp. 1-3.) Plaintiff moved for reconsideration under Rule 60(b), U.R.C.P., on the grounds that defendants' counsel misrepresented, and the court mistakenly relied on, the supposed facts of follow-up medication and treatment. (Rec. pp. 1046-88.) Plaintiff obtained the affidavit of Dr. Joseph L. Thorne to prove that Lynn's condition was in remission and asymptomatic in the years following the heart attack and that Lynn was not taking heart medication or being treated for heart disease. (Rec. pp. 1068-70, Add. pp. 53-55.) The court reexamined the matter but reaffirmed its prior decision of summary judgment. (Rec. p. 1146.)

SUMMARY OF ARGUMENT

In reviewing this summary judgment, this Court must view all evidence in a light favorable to the plaintiff, resolve all doubts in favor of the plaintiff, and reverse the judgment if there is any evidence from which a jury could possibly find the issues in favor of the plaintiff or against the defendants.

In this case, there are several issues of material fact precluding judgment as a matter of law. In essence, the plaintiff argues that: (1) the medical history omitted from the application was disclosed to the agent and imputed to Prudential; (2) the agent directed the insured to omit that information from the application and the insured was justified in relying on that direction; (3) the agent's explanation for omitting the information was that Prudential disregards medical history beyond five years old; moreover, Prudential does have and apply such a rule; (4) the insured did not intend to deceive Prudential, as evidenced by what he disclosed to the agent and on the application, and by his sincere belief that he was in good health; (5) the omissions were not material to Prudential's risk, as evidenced by the five-year rule, Prudential's waiver of a rating on the information it did have, and the fact that the policy still would have been issued; (6) Prudential is estopped to rely on the claimed omissions and to assert the defense of misrepresentation because it was "on notice" to conduct a further inquiry by checking available medical records and it failed to do so; (7) Prudential may not void the policy on the basis of statements made outside the application; and (8) Prudential is precluded from obtaining rescission by its discriminatory and bad faith handling of the claim and by the inequitable result that rescission would produce.

On each of these arguments there is evidence from which a jury could reasonably find for the plaintiff and against the defendants. Therefore, it was reversible error for the trial court to weigh the evidence, judge credibility, and decide these issues without a trial.

ARGUMENT

POINT I: THE TRIAL COURT ERRED BY GRANTING SUMMARY JUDGMENT IN THE FACE OF MATERIAL ISSUES OF FACT ON EACH ELEMENT OF THE MISREPRESENTATION DEFENSE.

Summary judgment may be granted only if the pleadings, depositions, affidavits and other documents show clearly that there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. Rule 56(c), U.R.C.P.[4]

In order to avoid liability under an insurance policy on the grounds of misrepresentation, the insurer must prove that (1) there was a misrepresentation of fact; (2) the misrepresentation was made with intent to deceive; (3) the fact misrepresented was material; and (4) the insurer reasonably relied upon the misrepresentation in issuing the policy. Utah Code Ann. §31-19-8(1)(1953); Moore v. Prudential Insurance Co. of America, 26 Utah 2d 430, 491 P.2d 227, 230 (1971). Each of these elements of Prudential's defense constitutes a separate question of material fact for the jury. See, e.g., Major Oil Corp. v. Equitable Life Assurance

[4]In reviewing a summary judgment, this Court must evaluate all the evidence and all reasonable inferences fairly drawn therefrom in a light most favorable to the losing party. E.g., Bowen v. Riverton City, 656 P.2d 434 (Utah 1982). All doubts or uncertainty as to the correctness of summary judgment must be resolved in favor of permitting the issues to go to trial. E.g., Butler v. Sports Haven International, 563 P.2d 1245 (Utah 1977). Summary judgment may be affirmed only if it appears to a certainty that the plaintiff in this case would not be entitled to relief under any state of facts which could be proved in support of her claims. See, e.g., Securities Credit Corp. v. Willey, 1 Utah 2d 254, 265 P.2d 422 (1953). If reasonable men could differ on the evidence in this case and could reasonably find for the plaintiff, summary judgment must be reversed. E.g., Jackson v. Dabney, 645 P.2d 613 (Utah 1982); Cardwell v. United States, 186 F.2d 382, 385 (5th Cir. 1951). It is not for the trial judge on motion for summary judgment to weigh evidence, judge credibility, and resolve factual disputes. The sole inquiry is whether a material factual issue exists, and if the trial judge went beyond that inquiry the summary judgment cannot stand. E.g., W.M. Barnes Co. v. Sohio Natural Resources Co., 627 P.2d 56 (Utah 1981).

Society, 457 F.2d 596 (10th Cir. 1972) (applying Utah law); Burnham v. Bankers Life & Casualty Co., 24 Utah 2d 277, 470 P.2d 261 (1970); Lester v. Sparks, 583 P.2d 1097, 1100-01 (Okla. 1978); 12A Appleman, Insurance Law and Practice §7297 (1981). When any one of these issues is disputed, summary judgment is inappropriate. Moreover, Prudential must establish each element of its defense not by a mere preponderance of the evidence, but by "clear and convincing" evidence. See Utah State Dept. of Social Services v. Pierren, 619 P.2d 1380, 1381-82 (Utah 1980); Pace v. Parrish, 122 Utah 141, 247 P.2d 273, 274 (1952); Ostrov v. Metropolitan Life Insurance Co., 379 F.2d 829, 838 (3rd Cir. 1967). Therefore, if a jury examining these issues could possibly find for the plaintiff, or find that the evidence of fraud is anything less than clear and convincing, the summary judgment must be reversed.

Applying the principles of appellate review to the elements of claimed misrepresentation in this case, it is evident that summary judgment was erroneous and must be reversed.

A. Misrepresentation

Prudential initially denied Mrs. Hardy's insurance claim for the stated reason that Lynn failed to disclose his 1974 heart attack on Part 2 of the application. (FDE-1 pp. 117-18, Add. pp. 49-50; FDE-1 pp. 116, 125, 187, 140-43, Add. pp. 42-45; FDE-1 pp. 113-14; Rigby Dep. pp. 47-48; FDE-1 pp. 102-03.) When it became apparent, after commencement of the litigation, that the plaintiff was prepared to dispute that claim, Prudential came up with the additional allegation that Lynn also failed to disclose follow-up medication and treatment for his heart problem. While this belated claim will be demonstrated to be immaterial and inaccurate, both claimed misrepresentations are addressed together.

While Lynn did not disclose his 1974 heart problem on the application, he and Cheryl <u>did</u> disclose it to Agent Rigby at the time of the application. Cheryl Hardy testified:

Q. Okay. At some point you and Mr. Rigby discussed Lynn's prior medical history?

A. Yes. There were a couple of different days involved. I can't remember which one it was, but it was why [sic] part of the application was being filled out.

Q. Where was this discussion held?

A. In the kitchen at my house.

Q. Mr. Rigby was there? Who else was there?

A. Mr. Rigby, Lynn and I and I keep thinking somebody else was there. I can't put my finger on who it was.

Q. Tell me about that discussion.

A. <u>I know that Lynn told him that he had a heart attack in 1974.</u>

Q. Okay.

A. <u>I told Mr. Rigby that he had some kind of clogged valve or something just below the heart.</u>

(Hardy Dep. pp. 47-48, emphasis added; <u>see also</u> pp. 60, 62, 73, 128.)

Agent Rigby's response was that this medical history would be no problem and need not be disclosed in the application because Prudential disregards medical history more than five years old. Mrs. Hardy testified:

Q. What did Mr. Rigby tell you about the application about how far back it went?

A. In essense, we only went back five years on the application. [Hardy Dep. p. 49.]

A. I do know that we discussed going back five years . . . . [Id. p. 59.]

Q. Do you remember him [Rigby] saying to Lynn in substance or effect that he did not have to report his heart attack on Exhibit C [Part 2]?

A. I would have to basically say, yes. [Id. p. 63.]

(See also id. pp. 65-66, 71-73.) The testimony of others present on that occasion corroborates these facts. Jan Hardy, a daughter-in-law, and Mark Ith, Cheryl's son and Lynn's step son, both were present in the Hardy home and heard Lynn tell Agent Rigby of his prior heart attack. Both also remember Rigby responding that it did not matter because medical history more than five years old was not required in the application. (Aff'ts of Jan Hardy and Mark Ith, Rec. pp. 1012-15, Add. pp. 30-33.)

Agent Rigby's instruction not to record the old heart attack in the application is corroborated by the fact that Prudential does have such a five-year rule. Corporate Claim Memorandum 76-40 (June 3, 1976) states the rule as follows:

> Even though an insured omitted information from the application, common knowledge or a review of the Underwriting Manual may disclose that the information would not have had underwriting significance. The file should be noted to reflect this unless the information relates to treatment so old or a condition so minor that it would obviously be of no significance. Question 9 on our application . . . is limited to treatment, tests, etc. within five years of the application date. Although the other questions on the application do not have any time limitation, it has been our practice to disregard treatment more than five years old.

(Frankel Dep., Ex. 2, p. 9, Add. p. 46, emphasis added. See also FDE-1 pp. 123-24, 117-18, Add. pp. 47-50.) This rule was current and applicable to the Lynn Hardy case, and the claims manual contained no provision for qualifications or exceptions to the rule. Claim consultant Mary Burke testified:

> Q. . . . Do you know of the existence of any guideline which sets forth the proposition that you should make exceptions in certain areas with reference to this five-year practice? [Question restated.]
>
> A. Not that I'm aware of. The only memorandum I'm aware of is the Exhibit 2 [Claim Memorandum 76-40].

(Burke Dep. p. 18; see also Frankel Dep. pp. 10-12, 15-16; LeRoux Dep. pp. 119-21.)

Thus, the record contains three sworn statements that Lynn Hardy did disclose his prior heart problem to Agent Rigby, and the law is clear that disclosure of information to an agent of the insurer constitutes disclosure to the insurer, whether the information is actually communicated to the insurer or not. E.g., Major Oil Corp. v. Equitable Life Assurance Society, 457 F.2d 596, 603 (10th Cir. 1972) (Utah law); Wootton v. Combined Insurance Co. of America, 16 Utah 2d 52, 395 P.2d 724 (1964); Lumbermens Mutual Insurance Co. v. Bowman, 313 F.2d 381, 388 (10th Cir. 1963); National Life Assurance Co. v. Neves, 370 S.W.2d 144, 146 (Tex. Civ. App. 1963) (agent's knowledge is imputed to his company); Johnson v. Life Insurance Co. of Georgia, 52 So.2d 813, 815 (Fla. 1951). The underlying rationale for this rule is that the potential insured may "reasonably assume" that the agent will perform his duty to report all relevant information to the officers of the insurer responsible for approving the policy. See 16C Appleman, Insurance Law and Practice §§9101, 9104; 3 Couch on Insurance 2d §§26:132-133.

Prudential's own claims manual acknowledges that disclosure to an agent is treated as disclosure to the insurer:

> [T]he courts ... generally impute any knowledge of the agent to the Company under the law of Agency, which holds that knowledge of an agent is knowledge of the principal.

(Corp. Claim Memo. 76-40 p. 18, Frankel Dep., Ex. 2.) Moreover Prudential has followed this rule in other similar cases. In the Emma Harris case, Claim No. N0D815009, Prudential paid the claim despite material misrepresentation in the application because its agent was told of the omitted information:

> Based on the agent's knowledge of the insured's kidney disease, which legally can be imputed to the Company, would suggest making payment of death benefits to [beneficiary]. Agent's knowledge would seem to estop us from claiming reliance on a material misrepresentation. [Add. p. 77, emphasis added.]

Likewise, in the Barbara Sullivan case, Claim No. N0D89484, Prudential's claim department concluded:

> Because it is apparent that Agent Painter ... was also cognizant (and had been for some time) of the insured's poor health at the time he took the applications, we have dropped our misrepresentation action and are accepting full death claim liability of $47,000. [Add. p. 78, emphasis added.]

Thus, the rule of imputing an agent's knowledge to the insurer is widely acknowledged and applied, even by Prudential.

Having disclosed his prior heart problem to Agent Rigby, Lynn was justified in relying on Rigby's representation that Lynn need not disclose the problem again to the medical examiners who completed the Part 2's:

> An insured is usually justified in relying upon the advice and assistance of a soliciting agent in preparing his application . . . .

17 Appleman, Insurance Law and Practice §9410. For example, in Central National Life Insurance Co. v. Peterson, 23 Ariz. App. 4, 529 P.2d 1213 (1975), the insured told the insurance agent of a prior hospitalization, but, as in the present case, the agent told the insured that it need not be included in the application because it "was not necessary to go back any further than five years." Id., 529 P.2d at 1215. The court held that the insurer was bound by its agent's representation as to the scope of the application and was barred from rescinding the policy for omission of the undisclosed hospitalization. Id. at 1215-16. See also Lazar v. Metropolitan Life Insurance Co., 290 F. Supp 179, 181 (D. Conn. 1968) (insurer bound by agent's explanation that certain medical history was not required by application); Howard v. Golden State Mutual Life Insurance Co., 60 Mich. App. 469, 231 N.W.2d 655 (1975).

Thus, based on the foregoing facts and law, it is apparent that there was no misrepresentation regarding Lynn's prior heart problem. Based on the evidence in the record, a jury could reasonably find that Lynn did disclose the heart attack to Prudential, through Agent Rigby. Therefore, it was clear error for the trial court to conclude that Lynn never disclosed the heart attack to Prudential "nor anyone else acting on behalf of Prudential." (Add. p. 2, Finding #5.) Whether Lynn disclosed the heart problem is clearly a material factual issue, and the trial court erred by weighing the evidence, judging credibility, and resolving that issue without trial.

B. Intent to Deceive

The law is clear that to support a misrepresentation defense the insurer must show that the omissions in the application were made with the "intent to deceive" the insurer. In Wootton v. Combined Insurance Co. of America, 16 Utah 2d 52, 395 P.2d 724 (1964), this Court stated:

> Unless the misrepresentations in the negotiation for an insurance policy are made with the intent to deceive ... the insurance contract cannot be avoided by an insurance company. Mere falsity of answers to questions propounded are insufficient if not knowingly made with intent to deceive and defraud.

Id., 395 P.2d at 725. See also Marks v. Continental Casualty Co., 19 Utah 2d 119, 427 P.2d 387, 389 (1967); Cardwell v. United States, 186 F.2d 382, 385 (5th Cir. 1951); 22 Appleman, Insurance Law and Practice §§13028, 13030. Moreover, the question of an insured's intent is a factual issue for the jury. Burnham v. Bankers Life & Casualty Co., 24 Utah 2d 277, 470 P.2d 261, 263 (1970) (reversing summary judgment for insurer).

In this case a jury could reasonably find that Lynn Hardy did not intend to deceive Prudential concerning the fact of his heart problem. To the contrary, the evidence shows that Lynn and Cheryl volunteered to Agent Rigby the information of the prior heart attack and occluded artery. Under similar facts in Wootton, supra, this Court held that omission of certain information from the application did not evidence an intent to deceive because the omitted information was disclosed to the agent. 395 P.2d at 726. See also Prudential Insurance Co. of America v. Willsey, 214 F.2d 729, 732 (10th Cir. 1954) (Utah law); Roy v. Trans-World Life Insurance Co., 199 So. 2d 416, 418 (La. App. 1967). Thus, a jury could reasonably make a similar finding in this case. Moreover, it was Agent Rigby who instructed Lynn not to include that information in the application because it occurred more than five years previously. Lynn's good faith reliance upon that instruction cannot be viewed as "intent to deceive." See Central National Life Insurance Co. v. Peterson and Lazar v. Metropolitan Life Insurance Co., supra.

The information Lynn did disclose on the application is also inconsistent with an intent to deceive. He freely disclosed information that would draw his health into question, such as his extensive family history of heart disease, his childhood rheumatic fever, and his heavy smoking habit, and also revealed the names of several doctors and a hospital where Prudential could go for further information. He also willingly submitted to two physical examinations, an ECG, and a chest X-ray. If he had actually intended to deceive Prudential, he could have disclosed much less detail on the application and been less cooperative.

Lynn's sincere belief that he was in good health at the time of the application is also consistent with his answers and belies an intent to deceive. Following his 1974 heart attack, Lynn's recovery was rapid and uneventful. He was discharged from the Cottonwood Hospital in "good condition" after only ten days, and within one month he was briskly walking one mile per day and driving trucks again, all without any sign of chest pain or cardiac irregularity. His condition was thereafter asymptomatic, and he returned to a normal active life. (FDE-1 pp. 57, 68, 160-61.) In 1979 Dr. Thorne referred Lynn to the Coronary Consultation Clinic at the University of Utah for tests as part of a study on the relationship between family lines and heart problems. (Thorne Aff't ¶6, Add. p. 54.) The tests there showed that Lynn's blood pressure, lungs, heart sounds, and cardiovascular data were all normal. The only abnormal finding was high cholesterol, for which he was taking atromid. (Rec. pp. 819-24, Add. pp. 56-61.) Dr. Thorne's final "Clinic Note," on January 2, 1980, confirmed those positive findings:

> Lynn is doing very well, he lives an active physical life, he has not had any symptoms to suggest coronary artery insufficiency and has not had anything to suggest angina pectoris. His physical capacity is good .... The heart is in a regular sinus rhythm, no cardiomegaly, no extrasystoles. The abdomen is not remarkable and the extremities are normal with no evidence of edema. [FDE-1 p. 155, Add. p. 62.]

Other physical examinations of Lynn during this period of time also indicate that he had recovered from the 1974 heart attack and was in good physical condition. Lynn was required by the Department of Transportation to undergo a complete physical every two years, and none of those examinations revealed any cardiac disorder. For example, on January 7, 1977, Lynn was examined by Dr. Val Sundwall, the same physician who attended Lynn at the time of his 1974 heart attack. Dr. Sundwall found no residual or continuing cardiovascular problem. (_Id._ p. 176.) Lynn's last D.O.T. exam, performed on August 7, 1981 by Dr. E.J. Capener, also reported normal cardiovascular findings. (Id. p. 144.)

Lynn also appeared to those closest to him to be in good health. For example, when Lynn married Cheryl in 1977, he told her of the old heart attack, but she found it difficult to believe because of his heavy work schedule and physical capacity. Lynn was able to do heavy lifting associated with his job and never seemed limited in his activities or worried by the old heart problem. The matter was rarely if ever discussed with his new wife and both they and the doctors assumed that the problem had improved or corrected itself. (Hardy Dep. pp. 53-58.)

Thus, when Lynn applied for life insurance from Prudential in August 1981, he reasonably believed himself to be in good health and fully recovered from the 1974 heart attack. Similarly, this Court held in Marks v. Continental Casualty Co., supra, that an omission in the insurance application was not made with intent to deceive because the question related to a condition from which the insured sincerely believed she had recovered years before. 427 P.2d at 389. See also National Life & Accident Ins. Co. v. Sumlar, 51 S.W.2d 866 (Ark. 1932) (no fraudulent intent where insured denied prior heart problem in the belief he had recovered); National Life & Accident Ins. Co. v. Bonner, 200 S.E. 319 (Ga. App. 1938) (insured's belief of good health is relevant to jury question of fraudulent intent.)[5]

Finally, Lynn's incomplete answers in the application may also be attributable to the negligence or inadequate explanations of the medical examiners. For example, in Rutherford v. Prudential Insurance Co. of America, 44 Cal. Rptr. 697 (Cal. App. 1965), the court held that Prudential was estopped to rely on omissions in the application because its own medical examiner did not adequately explain the questions, gave the impression that the partial answers were sufficient, and conducted the exam in a cursory and careless manner. Id. at 702-04. While the examiners in this case have testified that they read every question and recorded the answers, (Rec. pp. 730-33, 736-37), they have not yet been cross-examined on that testimony, and their claims do *not* preclude the reasonable possibility of unrecorded discussion regarding the scope or intent of the questions. For example, on the question regarding medication, Lynn may have been led to believe, upon inquiry, that it pertained only

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[5]Prudential also considers the insured's own belief regarding his good health as relevant to the question of fraud. In the case of Josephine Oertel, Claim No. DOD085459, Prudential approved the claim despite nondisclosure of an old myocardial infarction:

> It does not appear fraud would be a good defense in this case. The applicant gave a partial admission and considering the date of her last MI (1967) and no specific ongoing treatment for this, she, in all likelihood, may have believed she was giving truthful answers. She probably did not recognize the ongoing nature of her heart disease. [Add. pp. 79-80, emphasis added.]

to medication for current serious illnesses. In responding to the question about recent examinations by a physician, he may have been led to believe that it pertained only to the most recent or most serious examinations and that it did not call for mere "checkups." See id. at 703. See also Columbian National Life Insurance Co. v. Lanigan, 19 So. 2d 67, 68-69 (Fla. 1944).

In sum, because of (1) the information that Lynn did disclose; (2) his sincere belief that he was in good health; and (3) potential error or inattention by the examiners, a jury could reasonably find that Lynn Hardy did not intend to deceive Prudential; therefore, it was error to grant summary judgment on that issue.

C. Materiality

The materiality of a claimed misrepresentation is to be determined not by what the insurer may think about the importance of the omission with the advantage of hindsight, but by "an industry standard," that is, on the basis of what a reasonably prudent insurer would have done had it known the truth. Burnham v. Bankers Life & Casualty Co., 24 Utah 2d 277, 470 P.2d 261, 263 (1970); Prudential Property & Casualty Ins. Co. v. Mardanlou, 607 P.2d 291, 293 (Utah 1980). Moreover, this Court held in Moore v. Prudential Insurance Co. of America, 26 Utah 2d 430, 491 P.2d 227 (1971), that the issue of materiality is exclusively a question of fact for the jury. In that case, Prudential argued that the issue of materiality should not have gone to the jury because Prudential presented unrefuted evidence that it would not have issued the policy had it known the undisclosed medical history. This Court rejected that argument because it

> relates to a matter of post-mortem conjecture concerning which it is easy enough to now declaim in its own favor, and difficult if not impossible for the plaintiff to directly refute. This testimony was suffused with self-interest; and it was not mandatory for the jury to find in accordance therewith.

491 P.2d at 230, emphasis added. Thus, even where the evidence of materiality is unrefuted, the issue should still go to the jury to judge the credibility of the evidence.

In this case, Prudential claims that nondisclosure of the heart attack was material, not because disclosure would have precluded issuance of the policy, but because Prudential would have rated the policy and charged a higher premium. (Response to Interrogatory No. 7, Rec. p. 75.) Prudential now estimates that had it known of the old heart attack, it would have rated Lynn's policy a special class 4 and charged a temporary extra premium totaling $3,318 more than what Lynn actually paid. (FDE-1 p. 125; Rec. p. 942, ¶8; Rec. p. 948, ¶3.) [6] However, this Court rejected a similar claim of materiality in Pritchett v. Equitable Life and Casualty Insurance Co., 18 Utah 2d 279, 421 P.2d 943 (1966), because the insurer still would have issued the policy and the revised policy

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[6]Estimated monthly premium of $398.65 multiplied by the fourteen months the policy was in force equals $5,581.10, minus the $2,263.10 in premiums actually paid ($161.65 x 14 mos.) equals $3,318.

still would have covered the insured's ailment. Moreover, as the Court stated in Moore, supra, Prudential's claim of materiality is a matter of post-mortem conjecture ... suffused with self-interest" and the jury would not be required to believe it.

One basis for a jury's disbelief concerning materiality is Prudential's admitted rule, communicated to Lynn by Agent Rigby, of disregarding medical history beyond five years old. (Add. p. 46.) Prudential has frequently applied the rule in other cases. For example, in the Ida G. Floyd case, Policy No. 70 785 063, the claim investigator stated:

> Dr. Lindell last saw Mrs. Floyd as a patient in October 1973. Since this is well beyond the five year limit, we did not contact Dr. Lindell's office in person. [Add. p. 81.]

Prudential has also applied the five-year rule to cases of prior myocardial infarctions, such as that suffered by Lynn Hardy. In the case of William V. Cupp, Policy No. 84 116 781, payment was recommended with the following note:

> Even though it appears there was an old inferior myocardial infarction, there was no need to pursue it. [Add. p. 82.]

Similarly, in the cases of Josephine Oertel, Claim No. NOD085459, and Marcelino Garza, Policy No. 70 720 480, Prudential paid the claims despite unadmitted old myocardial infarctions. (Add. pp. 78-80, 83.)

Another reason for a jury to disbelieve Prudential's claim of materiality is that Prudential refused to rate the policy on the basis of the ratable information it did have. Underwriter Tom Shaw recommended rating Lynn's policy a special class 1 because of the family history and heart block:

> Please note, 42 year old male applying for 300,000. ECG indicates 1st degree AV block. Strong family history of circulatory disorders. No credits available. Suggest we accept at a special class-1. Please advise.

(FDE-1 p. 217, Add. p. 39, abbreviations extended; see also Shaw Dep. pp. 25-29.) The ECG test performed on Lynn by Prudential showed a PR interval of .22 seconds, which is classified as a first degree atrioventricular block. (FDE-1 p. 211, Add. p. 37.) Prudential's underwriting guidelines required an assignment of 30 debits for that impairment. (Reed Dep. p. 30 and Ex. 5, p. III-33.) Lynn's family history of three or more cases of cardiovascular disease required an additional 20 to 40 debits. (Reed Dep. p. 31 and Ex. 5, p. VII-1.) When multiple impairments are present the debits are combined, and when the impairments are inter-related, particularly cardiovascular impairments, additional debits are added to the sum "because of the added significance of the combination." (Reed Dep., Ex. 5 p. B.) Other factors, such as Lynn's long smoking habit, his mother's stroke, his brother's suicide, and the early death of seven out of fifteen siblings, were also significant and "call[ed] for special consideration," or additional debits. (Id. p. VII-1; Shaw Dep. p. 45; Ketchum Dep. p. 19.) Thus, Lynn's underwriting debits should have totaled at least 75, based solely on the heart block and family history.[7] A total of 75 debits would have required a rating of special class 2. (Reed Dep., Ex. 5 p. B.) Thus, Underwriter Shaw was being "liberal" with a recommendation of special class 1. (See Ketchum Dep. p. 17.)

However, other members of the underwriting department were even more liberal and rejected Shaw's recommendation in favor of issuing the policy standard. They figured that only 20 debits was appropriate for each of the heart block and family history impairments, for a total of 40 debits. (Reed Dep. pp 31-32.) 40 debits would still require a class 1 rating, but rather than combine the debits and add the inter-related impairment factor, the impairments were considered separately, both classified as "minor," and then totally disregarded to obtain a standard rating. (*Id*. pp. 34-36.) Dr. Robert Ketchum, the medical consultant to the underwriting department, acknowledged the indications for rating the policy, but concluded that "absent other ratable impairment feel he's standard physically." (FDE-1 p. 217, Add. p. 39.)

Thus, Prudential intentionally waived the justified rating of Lynn's policy, and frequently waives ratings for "competitive or business reasons." (Rec. p. 942 ¶9; Rec. p. 710 n.16.) The

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Impairment	Debits
Heartblock	30
Family history	30
Subtotal	60
Inter-related impairment factor	15 (25% of 60)
Total	75

See Reed Dep., Ex 5 p. B.

"competitive reason" is that an unrated policy has lower premiums and is therefore more marketable, especially to a middle-income buyer like Lynn Hardy. (*See* Reed Dep. pp. 67-69 on underwriting concern over Lynn's financial ability to buy $300,000 policy.) For example, in the case of Manfred Mandelbaum, Claim No. WOD082 820, the insured failed to disclose a history of heart disease in applying for a $300,000 policy. The same underwriter, Tom Shaw, recommended to the same medical consultant, Dr. Ketchum, that the policy be rated special class 2 on the basis of an abnormal ECG and a history of "vague chest pain." However, as in Lynn Hardy's case, the medical department down-played the significance of the known impairments and concluded to waive the rating: "Feel we may be liberal .... Feel we may accept standard." (Add. p. 84.) The policy was issued standard and the insured died of a myocardial infarction nine months later. The claims department then figured that if the insured's medical history had been fully disclosed, the policy would have been rated special class 3. However, claim consultant Susan Frankel recommended payment of the claim because underwriters had waived the rating on the basis of the information they did have:

> *Given that we waived a recommendation for Special Class 2 on the information we did have, which included references to the cardiac abnormalities,... I feel that we would have no basis now for declaring a misrepresentation* ... and that we should pay the claim.

(Add. pp. 85-86, emphasis added.) Prudential admits that the rating in the Mandelbaum case was waived "for competitive reasons." (Rec. p. 710 n.16.)

Prudential's "business reason" for opting not to rate a ratable policy is that it strengthens their claim in a potential misrepresentation action that they were not "on notice" of the medical impairment justifying the rating. Prudential acknowledges the rule that if it was "on notice" of an impairment at underwriting time, it would be estopped to later claim misrepresentation on the basis of that impairment. (Frankel Dep., Ex. 2 pp. 16-17.) Moreover, Prudential recognizes that a prior rating is prima facie evidence of prior notice. For example, in the case of Edward A. Klug , Policy No. D84 081 443, a prior rating showed that Prudential was on notice of the misrepresented condition; therefore, the claim was paid:

> In view of the fact that we knew of insured's condition, policy was rated, and insured died of same condition, will approve claim and waive contestability. [Add. p. 89.]

Prudential took the same action on rated policies in the Richard A. Colwell case, Policy No. 79 056 337, and the Katherin Opgaard case, Policy No. D44 866 890. (Add. pp. 90-91.) Therefore, to avoid this prima facie evidence of "notice," Prudential waives the rating when possible.

To illustrate the legal effect of a waived rating, in Tsosie v. Foundation Reserve Insurance Co., 77 N.M. 671, 427 P.2d 29 (1967), the auto insurer claimed that had it known of the insured's prior license revocation it would have still issued the policy, but with higher premiums. The court rejected that claim because of the insurer's failure to rate the policy and adjust the premium for the other negative information that was disclosed. The insurer's disregard of disclosed facts "could properly be considered by the court in determining" the materiality of omitted facts. Id., 427 P.2d at 31.

Thus, based on the facts that Prudential (1) still would have issued the policy; (2) disregards medical history beyond five years old; and (3) waived a rating on the basis of the adverse information it did have, a jury could reasonably reject Prudential's "post-mortem" claim that omission of the old heart problem was material.

D. Reasonable Reliance

The law in Utah is clear that an insurer may not rescind a policy for misrepresentation unless the insurer actually relies on the misrepresentation, and that reliance is reasonable. Reliance is not reasonable if the insurer had sufficient indications to put it "on notice" to conduct an inquiry which, if carried out with reasonable thoroughness, would have revealed the truth. In short, an insurer may not close its eyes to a misrepresentation and later plead reliance upon it to void the policy. See, e.g., Wootton v. Combined Insurance Co., 16 Utah 2d 52, 395 P.2d 724 (1964); Major Oil Corp. v. Equitable Life Assurance Society, 457 F.2d 596 (10th Cir. 1972) (Utah law).

Since the question of reasonable reliance parallels the issue of equitable estoppel to raise the misrepresentation defense, the two are addressed simultaneously under Point II. Suffice it to say at this point that there is sufficient evidence in the record from which a jury could reasonably find that Prudential either did not rely on the omissions in the application, or that its claimed reliance was unreasonable. Therefore, it was error for the trial court to grant Prudential summary judgment on the issue.

E. Claimed Misrepresentation of Follow-up Information

The trial court based its decision in part on the omission of Lynn's supposed heart medicatiion and treatment within five years prior to the application. (Add. pp. 2-3.) That finding is both false and immaterial. Dr. Joseph L. Thorne, the cardiologist who gave Lynn periodic check-ups following his 1974 heart attack, testified that Lynn's only medication within that period was atromid, taken to regulate his cholesterol level. He took no "heart medication," such as digitalis or nitroglycerine. (Rec. p. 1069, Add. p. 54, ¶5; see also Rec. pp. 822, 824, Add. pp. 59, 61.) Nor was Lynn receiving any "treatment" for heart disease. His condition was "totally asymptomatic," and his life was "active and normal." (Add. p. 54, ¶4; see also Add. p. 62.) As explained above, Lynn's visit to the University Medical Center in 1979, referred to by the court at Add. p. 2, ¶5, was merely for tests in connection with the Center's family studies, not for treatment of heart disease. (Add. p. 54, ¶6.)

More importantly, the atromid medication and the check-ups by Dr. Thorne are immaterial in the context of this case. If the heart attack itself were not disclosed, then this follow-up information would be material as evidence leading to knowledge of the heart attack. However, the evidence shows that the heart attack was disclosed; therefore, omission of the follow-up evidence is immaterial.

The same would be true in the analogous case of a real estate sales contract under which the seller discloses that the basement floods during rainstorms. The buyer could not later rescind the contract for the seller's failure also to disclose that the basement wall was cracked. Disclosure of the ultimate fact renders immaterial the omission of minor evidences of that fact. In this case, disclosure of the heart attack put Prudential on notice of the entire problem, rendering immaterial the omission of minor details. Moreover, there is no evidence that the follow-up information would have increased the rating above what it would have been for the heart attack alone. Thus, a jury could reasonably find this information immaterial, and it was therefore error for the court to rely upon it.

Point II: PRUDENTIAL IS EQUITABLY ESTOPPED FROM ASSERTING THE DEFENSE OF MISREPRESENTATION BECAUSE IT WAS "ON NOTICE" TO CONDUCT AN INQUIRY THAT REASONABLY WOULD HAVE REVEALED THE OMITTED INFORMATION AND IT FAILED TO CONDUCT SUCH AN INQUIRY.

The leading case of this Court illustrating application of equitable estoppel in the present context is Wootton v. Combined Insurance Co. of America, 16 Utah 2d 52, 395 P.2d 724 (1964). In Wootton, the insurer refused payment on a life insurance policy because the applicant stated on the application that her husband was in good health and free from physical defect, when in fact he had previously retired from work and applied for social security on the claim that he was totally disabled by polio. The Court rejected the insurer's defense of misrepresentation because the applicant informed the insurance agent at the time of the application that her husband had polio and the agent saw that the husband walked with a limp. The Court ruled that the false answer on the application that the husband was free from physical defect "must be taken in conjunction with the disclosure" to the agent that the husband had a polio defect. Id., 395 P.2d at 726. The Court concluded:

> 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. [Id., emphasis added.]

The case of Major Oil Corp. v. Equitable Life Assurance Society, 457 F.2d 596 (10th Cir. 1972), applying Utah law, is also similar factually to the present case and illustrates the rule of equitable estoppel. In Major Oil the insured had a history of hospitalization and treatment for alcoholism and an impaired liver. On his life insurance application, the insured falsely denied any treatment for a liver disorder, denied any treatment by a physician within the previous five years, and made no mention of his hospitalization and treatment for alcoholism. However, agents of the insurer were informed orally that the insured had been hospitalized for alcoholism, and the insurer's underwriting department learned from an independent information service that the insured had a drinking problem. The underwriting department then conducted its own routine investigation, which failed to confirm the drinking problem. The insurer then decided to issue the policy, without following its leads to make a further inquiry into the seriousness of the drinking problem. The insured died shortly thereafter, and only after the beneficiary's claim did the insurer investigate its lead from the information service to learn from another insurer of the insured's alcoholism and liver disorder. The insurer raised the defense of misrepresentation, and the beneficiary contended that the insurer was estopped to raise the defense because the insurer was "on notice" through disclosure to the agent and the lead from the information service. The court agreed with the beneficiary, stating the general rule in two parts, as follows:

> (1)if the insurer has actual knowledge of the true facts, or of the falsity of the statements, or at least has sufficient indications that would have put a prudent man on notice and would have caused him to start an inquiry which, if carried out with reasonable thoroughness would reveal the truth, he cannot blind himself to the true facts and choose to 'rely' on the misrepresentation; (2) if the insurer chooses to make an independent inquiry and the subject matter and the circumstances are such that he is in a position to ascertain the facts by a reasonable search, then he cannot plead reliance even if his investigation is as a matter of fact cursory and did not reveal the true facts--and if in the course of such an investigation he finds clues indicating the falsehood of some representations he is also bound, by the first rule, by what a reasonable inquiry into those clues would show. [Id. at 602. Quoted by Prudential as the applicable rule in Corp. Claim Memo. 76-40, p. 16, Frankel Dep., Ex. 2.]

Applying that rule to the facts of that case, the court first concluded that the information disclosed to the agent was imputed to the insurer. Id. at 603. Concerning the quantum and nature of the information necessary to put an insurer "on notice," the court ruled that the test is not whether the insurer had actual knowledge of the true facts or actual knowledge of the falsity of the insured's statements, "but whether it had sufficient information" to put a prudent man "on notice" to start an inquiry that reasonably would have revealed the truth. Id. at 604. Nor is it necessary that one disclosure alone be sufficient to put the insurer on notice; rather, the test "is whether the cumulative effect of all the evidence bearing on this issue was sufficient to put [the insurer] on notice." Id. If the insurer was on inquiry notice it "may be charged with knowledge of facts which it ought to have known." Id. at 603. The court concluded that the fact of the insured's "drinking problem," disclosed to the agent and reported by the information service, was sufficient to put the insurer on notice to investigate the seriousness of the drinking problem. Moreover, judging by the ease with which the insurer discovered the omitted history after the insured's death, it was apparent that a reasonable search would have revealed the same information before issuance of the policy. Therefore, the insurer was charged with knowledge of that information and was equitably estopped to raise the misrepresentation defense. Id. See also State Farm Mutual Automobile Ins. Co. v. Wood, 25 Utah 2d 427, 483 P.2d 892 (1971) (insurer lost right to rescind for misrepresentation by its failure to make reasonable investigation of insurability before issuing the policy); Taylor v. Moore, 87 Utah 493, 51 P.2d 222, 228-29 (1935) (party with means of discovering truth cannot be inactive and afterwards allege fraud); 16B Appleman, Insurance Law and Practice §§9081-9082, 9088; 7 Couch on Insurance 2d §§ 35:252, 35:254; 43 Am. Jur. 2d Insurance §1018.

A review of the information admittedly known to Prudential at the time of underwriting Lynn's policy demonstrates that Prudential was "on notice" to conduct a further inquiry and should be charged with knowledge of what that inquiry would have revealed. Prudential learned from the first Part 2, completed by Launa Perry, that Lynn's father and two brothers had died at young ages from heart attacks; his mother died of a stroke; one brother died of suicide; three other brothers and a sister died at birth; he smoked cigarettes; and he had been examined by Dr. Taylor in 1979. (Add. p. 8.) The Equifax report confirmed the smoking habit; disclosed that a third brother, still living, also had heart problems; and listed another physician, "Dr. Peterson." (Add. pp. 34-36.) Prudential then learned from the ECG performed by Ms. Perry that Lynn had a first-degree AV heart block. (Add. p. 37.) Prudential learned from the second Part 2, completed by Dr. Evans, that Lynn had smoked heavily for twenty years; he had rheumatic fever as a child; he received a recent I.C.C. exam from Dr. Capener; and he had been treated by Dr. Val Sundwall at Cottonwood Hospital. (Add. p. 10.)

The "cumulative effect" of the above information was "sufficient to excite attention and call for [further] inquiry" into Lynn's physical condition. See, Johnson v. Life Insurance Co. of Georgia, 52 So. 2d 813, 815 (Fla. 1951); Union Insurance Exchange, Inc. v. Gaul, 393 F.2d 151, 154-155 (7th Cir. 1968) (insurer had sufficient information "to awaken further inquiry"). Prudential admits the significance of Lynn's extensive family history of heart disease and his heart block. Prudential's underwriting manual states:

> A number of deaths from cardiovascular-renal disease in a family at ages under 60 is significant, especially if the applicant shows any indication of any cardiovascular-renal impairment.

(Reed Dep., Ex. 5, p. VII-1, emphasis added.) It also states that where three or more cases of cardiovascular disease exist "[i]n combination with ... any evidence of cardiovascular-renal disease" in the applicant, the debits for the two impairments should be combined, id., and additional debits should be added because the impairments are "inter-related." (Id. at B.)

In addition to the family history, Lynn's own childhood rheumatic fever could be indicative of future heart problems, Harrison's Principles of Internal Medicine, Ch. 257 pp. 1400-02 (10th ed. 1983); 1 Anderson's Pathology, pp. 606-07 (8th ed. 1985) (Add. pp. 65-71), and a first-degree AV heart block may be indicative of a prior inferior wall myocardial infarction, such as Lynn suffered in 1974, J. Hurst, The Heart, pp. 544-45 (5th ed. 1982); E. Goldberger, Textbook of Clinical Cardiology, p. 550 (1982) (Add. pp. 72-76); see also FDE-1 p. 59; Ketchum Dep. p. 12; Reed Dep., Ex. 5 p. II-33. The underwriting manual also indicates "special consideration" for a suicide in the family and "several early family deaths" where "the lack of longevity is very marked." (Reed Dep., Ex. 5 p. VII-1.) Smoking also has significance in conjunction with other impairments. (Shaw Dep. p. 45; Ketchum Dep. p. 19; Wiczek Dep. p. 12; see also Thorne Aff't ¶8, Add. p. 55.) Thus, Lynn's application did show indications of cardiovascular impairment.

Prudential's underwriters recognized the significance of the indicated impairments and the need for a further investigation, such as requesting medical records from the listed physicians and hospital. As shown previously, underwriter Shaw judged the impairments significant enough to rate the policy and charge a higher premium. (Add. p. 39.) He recognized that the AV heart block indicated "some sort of abnormality," and that the family history and heart block together were "indicative of a potential heart problem." (Shaw Dep. pp. 26-28.) Underwriter John Wiczek, who ultimately approved the policy unrated, also testified concerning the indicated impairments:

> Q. ... Having in mind that information as an underwriter and based upon your experience and training, would that be a significant factor which in your opinion would warrant some further investigation and analysis?
>
> A. Yes, I believe it would.

(Wiczek Dep. p. 12.) Jan Drosendahl LeRoux also testified:

> Q. Would you consider [the family history of heart disease] to be a red flag under those circumstances?
>
> A. Three more incidents of coronary artery disease under age 60, yes, in a family history.
>
> Q. Would you also consider a red flag the fact that the EKG showed a Class 1 heart block?
>
> A. Yes ....

(LeRoux Dep. p. 19.) Dr. Ketchum agreed that a prudent underwriter would have requested and reviewed available medical records:

> Q. ... Were those two red flags, family history and the ECG, sufficient to warrant a request from attending physicians for their statements?
>
> A. ... Certainly using those two--using the term red flag--taken together, could well prompt a reasonable underwriter to get an attending physician's statement perhaps from at least the most proximate physician who is listed on the declarations as having been seen in attendance .... [Ketchum Dep. p. 49.]

Prudential could have readily obtained or checked the medical records indicated in the application, and Lynn's signed release authorized it to do so. Underwriter Shaw testified that requests for medical records were commonly made, directly by Prudential or through Equifax:

> Q. It was not unusual in the Underwriting Department in various cases to make a request for attending physician's statements and hospital records; isn't that true?
>
> A. That is correct.
>
> Q. And those documents could either be procured directly by a secretary or someone working for Prudential Insurance communicating with the doctor or the hospital or by sending it out to these independent investigators; isn't that true?
>
> A. That is correct.

(Shaw Dep. p. 14; see also pp. 15, 38-39 and Wiczek Dep. pp. 9, 15.) Underwriter Wiczek testified that a request for Lynn's medical records should have been made to Equifax:

> Q. . . . [B]ased upon what you know of this case now and as a general rule, with reference to the practice that's followed in the Underwriting Department, wouldn't you normally expect that a form like Exhibit 8 [requesting medical records] would have been completed and sent to Equifax?
>
> A. Yes. [Id. at 23.]

In fact, no such form or request for medical records was sent to Equifax. Stanley Vogen, of Equifax, testified:

> Q. Since you have printed forms in that regard, is it fair for me to assume that insurance companies do make requests on occasion for you to secure medical history from doctors and from hospitals?
>
> A. True.
>
> Q. They would return that [form] to you together, apparently, with an authorization for you to get the information?
>
> A. Yes.
>
> . . . .
>
> Q. There's nothing in your files or records in this case of

Lynn Hardy to indicate that such requests were made by Prudential?

A. No. [Vogen Dep. pp. 27-28.]

Thus, despite the indications of cardiovascular impairment in Lynn's application, and the leads to four doctors and a hospital known to have further medical information, Prudential made no further inquiry beyond requesting the APS from Dr. Taylor, who was listed on the first Part 2. Prudential made no request from the doctors or hospital listed on the second part 2, or from the doctor listed in the Equifax report. Therefore, Prudential's conclusion in the claims investigation, that "[u]nder-writing thoroughly investigated all given possible leads to information," (Add. p. 50), is false. Prudential did not follow the leads to Doctors Sundwall, Capener, and Peterson, or the lead to Cottonwood Hospital. If Prudential had inquired with Dr. Sundwall or Cottonwood Hospital before issuing the policy, it would have learned of Lynn's 1974 heart attack, just as it did following his death.

Relevant case law demonstrates that Prudential's failure to check with the hospital or doctors listed on Lynn's application estops it from asserting misrepresentation. For example, in Rutherford v. Prudential Insurance Co. of America, 44 Cal. Rptr. 697 (Cal. App. 1965), the insured failed to disclose on Part 2 of the application a history of treatment for chest pain and the doctor who had been treating him. However, he did disclose the names of other doctors who had treated him for other ailments, and who were also aware of the insured's history of chest pain. The court found that the answers in the application put Prudential on notice of a possible misrepresentation, imposing a duty on Prudential to conduct a further inquiry by contacting the two doctors in the application. Had additional information been requested from those doctors, the insured's true condition would have been learned. Id. at 704, 707. Prudential's failure to make that further inquiry barred it from claiming misrepresentation.

On facts even closer to the present case, the court in Trawick v. Manhattan Life Insurance Co., 447 F.2d 1293 (5th Cir. 1971), reached the same result. There, the insured denied a prior history of heart disease on the application. However, the insurer possessed at the time of issue an abnormal ECG reading and the insured's family history revealing that his father and two brothers had previously died of heart trouble. Id. at 1296. The court concluded that while such evidence does not show "actual knowledge" of the insured's true condition, it is sufficient to put the insurer "on notice" to conduct a further inquiry. Since the insurer was on inquiry notice and was "in a position to ascertain the facts by a reasonable search, then the insurance company cannot avoid liability by pleading reliance on the insured's application." Id.

Likewise, in First National Bank v. Modern Woodmen of America, 486 F.2d 10 (10th Cir. 1973), the insured failed to disclose a history of hospitalization and treatment for potential heart disease and listed only one doctor and hospital that had treated him. However, he did disclose that his father had died of heart disease and also gave other answers indicating other hospitalizations. The court held that the purpose of the medical examination is "to develop leads for future investigation." Id. at 13. Had the insurer inquired at the listed hospital or requested the medical records from the listed physician it would have learned the full history; instead, the insurer made no such further inquiry. The court concluded:

> Appellant could have readily obtained all the relevant information from [the physician listed on the application] but it failed to do so. Upon these facts we can only conclude that appellant was sufficiently put on notice as to Kellams' condition and, therefore, is chargeable with knowledge of facts which a prudent inquiry would have revealed.

Id. at 14. For other cases illustrating the estoppel rule in the insurance claim context see Columbian National Life Insurance Co. v. Rodgers, 116 F.2d 705 (10th Cir. 1940) (courts loathe forfeitures); Security Life & Trust Co. v. Jones, 202 So. 2d 906, 909 (Fla. App. 1967) (estoppel based on failure to consult available physician and hospital records); National Life & Accident Ins. Co. v. Pollard, 19 S.E.2d 557, 559 (Ga. App. 1942) (failure to make inquiry of listed physician); Wabash Life Insurance Co. v. Maguire, 461 S.W.2d 916 (Ky. App. 1971), Washington National Insurance Co. v. Estate of Reginato, 272 F. Supp. 1016 (D. Cal. 1966); Northern National Life Ins. Co. v. Lacy J. Miller Machine Co., 305 S.E.2d 568 (N.C. App. 1983); Johnson v. Life Insurance Co. of Georgia, 52 So. 2d 813 (Fla. 1951); Pipes v. World Insurance Co., 150 F. Supp. 370 (W.D. La. 1957).

Prudential has acknowledged and applied the rule of estoppel for its failure to check available medical records in other similar cases. For example, in the Manfred Mandelbaum case, Claim

No. WOD082820, the insured failed to disclose an extensive history of heart disease but did disclose the names of two Kaiser medical centers where he had been treated. Prudential obtained the medical records from the Kaiser-Sunset center and discovered a history of chest pain and an abnormal ECG. Prudential waived the recommended rating and issued the policy standard. After the insured died of a myocardial infarction within the contestable period, Prudential obtained the medical records from the Kaiser-Cadillac center and learned the full undisclosed history of heart disease, which would have required a special class 3 rating. Prudential paid the claim despite the misrepresentation because it was "on notice" to check available medical records and failed to do so:

> Because it was decided at issue to waive a Special Class 3 rating based on the insured's cardiac abnormalities you are recommending that we pay the claim. I agree. As I see it, there is no basis for a misrepresentation defense. At underwriting time we were on notice. . . . Underwriting . . . did not pursue obtaining his medical records . . . .[Add. pp. 87-88, emphasis added.]

Likewise, in the Josephine Oertel case, Claim No. NOD085449, Prudential paid the claim despite a misrepresentation because of its failure to obtain available medical records:

> Underwriter's comment on reverse of Part I indicates that there was a basis for requesting an APS [attending physician's statement], but he opted not to. Thus we waived the APS and accepted the risk with our eyes open. [Add. p. 80, emphasis added.]

Prudential also paid the John Richardson claim, No. NOD 070413, despite a misrepresentation, for the same reason:

> The Company had an opportunity to obtain clarification of dx [diagnosis] and prognosis, etc. from the source (A.P.) and opted not to do so. These factors would substantially weaken a misrepresentation defense. . . .We would also be vulnerable to a contention that we were "reunderwriting" at time of claim and

> <u>thus be exposed to a damages action</u>. On balance, I am reluctant to resist liability in this case. Pay death benefits. [Add. pp. 92-93, emphasis added.]

Thus, in the case of Lynn Hardy, Prudential was on inquiry notice, it was in a position to learn the truth, and failed to conduct a further inquiry. Therefore, Prudential is charged with knowledge of what a reasonable search would have disclosed and is now estopped by its own inaction from claiming reliance on a misrepresentation.

<u>POINT III</u>: THE TRIAL COURT ERRED IN RELYING ON CLAIMED MISREPRESENTATIONS OUTSIDE THE APPLICATION.

The insurance policy issued to Lynn Hardy prohibits Prudential from relying on statements outside the application to void the policy:

> We will not use any statement, unless made in the application, to void the contract or to deny a claim.

(FDE-1 p. 233, Add. p. 16.) Prudential violated this provision by alleging, as grounds for rescission, that <u>Mrs</u>. Hardy intentionally withheld Lynn's medical history from Prudential. (Rec. p. 671 et seq.) The trial court seized upon this error and based its decision on claimed misrepresentations of Mrs. Hardy. The court's decision repeatedly refers to the "plaintiff" and to <u>both</u> Lynn and Cheryl. For example, paragraphs 4 and 5 of the court's decision cite omissions of "Mrs." Hardy, and the court concludes that "<u>the plaintiff</u>" has withheld information justifying rescission. (Add. pp. 2-3.)

The trial court's construction of the policy in relying on omissions of Mrs. Hardy, <u>outside</u> the application, constitutes reversible error. By the clear terms of the policy, Prudential may rely only on claimed misrepresentations made in the application. Since only Lynn Hardy made statements in the application, Prudential and the trial court were limited to reliance on those statements. To illustrate, in Wabash Life Insurance Co. v. Maguire, 461 S.W.2d 916 (Ky. App. 1971), the insurer attempted to rely on omissions of the insured's widow and beneficiary to void the policy. The court rejected the attempt:

> The further claim that ... the insured's widow and beneficiary under the policy, cannot recover because, in substance, she knew of the policies and knew her husband's condition is nothing short of ridiculous, and we shall not dignify it by further mention.

Id. at 919. The same holding is justified in this case.

POINT IV: PRUDENTIAL IS PRECLUDED FROM OBTAINING RESCISSION BY ITS OWN DISCRIMINATORY AND BAD FAITH HANDLING OF PLAINTIFF'S CLAIM AND BY THE INEQUITABLE RESULT THAT RESCISSION WOULD PRODUCE.

The Utah Insurance Code, U.C.A. §31-27-22(1), prohibits unfair discrimination by insurers in the handling and payment of claims. (Add. p. 63.) In this case, Prudential has engaged in flagrant, unjustified discrimination in the handling and denial of Mrs. Hardy's claim. For example, as demonstrated in the preceding arguments, Prudential failed to apply the rules commonly applied in its other similar cases, including (1) imputing the agent's knowledge to the company, supra p. 17; (2) accepting the insured's sincere belief of good health, supra p. 23; (3) disregarding medical history beyond five years prior to the application, including old myocardial infarctions, supra p. 26; (4) paying the claim where it was "on notice" of the condition and waived a rating, supra p. 29; and (5) paying the claim where it should have consulted available medical records but failed to do so, <u>supra</u> p. 44.

Prudential has also violated the duty of good faith and fair dealing inherent in every contractual relationship. <u>See, e.g.</u>, <u>Leigh Furniture and Carpet Co. v. Isom</u>, 657 P.2d 293, 306 (Utah 1982). In no other area of the law is this duty more applicable and better developed than in the area of insurance contracts. In the insurance context the insured occupies an inferior bargaining position, and where the loss insured against does occur, the insured is placed in an economically vulnerable position at the mercy of the insurer. Thus, to better protect insureds from arbitrary and unfair insurance practices, the majority of courts now recognize a cause of action for an insurer's bad faith handling and denial of a claim. <u>E.g.</u>, <u>Noble v. National American Life Insurance Co.</u>, 128 Ariz. 188, 624 P.2d 866, 867 (1981); <u>Christian v. American Home Assurance Co.</u>, 577 P.2d 899, 901 n.1 (Okla. 1978); Ghiardi & Kircher, Punitive Damages: Law and Practice §8.11 n.14 (1984); Annot., Insurer's Liability for Consequential or Punitive Damages for Wrongful Delay or Refusal to Make Payment Due Under Contracts, 47 A.L.R.3d 314 (1973).

This Court has also recognized a cause of action for an insurer's bad faith. In <u>Ammerman v. Farmers Insurance Exchange</u>, 19 Utah 2d 261, 430 P.2d 576, 578 (1967), the Court stated:

> [T]he cause of action for bad faith, though arising because of the policy, is not, strictly speaking, an action on the policy. . . .[I]t is properly regarded as a separate cause of action for a wrong done to the insured by violating a fiduciary duty owed to him.

See also Auerback v. Key Security Police, 680 P.2d 740, 743 (Utah 1984); Lyon v. Hartford Accident and Indemnity Co., 25 Utah 2d 311, 480 P.2d 739, 745 (1971); Espinoza v. Safeco Title Insurance Co., 598 P.2d 346, 349 n.7 (Utah 1979); American States Insurance Co. v. Walker, 26 Utah 2d 161, 486 P.2d 1042, 1044 (1971). This duty is reinforced by the Utah Insurance Code, U.C.A. §§31-1-8, 31-27-1(1), and by the Unfair Claims Settlement Practices Regulations of the Utah Insurance Department, sections 2 and 5. (Add. pp. 63-64.)

While space does not permit a discussion of all the bad faith practices of Prudential in this case, it is apparent from the "entire course of dealings between the parties" that Prudential has violated the duty of good faith and fair dealing. See Timmons v. Royal Globe Insurance Co., 653 P.2d 907 (Okla. 1982); Pistorious v. Prudential Insurance Co. of America, 123 Cal. App. 3d 541, 176 Cal. Rptr. 660 (1981). For example, (1) Agent Rigby mislead Lynn to believe that disclosure of the 1974 heart attack in the application was not required; (2) Prudential had at least imputed and constructive knowledge of Lynn's medical history, intentionally waived rating the policy, and now falsely denies that it was "on notice"; (3) Prudential failed to conduct the further inquiry indicated by the information it had; (4) Prudential falsely represented to Mrs. Hardy and the Utah Insurance Department that its underwriters "thoroughly investigated" all leads prior to issuing the policy and that it was not "on notice" of the omitted history; (5) Prudential knew that Mrs. Hardy would lose her trucking business if it denied her claim and yet acted with total disregard for those consequences;

(6) Prudential unfairly discriminated against Mrs. Hardy's claim, as shown above; and (7) Prudential sought rescission of the policy without attempting in good faith to settle the claim. This unfair and bad faith conduct of Prudential precludes it from now obtaining the "equitable" remedy of rescission.

Rescission is also precluded by the inequity that results from restoring the parties to their precontract, or "no-contract," position. As shown above, even if Prudential had known the omitted history, it still would have issued the policy for the additional premiums totaling $3318. Since the policy would have been issued in any event, it is not reasonable or equitable to restore the parties to a no-contract position. Rather, they should be restored to the position they would have occupied absent the claimed misrepresentation. Under that remedy, often referred to as "reformation," Mrs. Hardy would receive the insurance proceeds, less the additional premiums of $3318. Such a remedy is more consistent with the approach of "common sense and flexibility" that characterize a court of equity. D. Dobbs, Handbook on the Law of Remedies §4.3 (1973); see also Restatement of the Law of Restitution §28, comment d. Moreover, in the context of life insurance contracts it is impossible to restore the parties to their precontract positions:

> The need to protect the stability of transactions is especially important in the case of insurance policies, where the attempt to rescind is made by the insurer after the occurrence of the insured event. In these cases, of course, rescission does not return the parties to the status quo ante; after the loss it is too late to procure substitute insurance.

James & Gray, Misrepresentation--Part II, 37 Md. L. Rev. 488, 500-01 n.11 (1978) (emphasis added). Likewise, it is too late for Lynn

Hardy to obtain other life insurance. Thus, on the facts of this case, it would be inequitable to grant Prudential a windfall of $300,000 because of a disputed $3318.

CONCLUSION

Based on the foregoing, Mrs. Hardy respectfully requests that the order of summary judgment be reversed and that the case be remanded for trial.

Dated this 15th day of August, 1985.

Respectfully submitted,

KIRTON, McCONKIE & BUSHNELL

By Merrill F. Nelson
Dan S. Bushnell
Merrill F. Nelson
Attorneys for Plaintiff/Appellant

ADDENDUM

Index

IN THE DISTRICT COURT OF SALT LAKE COUNTY

STATE OF UTAH

FILED IN CLERKS OFFICE
Salt Lake County Utah

FEB 20 1985

H. Dixon Hindley, Clerk 3rd Dist. Court
By [signature]
Deputy Clerk

CHERYL HARDY,	:	
Plaintiff,	:	
vs.	:	MEMORANDUM DECISION
THE PRUDENTIAL INSURANCE	:	Civil No. C 83-7195
COMPANY OF AMERICA and	:	
WAYNE L. RIGBY,	:	
Defendants.	:	

Plaintiff has filed this lawsuit seeking damages and recovery on a life insurance policy issued by the defendant, Prudential. Defendant, Prudential, seeks rescision of the policy on the grounds that the plaintiff and her husband misrepresented material facts in connection with the application for the policy. Both sides have submitted Motions for Summary Judgment. Many facts are not in dispute and the court finds the following facts are undisputed facts in the case:

1. Lynn Hardy was the husband of the plaintiff herein.

2. The plaintiff and Lynn Hardy made application to Prudential for a $300,000.00 life insurance policy upon the life of Lynn Hardy with the plaintiff to be the owner and beneficiary under the policy.

3. Said application was made in August 1981.

4. Lynn Hardy had suffered a serious heart attack in January 1974, but this was never shown on the application by Mr. and Mrs. Hardy, nor was this information ever given to the examining physician, Dr. Evans.

5. Neither Mr. or Mrs. Hardy ever revealed to the Equifax investigator, acting on Prudential's behalf, nor anyone else acting on behalf of Prudential, the prior heart attack nor the fact that he was taking regular medication and had been monitored and treated for a heart disease at the University of Utah Medical Center and by Dr. Thorne, a cardiologist, as late as August1, 1979.

6. Prudential issued the $300,000.00 life insurance policy upon the life of Lynn Hardy without any additional premium rating.

7. Lynn Hardy died of a heart attack on December 4, 1982, within the policy's contestability period.

8. Prudential denied the plaintiff's claim for money under the policy on the grounds of false and fraudulent misrepresentation of material facts and seeks rescission of the insurance policy and tenders back to the plaintiff all premiums paid.

Plaintiff contends that she and her husband were informed by the defendant, Wayne L. Rigby, the insurance agent for the defendant, Prudential, that they need not disclose any medicial information that precedes the period of five years before the application. The prior heart attack was more than five years before the application. Certainly, this would be a sufficient issue of fact to deny the motion for summary judgment if it were not for the fact that the plaintiff and her husband withheld the information of the fact that Mr. Hardy had seen Dr. Thorne and the University of Utah Medical Center in 1979--both within the five year period. Certainly, this was a fact well known to both Mr. and Mrs. Hardy and was deliberately withheld from the Prudential. The court finds this to be a material fact which was deliberately withheld from the defendant and that the defendant, Prudential, relied upon the representations made by the Hardys. Furthermore, the evidence is uncontroverted that Mr. Hardy was on medication up to the time of his death. This material fact was not disclosed and would have materially effected the decision to issue the policy.

All of the foregoing facts clearly show that the plaintiff has purposely withheld material facts from the insurance application and justify the defendant, Prudential, to rescind its insurance policy.

Motion for Summary Judgment in favor of the defendant, Prudential, is granted. Plaintiff's Motion for Summary Judgment is denied.

Dated this 20 day of February, 1985.

Dean E. Conder

District Judge

ATTEST
H. DIXON HINDLEY
Clerk
By Roy Robinson
Deputy Clerk

Decl. to Cons. | Date | Initials
Rej. Letter
Sent on AUG 14 AUG 20 SEP 11

JR

>150 B

10-8

S | NS | Control No. 819 | U | | NC

EXHIBIT A

ACCEPTED SUBJECT TO CONDITIONS OF APPLICATION
BY ___
OCT 08 1981
(49) UNDERWRITING DIV.
☐ A-S ☐ BK ☐ RATE ☐ REE

A | B | C | Pol. Ltr.

FOR H.O. USE

Issue Details

SEND TO

RM	Tracer Sent	Initials	PC		
			la 6	☐ Multiple Parts 2 ☐ Cons. Comm. Adj.	☒ Appl. other than P. I. ☐ 31 Day Delivery

Exam

Region	Agency Code	Agency
G	SLCX	SALT LAKE CITY AGENCY

	Letter Des.	Contract No.	Rep. Inits.	Name (Print or Stamp)	Agency Code	Title
Issue to	TQ	9993	WLR	WAYNE L. RIGBY		FTSA
____% Credit to						

Check Applicable Box
☒ Individual
☐ Two or more lives

To Be Completed in Every Case
Premium Quoted
$ 161.65 (According to interval of premium payment)

Regular Ord.

Prudential Part 1 Application to The Prudential Insurance Company of America

No. 70 766 465 Z

1a. Proposed Insured's name — first, initial, last (Print): LYNN HARDY

1b. Sex ☒ M ☐ F

2a. Date of birth Mo. 4 Day 26 Yr. 39

2b. Age 42

2c. Place of birth UTAH

3. ☐ Single ☒ Married ☐ Widowed ☐ Separated ☐ Divorced

4. Address for mail
No. 1650 Street N. SOUTHGATE
City S L C State UT Zip 84119

5a. Occupations TRUCK DRIVER

5b. For how long? 24 YRS

6. If spouse is proposed for coverage, give:
a. Name ___
b. Date of birth Mo. | Day | Yr. c. Age d. Place of birth e. Amt. of life ins. in force $

7. For each child proposed for coverage give:

	First name & initial	Relation-ship	Date of birth Mo.	Day	Yr.	Amt. of life ins. in force
a.						
b.						
c.						
d.						
e.						
f.						

Insurance for a child will not start until the 15th day of life.

8a. Kind of policy 5 YR R+C TERM

8b. Initial amount $ 300,000

9. Rating if not Standard

10. Accidental death coverage
a. Initial amt. $___
b. Rating ☐ 2 ☐ 3 ☐ 4 ☐ 5

11. To apply for any of these Supplementary Benefits, give details:

a. ____Year Decreasing Term on Insured $________Initial Amount.

b. ____Year Decreasing Term on ☐ Spouse ☐ Insured & Spouse $________Initial Amount.

c. Decreasing Term to Age 65M/68F on Insured $________Initial Amount.

d. Decreasing Term to Age 62M/65F on Spouse $________Initial Amount.

e. ____Year Level Term on Insured $________ ☐ Level Premium ☐ Mod. Premium

f. Family Income to ____th Contract Anniversary on Insured $________per month.

g. Family Income to 20th Contract Anniversary on ☐ Spouse ☐ Insured & Spouse $____per month.

h. Family Income to Age 65M/68F on Insured $________per month.

i. Family Income to Age 52M/55F on Spouse $________per month.

j. Level Term on Dependent Children $________

k. Option to Purchase Additional Insurance $________ (Do not complete for a Family or Insured & Spouse Policy.)

12. Beneficiary:

13. State any special request.

14. List all life insurance, annuities and variable contracts on proposed Insured. (If NONE, so state.)

Company	Initial amt.	Year issued	Kind (Life, End't., Group)	Medical Yes	Medical No
Cuna Mu	5,000	80	Life	☒	☐
				☐	☐
				☐	☐
				☐	☐

15. Will this insurance replace or change any existing insurance or annuity in any company on any person named in 1a, 6 or 7? If "Yes", give their names, name of company, plan, amount and policy numbers. Yes ☐ No ☒

16. Is anyone applying for, or trying to reinstate, life or health insurance on any person named in 1a, 6 or 7 in this or any company? If "Yes", give amount, details and company. Yes ☐ No ☒

17. Does any person named in 1a, 6 or 7 plan to live or travel outside the United States and Canada within the next 12 months? If "Yes", give details. Yes ☐ No ☒

18. Does any person named in 1a, 6 or 7 plan to fly an aircraft, glider, balloon or like device or, within the last 2 years, has any such person flown as a student pilot, pilot or crew member or had any other duties aboard an aircraft, glider, balloon or like device while in flight (including flight for flight pay)? . . Yes ☐ No ☒
If "Yes", complete Aviation Questionnaire.

19. Has any person named in 1a or 6, within the last 12 months: Yes No
a. been treated by a doctor for or had a known heart attack, stroke or cancer other than of the skin? . . . . ☐ ☒
b. had an electrocardiogram for chest pain or for any other physical complaint, or taken medication for high blood pressure? . . . . ☐ ☒

20. Premiums payable ☐ Ann. ☐ Semi-Ann. ☐ Quar. ☒ Mon. ☐ Pay. Budg. ☐ Pru-Matic ☐ Gov't. Allot.

21. Amount paid $ 161.65 ☐ None (Must be "None" if either 19a or 19b is answered "Yes".)

22. Is it understood that a medical examination will be made on any person named in 1a, 6 or 7? If "Yes", on whom? Yes ☒ No ☐

23. If 22 is "Yes", is it agreed that no insurance will take effect on anyone until all medical examinations are made, even though 21 shows that an amount has been paid? . . . . Yes ☒ No ☐

24. **Changes made by Home Office.**

The proposed Insured declares that, to the best of his or her knowledge and belief, the above statements are complete and true. When Prudential gives a receipt form, ORD 22385-79, of the same date as this Part 1, coverage will start as shown in that form. Otherwise, no coverage will start unless: (1) a contract is issued, (2) it is accepted, and (3) the full first premium is paid while all persons to be covered are living and their health remains as stated in Parts 1 and 2. If all these take place, coverage will start on the contract date. Any entry in 24 made at a Home Office will be approved by acceptance of the contract. But where the law requires written consent for any change in the application, such a change can be made only if those who sign this form approve the change in writing. No agent can make or change a contract, or waive any of Prudential's rights or needs.

OWNERSHIP: Unless otherwise asked for above, the owner of the contract will be (1) the applicant if other than the proposed Insured, otherwise (2) the proposed Insured. But this is subject to any automatic transfer of ownership stated in the contract.

Application made at Salt Lake City State Utah

Date Aug 4, 1981

Witnessed by Licensed Agent (Writing Representative)
Signature Wayne L. Ryby

Signature of Proposed Insured
x Tammy Hardy

Signature of Applicant (If other than proposed Insured)
x Cheryl Hardy
(If applicant is a firm or corporation, insert name of company)

By
(Signature and title of officer signing for firm or corporation)

ORD 34362-79

TO FIELD OFFICE SERVICE STAFF:

County Code	Appl. Checked and County Code entered by
KR 45	Initials JF Date 8/5

TO WRITING REPRESENTATIVE:

1. If 19a or 19b of the application is answered "Yes":
   a. Any application which would normally have to be prepaid is to be written on a non-prepaid basis.
   b. If Government Allotment, Payroll Budget or Pru-Matic, 13 of the application MUST state "Insurance to begin when policy issued".
2. If the proposed Insured is a member of the Armed Forces, 13 of the application must state "Military Serial Number is ______". Also show in "REMARKS" the full name, relationship and permanent address of someone who will always know where the proposed Insured can be contacted during and after termination of military service.
3. You must furnish the information asked for below, and complete and sign the Certification below.

SUPPLEMENTARY INFORMATION

1. Give proposed Insured's HOME and BUSINESS addresses for last 3 years if amount at risk is less than $100,000; for 5 years if $100,000 to $249,999; for ¼ of lifetime if $250,000 or more. (Print)

HOME

From Mo.	From Yr.	To Mo.	To Yr.	No.	Street (If R.D., state number.)	Apt. No. or floor	City or Town (If in country, give distance from and name of trading town and nearest post-office.)	County	State
5	66	Present		1650	W Southgate		S L C	S. L.	Ut.

BUSINESS

From Mo.	From Yr.	To Mo.	To Yr.	Employer	No.	Street	City or Town	State
5	66	Present		Self	1650	Southgate	S. L. C	Ut.

2. Does more than 50% of the proposed Insured's support come from someone else? .... Yes ☐ No ☒
   If "Yes", give that person's: Full name ______ Relationship ______
   Occupation ______ Amount of life insurance in force $ ______
3. Did someone other than you suggest this insurance? If "Yes", state in "REMARKS" who and what prompted the request. Yes ☐ No ☒
4. How well do you know the proposed Insured? (Check each applicable box.)
   ☐ Met very recently ☒ Known slightly for 1/2 years at: ☐ Home ☒ Business ☐ Other (explain)
   ☐ Relative (state relationship) ☐ Known well for ____ years at: ☐ Home ☐ Business ☐ Other (explain)
5. Do you have, from any source, facts which you have not stated any place else in the application which indicate that any person named in 1a, 6 or 7 of the application may: (Yes / No)
   a. replace or change any current insurance or annuity in any company? .... ☐ ☒
   b. have in the last 3 years participated in hazardous sports (such as auto racing or parachuting), or been arrested for driving recklessly or while intoxicated? .... ☐ ☒
   c. have frequently drunk to excess, illegally used habit forming drugs or have a criminal record? .... ☐ ☒
   d. have volunteered or been ordered to report for active duty in the Armed Forces? .... ☐ ☒
   (Give details of "Yes" answers in "REMARKS".)
6. Does the amount applied for plus applications in the past 3 months in ALL companies equal $100,000 or more? .... Yes ☒ No ☐
   If "Yes", complete the following:

   a.

	Total Amount now in force in all companies	Total Amount being applied for in all companies
Personal	$ 50,000	$
Business	$	$ 300,000

   b. Is total amount being applied for in ALL companies to be placed? If "No", explain in "REMARKS". .... Yes ☒ No ☐
   c. Will more insurance than shown in a. be applied for in any company in the next 3 months? .... ☐ ☒
   If "Yes", state:
   Amount $ ______ Company ______
   ☐ Personal ☐ Business
7. Has the last name of any person named in 1a, 6 or 7 of the application been changed in the last 5 years (Marriage, court order, etc.)? Yes ☐ No ☒
   If "Yes", who, and what was the previous last name?

8a. What is the proposed Insured's total yearly income from all sources (before deductions)? $ 50,000
b. If married, what is the spouse's total yearly income from all sources (before deductions)? $ 0

9. Identify the group that best covers the proposed Insured's occupation: (Check one)
   (A) ☐ Professional, Executive, Scientific (F) ☒ Skilled, Semi-Skilled, Foreman, Part-time Farmer
   (B) ☐ Junior Professional, Junior Executive, Managerial (G) ☐ Unskilled, Service Worker, Laborer

(D) ☐ Full-time Farm Operator
(E) ☐ Clerical, Sales Clerk
(I) ☐ Student
(J) ☐ Military

10. Who is to pay the premium? (Check one)
(A) ☒ Insured
(B) ☐ Employer
(C) ☐ Policy Owner (not employer)__________(relationship)
(D) ☐ Third Party (not policy owner)__________ (name and relationship)

11. If this application is for personal insurance, what is(are) the purpose(s)? (Check appropriate boxes.)
(J) ☐ Estate Conservation
(C) ☒ Mortgage Insurance
(D) ☐ Education Fund
(E) ☐ Family Income
(F) ☐ Retirement
(V) ☐ Other__________

12. Check appropriate Special Financing (or None):
(A) ☐ Split Dollar
(B) ☐ Minimum Deposit/VOP
(C) ☐ Initial Premium from Policy Loan
(F) ☐ Other__________
(E) ☒ None

13. If this application is for business insurance, complete the following:
(a) (G) ☐ Buy-out
(H) ☐ Key Employee-Employer Indemnification
(Y) ☐ Key Employee-Deferred Compensation
(W) ☐ Non-Qualified Employee Benefits Plan
(X) ☐ Section 303 Plan
(Z) ☐ Other__________
(b) Is firm a: (1) ☐ Sole Proprietorship? (2) ☐ Partnership? (3) ☐ Corporation?
(c) Is proposed Insured: ☐ Owner of firm? (state _____%) ☐ Employee?
(d) Amount of business insurance in force and applied for in all companies on each officer or member of the firm.

Name	Age	Position	In force	Applied for
			$	$

14. What was the primary source of this sales lead? (Check one)
(A) ☐ Cold Call — Phone
(B) ☐ Cold Call — Visit
(C) ☐ Referral
(D) ☐ Direct Mail
(E) ☐ Policyholder Service
(F) ☐ Personal Acquaintance
(G) ☐ P & C Lead
(H) ☒ Other__________

15. What Sales Services did you use? (Check appropriate boxes.)
(A) ☐ CPI — Computer Ledger Statement
(B) ☐ Employers Advisory Service
(C) ☐ Variable Outlay Plan
(D) ☐ Estate Conservation Proposal Service
(E) ☐ Business Valuation Proposal Service
(F) ☐ Capital Planning Guide
(L) ☐ Business Security Analysis
(I) ☐ Other computer services
(K) ☒ __________
(J) ☐ None of the above used

16. Proposed Insured's telephone number 801 972-6562

Complete if children are to be covered

17. Are any of the children named in 7 of the application foster children or children whose legal adoption has not yet been made final? If "Yes", explain in "REMARKS" .... Yes ☐ No ☐

18. Are there other children less than 18 years of age who have not been named in 7 of the application? .... Yes ☐ No ☐
If "Yes", explain in "REMARKS".

19. Are there any children named in 7 of the application who are: Yes No
a. living in a household other than the proposed Insured's? .... ☐ ☐
b. dependent on someone other than the proposed Insured for support or maintenance? .... ☐ ☐
If either is "Yes", explain in "REMARKS".

CERTIFICATION

Did you deliver the notice that an investigative consumer report may be necessary? .... Yes ☒ No ☐

I certify that (a) on this date I saw the proposed Insured and (b), except as stated in "REMARKS", I am not aware of any information that was not shown in the answers to the questions in any Part of this application, which would adversely affect the eligibility, acceptability or insurability of any person proposed for coverage. I recommend that Prudential accept the risks proposed for coverage.

Date Aug 4, 19 81

Signature of Writing Representative (Agent) Wayne L. Ridy

REMARKS:

Mgr. or Asst. Mgr. must sign if present when application signed

Prudential Part 2 of Application or Request For Change of Policy

No.

1. Name of person examined — first, initial, last (Print)

Lynn Hardy

2. Family record

	Living (give age)	Dead Cause	Age	Year		Living (give age)	Dead Cause	Age	Year
Father		Heart Attack	?	1944	Mother		Stroke	?	1954
Brothers No. 10	37, 58,				Sisters No. 5				
4 living 6 Dead.					4 Living 1 Dead				

3. a. Has your weight changed more than 10 pounds in the past year? .... Yes ☐ No ☒
   b. If "Yes", Gain____lbs. Loss____lbs. Reason for change________
   c. How long has the present weight been the same? 5-6 years

4. Have you ever smoked? .... Yes ☒ No ☐
   If "Yes", give date(s) last smoked: Cigarettes Mo. 7 Yr. 81 Cigars Mo. Yr. Pipe Mo. Yr.

5. When did you last consult a doctor? Mo. 9 Yr. 79 (Give details in 12.)

6. Are you now being treated or taking medicine for any condition or disease? .... Yes ☐ No ☒

7. Have you ever: (Yes / No)
   a. had any surgery or been advised to have surgery and have not done so? .... ☐ ☒
   b. regularly used or are you now using, barbiturates or amphetamines, marijuana or other hallucinatory drugs, or heroin, opiates or other narcotics, except as prescribed by a doctor? .... ☐ ☒
   c. been treated or counseled for alcoholism? .... ☐ ☒
   d. had life or health insurance declined, postponed, changed, rated-up or withdrawn? .... ☐ ☒
   e. had life or health insurance canceled or its renewal or reinstatement refused? .... ☐ ☒

8. Have you ever been treated by a doctor for or had any known sign of: (Yes / No)
   a. high blood pressure? (If "Yes", state date found, if drugs are used and if still being treated.) .... ☐ ☒
   b. chest pain, pressure or discomfort? (If "Yes", state where located, number of attacks, their duration, date of last attack and treatment.) .... ☐ ☒
   c. heart murmur or rheumatic fever? (If rheumatic fever, state number of attacks, date of last attack and how long disabled for each.) .... ☐ ☒
   d. asthma, emphysema or tuberculosis? .... ☐ ☒
   e. tumor, cancer, leukemia, diabetes or syphilis? .... ☐ ☒
   f. nervous trouble, convulsions, epilepsy or mental disorder? .... ☐ ☒

9. Other than as shown above, have you ever been treated by a doctor for or had any known sign of a disease or disorder of the: (Yes / No)
   a. heart, arteries or veins? .... ☐ ☒
   b. lungs, chest or throat? .... ☐ ☒
   c. brain or nervous system? .... ☐ ☒
   d. liver, gallbladder, stomach, intestines or rectum? .... ☐ ☒
   e. kidneys, bladder, genital organs or urinary tract? .... ☐ ☒
   f. spine, joints, skull or other bones? .... ☐ ☒
   g. blood, glands or skin? .... ☐ ☒
   h. ears, eyes, nose or sinuses? .... ☐ ☒

10. Other than as shown above, have you in the past 5 years: (Yes / No)
   a. consulted or been attended or examined by any doctor or other practitioner? .... ☐ ☒
   b. been in a hospital, sanitarium or other institution for observation, rest, diagnosis or treatment? ☐ ☒
   c. had electrocardiograms, X-rays for diagnosis or treatment, or blood, urine, or other medical tests? (If "Yes", state dates, why made and by whom.) .... ☐ ☒
   d. made claim for or received benefits, compensation, or a pension because of sickness or injury? ☐ ☒

11. Do you now have a known sign of any physical disorder, disease or defect not shown above? .. Yes ☐ No ☒

12. What are the full details of the answer to 5 and to each part of 6 through 11 which is answered "Yes"?

Question No.	Illness or other reason. If operated, so state. Reason for any check-up, doctor's advice, treatment and medication.	Began Mo. Yr.	Time lost from normal activities	Full recovery Mo. Yr.	PRINT full names and addresses of doctors and hospitals
2.	3 brothers died at birth. 2 died of heart attack. 1 died of suicide. 1 Sister died at birth. He doesn't know the ages of his brothers and sisters.				
5.	DOT physical for driving trucks.	9-79			Dr. G. W. Taylor 1235 S. Redwood Rd Salt Lake City, Ut.

I declare that, to the best of my knowledge and belief, the above statements are complete and true.

(Be sure you have read all the questions and answers before signing.)

Witness Shauna Perry

Signature of person examined X Lynn Hardy

Date 8-7-81, 19

COMB 72 T-79 CM

TO EXAMINER: This authorization must be signed and dated by the proposed Insured.

Date 8-7-81, 19

AUTHORIZATION
For the Release of Information

To: Any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person.

So that eligibility for life or health insurance coverage can be determined, I authorize you to give The Prudential Insurance Company of America, and, through it, to its reinsurers and the Medical Information Bureau, any data or records you may have about me or my mental or physical health.

EXAMINER'S CONFIDENTIAL REPORT

A. Examination was made at ☐ Home ☒ Business ☐ My Office

B. Time of day examined A.M. 3:00 P.M.

C. Is the person examined your patient? .... Yes ☐ No ☒
If "Yes" and any information was not disclosed, give details below.

D. HEIGHT 6 ft. 1 in. Did you measure? Yes ☒ No ☐

E. WEIGHT (in clothes) 185 lbs. Did you weigh? Yes ☒ No ☐

F. BLOOD PRESSURE

	SYSTOLIC	DIASTOLIC Disappearance of Sound (5th Point)
1st Reading	108	62
2nd "		
3rd "		

Record first reading taken. If systolic is over 140 or diastolic over 90, or if definitely overweight, record two more readings taken at intervals. Mail us a urine specimen if systolic is over 140 or diastolic is over 90.

G. PULSE

	Pulse Rate per Minute	Premature Contractions No. per Minute
At rest (seated)	68	
Immediately after exercise (20 body bendings in 60 seconds or equivalent)		
Two minutes after exercise		

(1) If lowest rate exceeds 90, repeat observations later in examination.
(2) Any irregularities other than premature contractions? .... Yes ☐ No ☐
If "Yes", describe below.

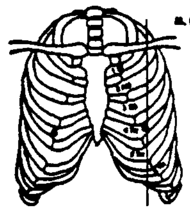
H. ARE THERE ANY ABNORMALITIES OF: (Record all details below)
1. BLOOD VESSELS (arteriosclerosis, peripheral vascular)? .... Yes ☐ No ☐
2. RESPIRATORY ORGANS (including nose, throat and mouth)? .... Yes ☐ No ☐
3. ABDOMINAL ORGANS (including tenderness, hernia)? .... Yes ☐ No ☐
4. NERVOUS SYSTEM? (Examine eye, patellar and, when indicated, other reflexes) .... Yes ☐ No ☐
5. EYES? (If marked refractive error or history of disease or injury, record vision by Snellen Notation in each eye) .... Yes ☐ No ☐
6. EARS? (Describe any discharge present or impaired hearing) .... Yes ☐ No ☒

Note: Examine heart in upright, recumbent and left lateral recumbent positions.

I. HEART — ANY MURMUR PRESENT? .... Yes ☐ No ☐
If "Yes", complete 1, 2, 3, 4 and 5 below: (If more than one murmur, describe second murmur in open space below.)

1. Murmur details —
   - A. ☐ Apical ☐ Basal ☐ Other
   - B. ☐ Systolic ☐ Presystolic ☐ Diastolic
   - C. ☐ Rough ☐ Blowing ☐ Other
   - D. ☐ Barely Heard-Gr. 1 ☐ Mod.-Gr.3 ☐ Very Loud-Gr. 5
     ☐ Faint-Gr. 2 ☐ Loud-Gr. 4 ☐ Loudest Possible-Gr. 6
   - E. ☐ Transmitted ☐ Localized
2. Effect of body position?
3a. Is heart enlarged? .... Yes ☐ No ☐
b. Any other abnormal cardiac findings? ...... Yes ☐ No ☐
(If either is "Yes", describe below.)
4. What is your diagnosis or opinion?
5. Mark position of apex, location of murmur(s) and transmission on diagram.

Position of apex beat... X
Area of distribution of murmur.......... ◯
Point of maximum intensity of murmur......... O
Direction of transmission of murmur........... ➔



J. ANALYSIS OF URINE
Albumin Yes ☐ No ☒ Sugar Yes ☐ No ☒
If either is "Yes", mail us a portion of the urine examined.

K. Are you mailing us a urine specimen? .... Yes ☒ No ☐
Mail a specimen:
(1) If required by instructions on reverse of voucher.
(2) If Life insurance application for —
$30,000 or more, and age 50 or over, or
$50,000 or more, at any age.

L. Have you any information about this person not recorded elsewhere on this form relating to physical or mental impairment? .... Yes ☐ No ☒

GIVE COMPLETE DETAILS OF ALL "YES" ANSWERS TO QUESTIONS G(2), H, I 3a-b, and L

ok8

CREDITED 17

AUG - 1 1981

I certify that on the date shown I examined the person named on the reverse whose answers to the questions on the reverse were reviewed by me, and that he or she signed this form in my presence.

Application received 8-7, 19 81	Examiner Lorena Perry
Date of examination 8-7, 19 81	No. Street City State Zip

COMB 72T 79

EXAMINATION MANAGEMENT SERVICES, INC.
1735 SOUTH REDWOOD ROAD SUITE 115
SALT LAKE CITY, UTAH 84104

Prudential Part 2 of Application or Request For Change of Policy

No.

1. Name of person examined — first, initial, last (Print) 8

LYNN HARDY

2. Family record	Living (give age)	Dead Cause	Age	Year		Living (give age)	Dead Cause	Age	Year
Father			unknown		Mother		unknown		
Brothers No.___	unknown				Sisters No.___	unknown			

3\. a. Has your weight changed more than 10 pounds in the past year? .... Yes ☐ No ☒
b. If "Yes", Gain____lbs. Loss____lbs. Reason for change____
c. How long has the present weight been the same?

4\. Have you ever smoked? ...... Has smoked 20 years - 1 pkg/day ...... Yes ☒ No ☐
If "Yes", give date(s) last smoked: Cigarettes Mo. Yr. Cigars Mo. Yr. Pipe Mo. Yr.

5\. When did you last consult a doctor? Mo. 9 Yr. 79 (Give details in 12.)

6\. Are you now being treated or taking medicine for any condition or disease? .... Yes ☐ No ☒

7\. Have you ever: Yes No
a. had any surgery or been advised to have surgery and have not done so? .... ☐ ☒
b. been in a hospital, sanitarium or other institution for observation, rest, diagnosis or treatment? ☒ ☐
c. regularly used or are you now using, barbiturates or amphetamines, marijuana or other hallucinatory drugs, or heroin, opiates or other narcotics, except as prescribed by a doctor? ..... ☐ ☒
d. been treated or counseled for alcoholism? .... ☐ ☒
e. had life or health insurance declined, postponed, changed, rated-up or withdrawn? .... ☐ ☒
f. had life or health insurance canceled or its renewal or reinstatement refused? .... ☐ ☒

8\. Have you ever been treated by a doctor for or had any known sign of: Yes No
a. high blood pressure? (If "Yes", state date found, if drugs are used and if still being treated.) .. ☐ ☒
b. chest pain, pressure or discomfort? (If "Yes", state where located, number of attacks, their duration, date of last attack and treatment.) .... ☐ ☒
c. heart murmur or rheumatic fever? (If rheumatic fever, state number of attacks, date of last attack and how long disabled for each.) .... ☒ ☐
d. asthma, emphysema or tuberculosis? .... ☐ ☒
e. tumor, cancer, leukemia, diabetes or syphilis? .... ☐ ☒
f. nervous trouble, convulsions, epilepsy or mental disorder? .... ☐ ☒

9\. Other than as shown above, have you ever been treated by a doctor for or had any known sign of a disease or disorder of the:

	Yes	No		Yes	No
a. heart, arteries or veins?	☐	☒	e. kidneys, bladder, genital organs or urinary tract?	☐	☒
b. lungs, chest or throat?	☐	☒	f. spine, joints, skull or other bones?	☐	☒
c. brain or nervous system?	☐	☒	g. blood, glands or skin?	☐	☒
d. liver, gallbladder, stomach, intestines or rectum?	☐	☒	h. ears, eyes, nose or sinuses?	☐	☒

10\. Other than as shown above, have you in the past 5 years: Yes No
a. consulted or been attended or examined by any doctor or other practitioner? .... ☒ ☐
b. had electrocardiograms, X-rays for diagnosis or treatment, or blood, urine, or other medical tests? (If "Yes", state dates, why made and by whom.) .... ☒ ☐
c. made claim for or received benefits, compensation, or a pension because of sickness or injury? ☐ ☒

11\. Do you now have a known sign of any physical disorder, disease or defect not shown above? .. Yes ☐ No ☒

12\. What are the full details of the answer to 5 and to each part of 6 through 11 which is answered "Yes"?

Question No.	Illness or other reason. If operated, so state. Reason for any check-up, doctor's advice, treatment and medication.	Began Mo. Yr.	Time lost from normal activities	Full recovery Mo. Yr.	PRINT full names and addresses of doctors and hospitals
5	ECG Exam	8 81			Dr Jay Cypress
7b	Prostate infection	10 yrs ago +			Cottonwood Hosp Murray Utah Dr Val Gundersen
8c	[illegible]				
10a	ECG every 2 years				
	EKG for Prudential [illegible] at Med Exam Center in Salt Lake this month				

I declare that, to the best of my knowledge and belief, the above statements are complete and true.

(Be sure you have read all the questions and answers before signing.)

Witness: Joseph R Evans MD

Signature of person examined: X Lynn Hardy

Date 8-25, 19 81

COMB 72 T-79

TO EXAMINER: This authorization must be signed and dated by the proposed insured.

Date ______, 19

AUTHORIZATION
For the Release of Information

To: Any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person ...

EXAMINER'S CONFIDENTIAL REPORT

A. Examination was made at ☐ Home ☐ Business ☒ My Office

B. Time of day examined A.M. 415 P.M.

C. Is the person examined your patient? .... Yes ☐ No ☒
If "Yes" and any information was not disclosed, give details below.

D. HEIGHT 6 ft. 2 in. — Did you measure? Yes ☒ No ☐

E. WEIGHT (in clothes) 187 1/2 lbs. — Did you weigh? Yes ☒ No ☐

F. BLOOD PRESSURE

	SYSTOLIC	DIASTOLIC Disappearance of Sound (5th Point)
1st Reading	132	78
2nd "		
3rd "		

Record first reading taken. If systolic is over 140 or diastolic over 90, or if definitely overweight, record two more readings taken at intervals. Mail us a urine specimen if systolic is over 140 or diastolic is over 90.

G. PULSE

	Pulse Rate per Minute	Premature Contractions No. per Minute
At rest (seated)	76	less than 1
Immediately after exercise (20 body bendings in 60 seconds or equivalent)	84	6
Two minutes after exercise	68	less than 1

(1) If lowest rate exceeds 90, repeat observations later in examination.
(2) Any irregularities other than premature contractions? .... Yes ☐ No ☒
If "Yes", describe below.

H. ARE THERE ANY ABNORMALITIES OF: (Record all details below)
1. BLOOD VESSELS (arteriosclerosis, peripheral vascular)? .... Yes ☐ No ☒
2. RESPIRATORY ORGANS (including nose, throat and mouth)? .... Yes ☐ No ☒
3. ABDOMINAL ORGANS (including tenderness, hernia)? .... Yes ☐ No ☒
4. NERVOUS SYSTEM? (Examine eye, patellar and, when indicated, other reflexes) .... Yes ☐ No ☒
5. EYES? (If marked refractive error or history of disease or injury, record vision by Snellen Notation in each eye) .... Yes ☐ No ☒
6. EARS? (Describe any discharge present or impaired hearing) .... Yes ☐ No ☒

Note: Examine heart in upright, recumbent and left lateral recumbent positions.

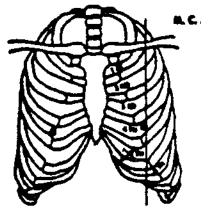
I. HEART — ANY MURMUR PRESENT? .... Yes ☐ No ☒
If "Yes", complete 1, 2, 3, 4 and 5 below: (If more than one murmur, describe second murmur in open space below.)

1. Murmur details —

A. ☐ Apical	☐ Basal	☐ Other
B. ☐ Systolic	☐ Presystolic	☐ Diastolic
C. ☐ Rough	☐ Blowing	☐ Other
D. ☐ Barely Heard-Gr. 1 ☐ Faint-Gr. 2	☐ Mod.-Gr.3 ☐ Loud-Gr. 4	☐ Very Loud-Gr. 5 ☐ Loudest Possible-Gr. 6
E. ☐ Transmitted	☐ Localized	

2. Effect of body position?
3a. Is heart enlarged? .... Yes ☐ No ☒
b. Any other abnormal cardiac findings? ...... Yes ☐ No ☒
(If either is "Yes", describe below.)
4. What is your diagnosis or opinion?
5. Mark position of apex, location of murmur(s) and transmission on diagram.

Position of apex beat... X
Area of distribution of murmur............ O
Point of maximum intensity of murmur......... O
Direction of transmission of murmur...........



J. ANALYSIS OF URINE
Albumin Yes ☐ No ☒ — Sugar Yes ☐ No ☒
If either is "Yes", mail us a portion of the urine examined.

K. Are you mailing us a urine specimen? .... Yes ☐ No ☐
Mail a specimen:
(1) If required by instructions on reverse of voucher.
(2) If Life Insurance application for — $30,000 or more, and age 50 or over, or $50,000 or more, at any age.

L. Have you any information about this person not recorded elsewhere on this form relating to physical or mental impairment? .... Yes ☐ No ☒

GIVE COMPLETE DETAILS OF ALL "YES" ANSWERS TO QUESTIONS G(2), H, I 3a-b, and L

CREDITED

I certify that on the date shown I examined the person named on the reverse whose answers to the questions on the reverse were reviewed by me, and that he or she signed this form in my presence.

Application received ...., 19

Examiner Joseph R Evans

Date of examination 8-25, 1981

No. Street City State Zip
JOSEPH R. EVANS, M.D.
808 East South Temple
Salt Lake City, Utah 84102

COMB 72T 79

Prudential

The Prudential Insurance Company of America
a mutual life insurance company
Corporate Office, Newark, New Jersey

Insured	LYNN HARDY	70 766 463	**Policy Number**
		SEP 17, 1981	**Contract Date**
Face Amount	$300,000--		
Term Period	5 YEARS, BUT SEE PAGE 4		
Premium Period	5 YEARS, BUT SEE PAGE 4		
Agency	G-SLCX		

We will pay the beneficiary the proceeds of this contract promptly if we receive due proof that the Insured died in the term period. We make this promise subject to all the provisions of the contract. The term period starts on the contract date. The term period and the contract date are shown in the window of this page.

Please read this contract with care. A guide to its contents is on the last page. A summary is on page 2. If there is ever a question about it, or if there is a claim, just see a Prudential agent or get in touch with one of our offices.

Right to Cancel Contract.—Not later than ten days after you get this contract, you may return it to us. All you have to do is take it or mail it to one of our offices or to the agent who sold it to you. We will cancel the contract from the start and give back your money promptly.

P 00229

Signed for Prudential.

Isabelle L. Kirchner
Secretary

President

rm Life Policy. Insurance payable only upon death within stated term period. Premiums payable during Insured's 'etime for stated premium period. Convertible and renewable as limited. Supplementary Benefits, if any, as listed on ontract Data page(s). Eligible for annual dividends as stated in Dividends provision.

CONTRACT SUMMARY

We offer this summary to help you understand this contract. We do not intend that it change any of the provisions of the contract.

This is a contract of term life insurance. It is payable only if the Insured dies in the term period shown in the window of the first page or any later renewal term period which we describe under Renewal on page 15. We show the amount(s) of renewal premiums in the Table of Renewal Premiums on page 4. The amount of the premiums will change as we show in the Schedule of Premiums. Premiums are to be paid during the premium period. If a premium is not paid before its days of grace are over, the contract may end and have no value except as we state under Dividends on page 8. If this occurs, you may be able to reinstate its full benefits.

Proceeds is a word we use to mean the amount we would pay if we were to settle the contract in one sum. To compute the proceeds which may arise from the Insured's death, we start with a basic amount. We may adjust that amount if there are dividend credits, premium in default, or a premium paid (but not waived under a waiver of premium benefit, if any) past the date of death. The table on page 15 tells what the basic amount is. The table will refer you to the parts of the contract which tell you how we adjust the basic amount.

Proceeds which arise from the Insured's death often are not taken in one sum. For instance, for all or part of those proceeds, you may be able to choose a manner of payment to fit the beneficiary's expected needs. If the Insured dies, and one has not been chosen, the beneficiary may be able to do so. We will pay interest under Option 3 from the date of death on any proceeds to which no other manner of payment applies. This will be automatic as we state on page 14. There is no need to ask for it.

You and we may agree on a change in the ownership of this contract. Also, unless we endorse it to say otherwise, the contract gives you these rights, among others:

- You may change the beneficiary under it.
- You may obtain any dividend credits under it.
- You may be able to renew it for further term period(s).
- You may be able to exchange it for a new contract of life insurance.

The contract, as issued, may or may not have extra benefits which we call Supplementary Benefits. If it does, we list them under Supplementary Benefits on the Contract Data page(s) and describe them after page 14. The contract may or may not have other extra benefits. If it does, we add them by rider. Any extra benefit ends as soon as any premium is in default past its days of grace, unless the form which describes it states otherwise.

(Contract Summary Continued on Page 15)

[redacted]

P 00230

CONTRACT DATA

CONTRACT DATA

INSURED'S SEX AND ISSUE AGE M-42
RATING CLASS STANDARD

INSURED	LYNN HARDY	70 766 463	POLICY NUMBER
		SEP 17, 1981	CONTRACT DATE
FACE AMOUNT	$300,000--		
TERM PERIOD	5 YEARS, BUT SEE PAGE 4		
PREMIUM PERIOD	5 YEARS, BUT SEE PAGE 4		
AGENCY	G-SLCX		

BENEFICIARY CHERYL HARDY, WIFE, IF LIVING, OTHERWISE
THE ESTATE OF SAID CHERYL HARDY

LIST OF SUPPLEMENTARY BENEFITS
(EACH BENEFIT IS DESCRIBED IN THE FORM
WHICH BEARS THE NUMBER SHOWN FOR IT)

E6100R INSURED'S WAIVER OF PREMIUM BENEFIT.

***** END OF LIST *****

SCHEDULE OF PREMIUMS

DUE DATES OF CONTRACT PREMIUMS OCCUR ON THE CONTRACT DATE AND AT INTERVALS OF 1 MONTH AFTER THAT DATE.

CONTRACT PREMIUMS ARE $161.65 EACH*

CONTRACT PREMIUMS INCLUDE THE PREMIUMS FOR BENEFIT EG100R.

***** END OF SCHEDULE *****

* SEE PAGE 4 FOR TABLE OF RENEWAL PREMIUMS

P C0231

TABLE OF RENEWAL PREMIUMS

ATTAINED AGE	MONTHLY PREMIUM
47	$230.65
52	362.65
57	557.65
62	821.65*
67#	1,187.65
70	1,676.65

THIS RENEWAL TERM PERIOD IS FOR LESS THAN 5 YEARS.
* CHANGING ON FIRST ANNIVERSARY AFTER INSURED'S 65TH BIRTHDAY TO $738.65.

P 00232

ENDORSEMENTS

(Only we can endorse this contract.)

GENERAL PROVISIONS

Definitions.—We define here some of the words and phrases used all through this contract. We explain others, not defined here, in other parts of the text.

We, Our and Us.—Prudential.

You and Your.—The owner of the contract.

Insured.—The person whose name is in the window of the first page. He or she need not be the owner.

Example: *Suppose we issue a contract on the life of your spouse. You applied for it and named no one else as owner. Your spouse is the Insured and you are the owner.*

Issue Date.—The contract date.

Anniversary or Contract Anniversary.—The same day and month as the contract date in each later year.

Example: *If the contract date is March 9, 1980, the first anniversary is March 9, 1981. The second is March 9, 1982, and so on.*

Contract Year.—A year which starts on the contract date or on an anniversary.

Example: *If the contract date is March 9, 1980, the first contract year starts then and ends on March 8, 1981. The second starts on March 9, 1981 and ends on March 8, 1982, and so on.*

Attained Age.—The Insured's attained age at any time is the issue age plus the length of time since the contract date. You will find the issue age near the top of page 3.

The Contract.—This policy and the application, a copy of which is attached, form the whole contract. We assume that all statements in the application were made to the best of the knowledge and belief of the person(s) who made them; in the absence of fraud they are deemed to be representations and not warranties. We relied on those statements when we issued the contract. We will not use any statement, unless made in the application, to void the contract or to deny a claim.

Contract Modifications.—Only a Prudential officer may agree to modify this contract, and then only in writing.

Ownership and Control.—Unless we endorse this contract to say otherwise: (1) the owner of the contract is the Insured; and (2) while the Insured is living the owner alone is entitled to (a) any contract benefit and value, and (b) the exercise of any right and privilege granted by the contract or by us.

Suicide Exclusion.—If the Insured, whether sane or insane, dies by suicide within two years from the issue date, we will pay no more than the sum of the premiums paid.

Currency.—Any money we pay, or which is paid to us, must be in United States currency. Any amount we owe will be payable at our Corporate Office.

(Continued on Next Page)

P 00233

Misstatement of Age or Sex.—If the Insured's stated age or sex or both are not correct, we will change each benefit and any amount to be paid to that which the premium would have bought for the correct age and sex.

The Schedule of Premiums may show that premiums change or stop on a certain date. We may have used that date because the Insured would attain a certain age on that date. If we find that the issue age was wrong, we will correct that date.

Incontestability.—Except for non-payment of premium, we will not contest this contract after it has been in force during the Insured's lifetime for two years from the issue date.

Assignment.—We will not be deemed to know of an assignment unless we receive it, or a copy of it, at our Home Office. We are not obliged to see that an assignment is valid or sufficient.

BENEFICIARY

You may designate or change a beneficiary. Your request must be in writing and in a form which meets our needs. It will take effect only when we file it at our Home Office; this will be after you send the contract to us to be endorsed, if we ask you to do so. Then any previous beneficiary's interest will end as of the date of the request. It will end then even if the Insured is not living when we file the request. Any beneficiary's interest is subject to the rights of any assignee of whom we know.

When a beneficiary is designated, any relationship shown is to the Insured, unless otherwise stated. To show priority, we may use numbered classes, so that the class with first priority is called class 1, the class with next priority is called class 2, and so on. When we use numbered classes, these statements apply to beneficiaries unless the form states otherwise:

1. One who survives the Insured will have the right to be paid only if no one in a prior class survives the Insured.
2. One who has the right to be paid will be the only one paid if no one else in the same class survives the Insured.
3. Two or more in the same class who have the right to be paid will be paid in equal shares.
4. If none survives the Insured, we will pay in one sum to the Insured's estate.

Example: *Suppose the class 1 beneficiary is Jane and the class 2 beneficiaries are Paul and John. We owe Jane the proceeds if she is living at the Insured's death. We owe Paul and John the proceeds if they are living then but Jane is not. But if only one of them is living, we owe him the proceeds. If none of them is living we owe the Insured's estate.*

Beneficiaries who do not have a right to be paid under these terms may still have a right to be paid under the Automatic Mode of Settlement.

Before we make a payment, we have the right to decide what proof we need of the identity, age or any other facts about any persons designated as beneficiaries. If beneficiaries are not designated by name and we make payment(s) based on that proof, we will not have to make the payment(s) again.

RIDER FORM NO. 27716 ATTACHED

Prudential

The Prudential
Insurance Company
of America

Insured	Policy No.
Lynn Hardy	70 766 463

Ownership and Control

This contract is amended at issue to provide that, except as we may state below, all rights of ownership and control will belong to the owner(s) shown here:

P 00234

Cheryl Hardy, wife of the Insured, the estate of said wife.

While the Insured is living, the owner(s), with no one else's consent, is entitled to any benefit and value, and to the exercise of any right and privilege granted by the contract or by us. But if we are settling with an owner or someone else who is not the Insured, then: (1) our consent is needed for a settlement option to be chosen for any proceeds which may arise other than from the Insured's death; and (2) if this is a contract which calls for monthly payments upon its maturity as an endowment, we will have the right at that time to pay its cash value in one sum instead.

Endorsed by attachment on Contract Date

The Prudential Insurance Company of America.
By Isabelle L. Kirchner
Secretary

Printed in U.S.A.
ORD 27710 79 Ownership and control—No succession (Issue)

Printed in U.S.A.

PREMIUM PAYMENT AND REINSTATEMENT

Payment of Premiums.—The Schedule of Premiums shows the amounts of the premiums and how often they must be paid. We tell you below how you may be able to have them fall due either more or less often. Due dates fall on the same day of the month as the contract date. They occur only while the Insured is living and only in the premium period. The premium period, shown in the window of the first page, starts on the contract date. Each premium is to be paid by its due date. It may be paid at our Home Office or to any of our authorized agents. If we are asked to do so, we will give a signed receipt. A premium is in default if it is not paid when it is due.

Change of Frequency.—You may ask us in writing to have premiums fall due either more or less often. If we agree, we will make the change and tell you what the new premiums are and when they are due. The more often premiums are due, the larger the total amount that will have to be paid for a contract year.

Grace Period.—We grant 31 days of grace for paying each premium except the first one. If a premium has not been paid by its due date, the contract will stay in force during its days of grace. If a premium has not been paid when its days of grace are over, the contract will end and have no value, except as we state under Dividends.

Premium Adjustment.—The Insured might die in the premium period while no premium is in default. If so, we will make an adjustment so that the proceeds will include that part of the last premium paid which is more than that which was needed to pay premiums through the date of death. Or the Insured might die in the days of grace of a premium in default. If so, the amount needed to pay premiums through the date of death is due us. We will make an adjustment so that the proceeds will not include that amount.

Example: *Suppose the contract date is in 1980. An annual premium of $400 due in 1982 is paid. The Insured dies nine months later. The proceeds will include about $100 from the premium, since $300 was enough to pay premiums through the date of death. The proceeds could include slightly more or less than $100, since some months have more days than others.*

If a claim arises while the Insured is living, we will subtract any premium in default when we settle the claim.

Reinstatement.—You may reinstate this contract after the days of grace of a premium in default. All these conditions must be met:

1. The final term period for which the contract may be renewed must not have ended.

2. Premium payment must not be in default more than three years.

3. You must give us any facts we need to satisfy us that the Insured is insurable for the contract.

4. We must be paid all premiums in arrears with compound interest at 6% a year. We may set a lower rate for any period in which there are arrears.

Example: *Suppose a premium due May 1st is not paid on time. The contract will stay in force until June 1st whether the premium is paid or not. If the premium is not paid by June 1st, you must meet all the above conditions if you want to reinstate the contract.*

P 00235

DIVIDENDS

Participation.—We will decide each year what part of our surplus, if any, to credit to this contract as a dividend. The contract will be eligible for such a dividend if (1) the Insured is living; and (2) all premiums due before the anniversary have been paid.

We will credit any such dividend on the anniversary. But we do not expect to credit one before the second anniversary.

Dividend Options.—If you ask us in writing at our Home Office and in a form which meets our needs, you may choose any of these uses for any such dividend:

1. Cash.—We will pay it to you in cash.

2. Premium Reduction.—We will use it to reduce any premium then due.

3. Addition.—We will use it at the net single premium rate at the Insured's attained age to provide an addition, which is paid-up endowment insurance on the Insured's life to mature on the contract anniversary when his or her attained age is 75.

Example: *Suppose we credit a dividend of $10 to the contract on an anniversary. Suppose it will provide an addition in the amount of $17. The amount of this addition will not change. Its net value is that which we will pay if the addition is surrendered. The net value, which starts at $10, will increase with time and grow to $17 by the Insured's attained age 75 when that amount will be paid as an endowment.*

4. Accumulation.—We will hold it at interest. The rate will be at least 3% a year. We may use a higher rate.

If you have not made another choice by 31 days after the anniversary, we will use the dividend as we state in 3 above.

Dividend Credits Described.—The phrase dividend credits means the total of (1) any dividends and interest we hold under 4 above; (2) either the amount or value, as we explain below, of any additions under 3 above; and (3) any other dividends we have credited to the contract but have not yet paid. It includes the amount of any of those additions when we refer to the proceeds which arise from the Insured's death. It includes the net value of any of those additions when we use it under Surrender of Dividends and Automatic Cash Payment. The surrender value of those additions will never be less than the dividends we used to provide them.

Surrender of Dividends.—You may surrender any dividend credits for their net value. But we must have your request in writing at our Home Office and in a form which meets our needs.

Automatic Cash Payment.—We will pay promptly in cash any dividend credits which exist (1) at the end of the last day of grace of a premium in default; or (2) on the date this contract is exchanged for a new contract of life insurance on the Insured's life; or (3) at the end of any term period if the contract is not renewed for a further term period; or (4) on the contract anniversary when the Insured's attained age is 75.

Settlement.—If any dividend credits exist at the Insured's death, we will include them in the proceeds when we settle the contract.

ENDORSEMENTS

(Only we can endorse this contract.)

P C0236

CONVERSION TO ANOTHER PLAN OF INSURANCE

CONVERSION TO ANOTHER PLAN OF INSURANCE

Right to Convert.—You may be able to exchange this contract for a new contract of life insurance on the Insured's life. You will not have to prove to us that the Insured is insurable. When we use the phrase new contract we mean the contract for which this contract may be exchanged.

Conditions.—Your right to make this exchange is subject to all these conditions: (1) You must ask for the exchange in writing and in a form which meets our needs. (2) You must surrender this contract to us. (3) We must have your request and the contract at our Home Office while this contract is in force and not later than its contract anniversary when the Insured's attained age is 70.

The new contract will not take effect unless the premium for it or the charge we describe under Charge for Exchange is paid while the Insured is living. This must be done within 31 days after the first to occur of (1) the date of your request; and (2) the date to which premiums for this contract are paid.

There will be no charge for the exchange if the contract date of the new contract is the same as the date of your request. We will return that part, if any, of the last premium paid for this contract which is more than that which was needed to pay premiums to the contract date of the new contract.

Contract Date.—The date of the new contract will be the date you ask for in your request. But it may not be after the date of your request or after the date to which premiums are paid for this contract. It may not be before the date of this contract or after the contract anniversary when the Insured's attained age is 70. And it may not be before the date when we first offered the form of the new contract.

Contract Specifications.—The new contract will be in the same rating class as this contract. We will set the issue age and the premiums for the new contract in accord with our regular rules in use on the contract date of the new contract.

The new contract may call for annual premiums. If we agree, you will be able to have premiums fall due more often.

The new contract may be on any life or endowment plan we would regularly issue on its contract date for the same rating class, amount, issue age and sex. But it cannot be any of these: (1) a single premium contract; or (2) one which insures anyone other then the Insured; or (3) one which includes or provides for term insurance other than extended insurance; or (4) one with premiums which increase after a stated time, if its first premium is less than 80% of any later premium; or (5) one which provides an income if the Insured becomes disabled; or (6) one with Supplementary Benefits other than the benefits to which we refer later in these paragraphs.

Its face amount will be the amount you ask for in your request. But except as we state below, that amount must be an amount we would regularly issue for the plan chosen. And it cannot be less than $5,000 or more than the face amount of this contract. If the face amount you want is less than the smallest amount we would regularly issue on the plan you wish, we will issue a new contract for as low as $5,000 on the Life Paid Up at Age 85 plan if you ask us to do so.

If (1) the new contract is either on the Life Paid Up at Age 85 plan or has a premium period at least as long as for that plan; (2) this contract has a benefit for waiving premiums in the event of disability; and (3) we would include that kind of benefit in other contracts like the new contract, we will put that kind of benefit in the new contract, as we state in General below.

We will not deny a benefit for waiving premiums which we would have allowed under this contract, and which we would otherwise allow under the new contract, just because disability started before the contract date of the new contract. But any premium to be waived for that disability under the new contract must be at the frequency which was in effect for this contract when the disability started.

We will not waive any premium which would have been due for the new contract before the date of the exchange. And we will not waive any premium under the new contract unless it has a benefit for waiving premiums in the event of disability. This will be so even if we have waived premiums under this contract.

If this contract has an accidental death benefit and we would regularly issue contracts like the new contract with that benefit, we will put that kind of benefit in the new contract, as we state in General below. But (1) you must ask for it in your request for the exchange; (2) the face amounts of this contract and the new contract must be the same; and (3) the amount of accidental death benefit in the new contract will be the smaller of the face amount of the new contract and the amount of the accidental death benefit in this contract.

General.—Any benefit for waiving premiums and any accidental death benefit in the new contract will be the same one, with the same provisions, that we put in other contracts like it on its contract date. But if either benefit was added to this contract by rider and the contract date of the new contract is earlier than the date of that rider, the benefit, if any, in the new contract will be the same as that provided by the rider. In any of these paragraphs,

(Continued on Next Page)

P 00237

CONVERSION TO ANOTHER PLAN OF INSURANCE (Continued)

when we use the phrases other contracts like it and other contracts like the new contract, we mean contracts which we would regularly issue on the same plan and for the same rating class, amount, issue age and sex.

Charge for Exchange.—If the contract date for the new contract is before the date of your request, there may be a charge to make the exchange. We will compute the amount of any charge in two ways as we show below. When we use the word interest, we mean compound interest at 6% a year from each premium due date to the date to which premiums have been paid.

1. We will compute the sum of the premiums, with interest, which would have been due for the new contract from its contract date to the date to which premiums have been paid on this contract. Then we will subtract the sum of the premiums, with interest, which were due for this contract from the contract date of the new contract to the date to which premiums have been paid on this contract. But we will not subtract (a) any premiums, with interest, due on this contract for any portion of its face amount which is more than the face amount of the new contract; or (b) any premiums, with interest, for any extra benefits not included in the new contract.

2. We will compute the cash value of the new contract as of the date to which premiums have been paid on this contract. We will increase this amount by not more than 14%. We will add to this the sum of the premiums, with interest, which would have been due for any extra benefits under the new contract from the date the benefit took effect to the date to which premiums have been paid on this contract. Then we will subtract the sum of the premiums, with interest, which were due for the same extra benefits under this contract for the same length of time.

We will compare the amounts we compute in 1 and 2 above. The charge to be paid will never be more than the larger of the two. It may be less.

Changes in Plan.— You may be able to have this contract changed to another plan of life insurance other than in accord with the requirements for exchange which we state above. But any change may be made only if we consent, and will be subject to conditions and charges which we then determine.

ENDORSEMENTS

(Only we can endorse this contract.)

P 00238

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SETTLEMENT OPTIONS

Payee Defined.—In these provisions and under the Automatic Mode of Settlement, the word Payee means a person who has a right to receive a settlement under the contract. Such a person may be the Insured, the owner, a beneficiary or a contingent payee.

Choosing an Option.—While the Insured is living you may choose, or change the choice of, an option for all or part of the proceeds which may arise from the Insured's death. The requirements are the same as those to designate or change a beneficiary. We describe them under Beneficiary.

A Payee may choose an option for all or part of any proceeds or residue which becomes payable to him or her in one sum. We explain residue under Residue Described.

In some cases, you or another Payee will need our consent to choose an option. We describe these cases under Conditions.

Options Described.—Here are the options we offer. We may also consent to other arrangements. As we use it in Options 2 and 5, the phrase regularly issued does not include contracts which are used to qualify for special Federal income tax treatment as a retirement plan.

Option 1 (Instalments for a Fixed Period).—We will make equal payments for up to 25 years based on the Option 1 Table. The payments will include interest at an effective rate of 3½% a year. We may credit more interest. If and while we do so, the payments will be larger.

Option 2 (Life Income).—We will make equal monthly payments for as long as the person on whose life the settlement is based lives, with payments certain for the period chosen. The choices are either ten years (10-Year Certain) or until the sum of the payments equals the amount put under this option (Instalment Refund). The amount of each payment will be based on the Option 2 Table and the age and sex, on the due date of the first payment, of the person on whose life the settlement is based. But if a choice is made more than two years after the contract proceeds first become payable, we may use the Option 2 rates in Ordinary policies we regularly issue, based on United States currency, on the due date of the first payment. On request, we will quote the payment rates in policies we then issue. We must have proof of the date of birth of the person on whose life the settlement is based. The settlement will share in our surplus to the extent and in the way we decide.

Option 3 (Interest Payment).—We will hold an amount at interest. We will pay interest at an effective rate of at least 3% a year ($30.00 annually, $14.89 semi-annually, $7.42 quarterly or $2.47 monthly per $1,000). We may pay more interest.

Option 4 (Instalments of a Fixed Amount).—We will make equal annual, semi-annual, quarterly or monthly payments if they total at least $90 a year for each $1,000 put under this option. We will credit the unpaid balance with interest at an effective rate of at least 3½% a year. We may credit more interest. If we do so, the balance will be larger. The final payment will be any balance equal to or less than one payment.

Option 5 (Non-Participating Life Income).—We will make payments like those of any life annuity we then regularly issue which (1) is based on United States currency; (2) is bought by a single sum; (3) is not eligible for dividends; and (4) does not normally provide for deferral of the first payment. For the first $250,000 or less placed under this option on any date, the payment will be 103% of what we would pay under that kind of annuity with its first payment due on its contract date. For any excess placed under this option on that date, the part of the payment provided by the excess will be 101.5% of the part of the payment the excess would buy under that kind of annuity. In any case, we will compute the present value of any unpaid payments certain at the same interest rate we would use for that kind of annuity with the same provisions as to withdrawal. At least one of the persons on whose life the Option 5 is based must be a Payee. We must have proof of the date of birth of any person on whose life the option is based. Option 5 cannot be chosen more than 30 days before the due date of the first payment. On request, we will quote the payment which would apply for any amount placed under the option at that time.

First Payment Due Date.—Unless a different date is stated when the option is chosen: (1) the first payment for Option 3 will be due at the end of the chosen payment interval; and (2) the first payment for any of the other options will be due on the date the option takes effect.

Residue Described.—For Options 1 and 2, residue on any date means the then present value of any unpaid payments certain. We will compute it at an effective interest rate of 3½% a year. But we will use the rate we used to compute the actual Option 2 payments if they were not based on the table in this contract.

For Options 3 and 4, residue on any date means any unpaid balance with interest to that date. For Option 5, it means the then present value of any unpaid payments certain. We will compute it at the interest rate to which we refer in Option 5.

For Options 2 and 5, residue does not include the value of any payments which may become due after the certain period.

(Continued on Next Page)

P 00239

SETTLEMENT OPTIONS (Continued)

OPTION 1 TABLE

MINIMUM AMOUNT OF MONTHLY PAYMENT FOR EACH $1,000, THE FIRST PAYABLE IMMEDIATELY

Number of Years	Monthly Payment
1	$84.65
2	43.05
3	29.19
4	22.27
5	18.12
6	15.35
7	13.38
8	11.90
9	10.75
10	9.83
11	9.09
12	8.46
13	7.94
14	7.49
15	7.10
16	6.76
17	6.47
18	6.20
19	5.97
20	5.75
21	5.56
22	5.39
23	5.24
24	5.09
25	4.96

Multiply the monthly amount by 2.989 for quarterly, 5.952 for semi-annual or 11.804 for annual.

OPTION 2 TABLE

MINIMUM AMOUNT OF MONTHLY PAYMENT FOR EACH $1,000, THE FIRST PAYABLE IMMEDIATELY

AGE LAST BIRTHDAY	KIND OF LIFE INCOME: 10-Year Certain		KIND OF LIFE INCOME: Instalment Refund	
	Male	Female	Male	Female
10 and under	$3.23	$3.16	$3.22	$3.15
11	3.24	3.17	3.23	3.16
12	3.26	3.18	3.25	3.17
13	3.27	3.19	3.26	3.18
14	3.29	3.20	3.28	3.19
15	3.30	3.21	3.29	3.20
16	3.32	3.23	3.31	3.22
17	3.34	3.24	3.33	3.23
18	3.36	3.26	3.34	3.25
19	3.37	3.27	3.36	3.26
20	3.39	3.29	3.38	3.28
21	3.41	3.30	3.40	3.29
22	3.44	3.32	3.42	3.31
23	3.46	3.34	3.44	3.33
24	3.48	3.36	3.46	3.34
25	3.51	3.37	3.49	3.36
26	3.53	3.39	3.51	3.38
27	3.56	3.42	3.54	3.40
28	3.59	3.44	3.56	3.42
29	3.62	3.46	3.59	3.44
30	3.65	3.48	3.62	3.47
31	3.68	3.51	3.65	3.49
32	3.71	3.54	3.68	3.52
33	3.75	3.56	3.71	3.54
34	3.78	3.59	3.74	3.57
35	3.82	3.62	3.78	3.60
36	3.86	3.65	3.81	3.63
37	3.91	3.69	3.85	3.66
38	3.95	3.72	3.89	3.69
39	4.00	3.76	3.93	3.72
40	4.05	3.79	3.97	3.76
41	4.10	3.83	4.02	3.79
42	4.15	3.87	4.06	3.83
43	4.21	3.92	4.11	3.87
44	4.27	3.96	4.16	3.91

AGE LAST BIRTHDAY	KIND OF LIFE INCOME: 10-Year Certain		KIND OF LIFE INCOME: Instalment Refund	
	Male	Female	Male	Female
45	$4.33	$4.01	$4.21	$3.96
46	4.39	4.06	4.27	4.00
47	4.46	4.12	4.32	4.05
48	4.53	4.17	4.38	4.10
49	4.60	4.23	4.44	4.15
50	4.67	4.30	4.51	4.21
51	4.75	4.36	4.58	4.26
52	4.83	4.43	4.65	4.33
53	4.92	4.50	4.72	4.39
54	5.00	4.58	4.79	4.46
55	5.10	4.66	4.87	4.53
56	5.19	4.74	4.96	4.60
57	5.29	4.83	5.05	4.68
58	5.40	4.92	5.14	4.76
59	5.51	5.02	5.24	4.85
60	5.62	5.12	5.34	4.94
61	5.74	5.23	5.45	5.04
62	5.87	5.34	5.56	5.14
63	6.00	5.46	5.68	5.25
64	6.13	5.59	5.81	5.37
65	6.28	5.73	5.94	5.49
66	6.43	5.87	6.08	5.62
67	6.58	6.02	6.23	5.76
68	6.74	6.19	6.39	5.91
69	6.91	6.36	6.56	6.07
70	7.08	6.53	6.74	6.23
71	7.26	6.72	6.93	6.41
72	7.43	6.92	7.13	6.61
73	7.61	7.12	7.34	6.81
74	7.80	7.32	7.57	7.03
75	7.98	7.53	7.81	7.26
76	8.16	7.74	8.06	7.51
77	8.33	7.95	8.34	7.77
78	8.52	8.15	8.63	8.06
79	8.68	8.35	8.95	8.36
80 and over	8.85	8.54	9.29	8.68

(Continued on Next Page)

P 00240

SETTLEMENT OPTIONS (Continued)

Withdrawal of Residue.—Unless otherwise stated when the option is chosen: (1) under Options 1, 2 and 5 the residue may be withdrawn; and (2) under Options 3 and 4 all, or any part not less than $100, of the residue may be withdrawn. If an Option 3 residue is reduced to less than $1,000, we have the right to pay it in one sum. Under Options 2 and 5, withdrawal of the residue will not affect any payments that may become due after the certain period; the value of those payments cannot be withdrawn. Instead, the payments will start again if they were based on the life of a person who lives past the certain period.

Designating Contingent Payee(s).—A Payee under an option has the right, unless otherwise stated, to name or change a contingent payee to receive any residue at that Payee's death. This may be done only if (1) the Payee has the full right to withdraw the residue; or (2) the residue would otherwise have been payable to that Payee's estate at death.

A Payee who has this right may choose, or change the choice of, an option for all or part of the residue. In some cases, the Payee will need our consent to choose or change an option. We describe these cases under Conditions.

Any request to exercise any of these rights must be in writing and in a form which meets our needs. It will take effect only when we file it at our Home Office. Then the interest of anyone who is being removed will end as of the date of the request, even if the Payee who made the request is not living when we file it.

Changing Options.—A Payee under Option 1, 3 or 4 may choose another option for any sum which the Payee could withdraw on the date the chosen option is to start. That date may be before the date the Payee makes the choice only if we consent. In some cases, the Payee will need our consent to choose or change an option. We describe these cases next.

Conditions.—Our consent is needed for an option to be used for any person under any of these conditions:

1. The person is not a natural person who will be paid in his or her own right.

2. The person will be paid as assignee.

3. The amount to be held for the person under Option 3 is less than $1,000. But we will hold any amount for at least one year under the Automatic Mode of Settlement.

4. Each payment to the person under the option would be less than $20.

5. The option is for residue arising other than at (a) the Insured's death, or (b) the death of the beneficiary who was entitled to be paid as of the date of the Insured's death.

6. The option is for proceeds which arise other than from the Insured's death, and we are settling with an owner or any other person who is not the Insured.

Death of Payee.—If a Payee under an option dies and if no other distribution is shown, we will pay any residue under that option in one sum to the Payee's estate.

ENDORSEMENTS

(Only we can endorse this contract.)

AUTOMATIC MODE OF SETTLEMENT

Applicability.—These provisions apply to proceeds arising from the Insured's death and payable in one sum to a Payee who is a beneficiary. They do not apply to any periodic payment.

Interest on Proceeds.—We will hold the proceeds at interest under Option 3. The Payee may withdraw the residue. We will pay it promptly on request. We will pay interest annually unless we agree to pay it more often. We have the right to pay the residue in one sum after one year if (1) the Payee is not a natural person who will be paid in his or her own right; (2) the Payee will be paid as assignee; or (3) the original amount we hold under Option 3 for the Payee is less than \$1,000.

Settlement at Payee's Death.—If the Payee dies and leaves an Option 3 residue, we will honor any contingent payee provision then in effect. If there is none, here is what we will do. We will look to the beneficiary designation of the contract; we will see what other beneficiary(ies), if any, would have been entitled to the portion of the proceeds which produced the Option 3 residue if the Insured had not died until immediately after the Payee died. Then we will pay the residue in one sum to such other beneficiary(ies), according to that designation. But if, as stated in that designation, payment would be due the estate of someone else, we will instead pay the estate of the Payee.

Example: *Suppose the class 1 beneficiary is Jane and the class 2 beneficiaries are Paul and John. Jane was living when the Insured died. Jane later died without having chosen an option or naming someone other than Paul and John as a contingent payee. If Paul and John are living at Jane's death we owe them the residue. If only one of them is living then, and if the contract called for payment to the survivor of them, we owe him the residue. If neither of them is living then, we owe Jane's estate.*

Spendthrift and Creditor.—A beneficiary or contingent payee may not, at or after the Insured's death, assign, transfer or encumber any benefit payable. To the extent allowed by law, the benefits will not be subject to the claims of any creditor of any beneficiary or contingent payee.

ENDORSEMENTS

(Only we can endorse this contract.)

Voting Rights.—We are a mutual life insurance company. Our principal office is in Newark, New Jersey, and we are incorporated in that State. By law, we have 24 directors. This includes 16 elected by our policyholders (four each year for four year terms), two of our officers, and six public directors named by New Jersey's Chief Justice.

The election is held on the first Tuesday in April from 10:00 A.M. to 2:00 P.M. in our office at the Secretary's address shown here. After this contract has been in force for one year, you may vote either in person or by mail. We will send you a ballot if you ask for one. Just write to our Secretary at Prudential Plaza, Newark, New Jersey 07101, at least 60 days before the election date. By law, your request must show your name, address, policy number and date of birth. If you are an individual, you must be at least 18 years old to vote.

Home Office Locations.—When we use the phrase Home Office we mean any of these Prudential offices:

Corporate Office, Newark, N.J.

Central Atlantic Home Office, Fort Washington, Pa.
Eastern Home Office, South Plainfield, N.J.
Head Office, Canadian Operations, Toronto, Ont.
Mid-America Home Office, Chicago, Ill.
North Central Home Office, Minneapolis, Minn.

Northeastern Home Office, Boston, Mass.
South-Central Home Office, Jacksonville, Fla.
Southwestern Home Office, Houston, Tex.
Western Home Office, Los Angeles, Calif.

The Prudential Insurance Company of America,

By Isabelle L. Kirchner
Secretary

COMB 34693—79

P 00242

Printed in U.S.A.

RIDER FOR

Printed in U.S.A.

RIDER FOR INSURED'S WAIVER OF PREMIUM BENEFIT

This Benefit is a part of this contract only if it is listed on the Contract Data page(s)

Total Disability Benefit.—We will waive contract premiums which fall due while the Insured is totally disabled. But this is subject to all the provisions of this Benefit and of the rest of this contract.

Disability Defined.—When we use the words disability and disabled in this Benefit we mean total disability and totally disabled. Here is how we define them: (1) until the Insured has stayed disabled for two years, we mean that he or she cannot, due to sickness or injury, do any of the duties of his or her regular occupation; but (2) after the Insured has stayed disabled for two years, we mean that he or she cannot, due to sickness or injury, do any gainful work for which he or she is reasonably fitted by education, training, or experience.

Except for what we state in the next sentence, we will at no time regard an Insured as disabled who is doing gainful work for which he or she is reasonably fitted by education, training, or experience. We will regard an Insured as disabled, even if working or able to work, if he or she incurs, during a period in which premiums are eligible to be waived as we describe below, one of these conditions: (1) permanent and complete blindness of both eyes; or (2) severance of both hands at or above the wrists or both feet at or above the ankles; or (3) severance of one hand at or above the wrist and one foot at or above the ankle.

Premiums Eligible To Be Waived.—If the Insured becomes disabled before the first contract anniversary after his or her 60th birthday and that disability begins (1) on or after the first contract anniversary after his or her 5th birthday, if the contract date was before that birthday; or (2) on or after the contract date, if that date was on or after his or her 5th birthday, we will waive all premiums which fall due while he or she stays disabled.

If the Insured becomes disabled on or after the first contract anniversary after his or her 60th birthday, we will waive only those premiums which fall due before the first contract anniversary after his or her 65th birthday and while he or she stays disabled.

If the Insured becomes disabled on or after the first anniversary after his or her 65th birthday, we will not waive any premium which falls due in that period of disability.

Conditions.—Both of these conditions must be met: (1) The Insured must become disabled while this contract is in force with no premium in default past its days of grace. (2) The Insured must have stayed disabled for a period of at least six months while living.

Exceptions.—We will not waive any premium if the Insured becomes disabled from: (1) an injury he causes to himself, or she causes to herself, on purpose; or (2) sickness or injury due to service on or after the contract date in the armed forces of any country(ies) at war. The word war means declared or undeclared war and includes resistance to armed aggression.

Successive Disabilities.—Here is what happens if the Insured has at least one premium waived while disabled, then gets well so that premium payment resumes, and then becomes disabled again. In this case, we will ignore the six-month period which would otherwise be required by Condition (2) and consider the second period of disability to be part of the first period unless (1) the Insured has done gainful work, for which he or she is reasonably fitted, for at least six months between the periods; or (2) the Insured became disabled the second time from an entirely different cause.

If we ignore the six-month period required by Condition (2), we also will not count the days when there was no disability as part of the two year period when disability means the Insured cannot work at his or her regular occupation.

Notice and Proof of Claim.—Notice and proof of any claim must be given to us while the Insured is living and disabled, or as soon as reasonably possible. If notice or proof is not given as soon as reasonably possible, we will not weive any premium due more than one year before the date that notice or proof is given to us. We may require proof at reasonable times that the Insured is still disabled. After he or she has been disabled for two years, we will not ask for proof more than once a year. As a part of any proof, we may require that the Insured be examined at our expense by doctors of our choice.

Recovery from Disability.—We will stop waiving premiums if (1) disability ends; or (2) we ask for proof that the Insured is disabled and we do not receive it; or

(Continued on Next Page)

(Continued from Preceding Page)

(3) we require that the Insured be examined and he or she fails to do so.

Miscellaneous.—Any premiums which fall due are payable until we approve a claim. We will refund any premium paid which is later waived. There might be unpaid premiums which fall due (1) after disability starts; but (2) more than one year before we have notice of claim at our Home Office. Or disability might start in the days of grace of a premium which is unpaid. In either case, if we are otherwise able to approve a claim, those unpaid premiums which we do not waive will be due us with compound interest at 6% a year. If we do not receive them, we will deduct them with interest from any amount which we pay under the contract.

Any premium we waive will be at the frequency in effect when the Insured becomes disabled.

If we waive premiums, the effect on this contract will be the same as if the premiums had been paid in cash. But the Premium Adjustment provision in the contract will not apply to any premium we waive under this Benefit.

If we owe the Insured a refund of premium but have not paid it before his or her death, we have the choice of paying the beneficiary for insurance payable upon the death of the Insured or the Insured's estate.

Benefit Premiums.—The premiums for this Benefit are a part of the contract premiums due before the first contract anniversary after the Insured's 65th birthday.

Termination.—This Benefit will end on the earliest of:

1. the end of the last day of grace of a premium in default; it will not continue if a benefit takes effect under any contract value options provision which may be in the contract;
2. the end of the day which is the last premium due date in the premium period;
3. the date the contract is surrendered under its Cash Value Option, if it has one;
4. the end of the day before the first contract anniversary after the Insured's 65th birthday, unless the Insured has stayed disabled since before the first contract anniversary after the 60th birthday; and
5. the date the contract ends for any other reason.

This Supplementary Benefit rider attached to this contract on the Contract Date

The Prudential Insurance Company of America,

By Isabelle L. Kirchner

Secretary

P 00244

Printed in U.S.A.

...Company of America

1a. Proposed Insured's name — first, initial, last (Print) | 1b. Sex | 2a. Date of birth

Lynn

10 166 465

RENEWAL

You may renew this contract at the end of either its term period or a renewal term period. You will not have to prove to us that the Insured is insurable. All these conditions must be met:

1. A renewal term period must start not later than the contract anniversary on which the Insured's attained age is 70.

2. The contract must be in force with no premium in default past its days of grace.

3. We must be paid the first premium for a renewal term period as we describe below.

In any of these paragraphs when we use the phrase renewal term period we mean a term period for which the contract may be renewed. Except as we state in the next sentence, a renewal term period will be the term period of this contract, as we show on page 3. But if a renewal term period begins on the contract anniversary when the Insured's attained age is 66, 67, 68 or 69, that renewal term period will be for the number of years between the Insured's attained age on that anniversary and age 70. We show the amount(s) of renewal premiums in the Table of Renewal Premiums on page 4. We base them on the Insured's attained age on the due date of the first premium for the renewal term period. The first of the premiums to be paid during a renewal term period will be due on the anniversary at the end of the most recent of the term periods; the premium period for the renewal term period will start on that date. The Premium Payment and Reinstatement provisions of this contract will also apply to all premiums which become due during that period.

The anniversary at the end of the final renewal term period is part of that term period. Unless we endorse it to say otherwise, any renewal of the contract will continue the interest of any beneficiary, owner or assignee.

BASIS OF COMPUTATION

Mortality Table and Interest Rate.—For dividend additions, we base net premiums and net values on the Insured's attained age and sex. We use the Commissioners 1958 Standard Ordinary Mortality Table. If the Insured is female and at least age 15, we set the table back 3 years. If she is younger, we use the female extension of the table for ages less than 15. We use continuous functions based on age last birthday. We use an interest rate of 4% a year.

CONTRACT SUMMARY (Continued from Page 2)

TABLE OF BASIC AMOUNTS

If the contract is in force and the proceeds arise from the Insured's death within the term period:

Then The Basic Amount Is:	And We Adjust The Basic Amount For:
the face amount (in window on page 1), plus the amount of any extra benefit arising from the Insured's death	dividend credits (see page 8), and premium in default or paid (other than by a waiver benefit, if any) past the date of death (see page 7).

P C0247

GUIDE TO CONTENTS

Any Supplementary Benefits and a copy of the application follow page 14.

Term Life Policy. Insurance payable only upon death within stated term period. Premiums payable during Insured's lifetime for stated premium period. Convertible and renewable as limited. Supplementary Benefits, if any, as listed on Contract Data page(s). Eligible for annual dividends as stated in Dividends provision.

ERT—80

P C0248

Printed in U.S.A.

Dan S. Bushnell #0522
Merrill F. Nelson #3841
KIRTON, McCONKIE & BUSHNELL
Attorneys for Plaintiff
330 South Third East
Salt Lake City, Utah 84111
Telephone: (801) 521-3680

IN THE THIRD JUDICIAL DISTRICT COURT OF SALT LAKE COUNTY

STATE OF UTAH

CHERYL HARDY,	:	
Plaintiff	:	AFFIDAVIT OF JAN HARDY
vs.	:	
THE PRUDENTIAL INSURANCE COMPANY OF AMERICA; WAYNE L. RIGBY, Insurance Agent,	:	Civil No. C83-7195
Defendants	:	

STATE OF UTAH)
: ss.
COUNTY OF SALT LAKE)

JAN HARDY, being first duly sworn, deposes and states that:

1. She is a former daughter-in-law of LYNN and CHERYL HARDY, and at the time of the events discussed here, she was married to Lynn and Cheryl's son, David Hardy.

2. She makes this affidavit on the basis of her personal, first-hand knowledge.

3. She was present in the home of Lynn Hardy when Agent Wayne L. Rigby was there discussing the matter of life insurance with Lynn Hardy.

4. She heard Lynn Hardy tell Agent Rigby that he had a heart attack in 1974.

5. She heard Agent Rigby respond that Lynn need not worry about the heart attack because it occurred more than five years before and would therefore not be relevant to the application.

6. She was present in the Hardy Trucking Co. office when Agent Rigby delivered the insurance policy to the Hardys.

7. She heard Agent Rigby exclaim that there was no problem with the policy, that it was issued without rating or waiver.

DATED this 12 day of February, 1985.

Jan Hardy
JAN HARDY

SUBSCRIBED AND SWORN TO before me this 12th day of February, 1985.

Merrill F. Nelson
Notary Public
Residing in Salt Lake County, Utah

My commission expires:
9/15/87

Dan S. Bushnell #0522
Merrill F. Nelson #3841
KIRTON, McCONKIE & BUSHNELL
Attorneys for Plaintiff
330 South Third East
Salt Lake City, Utah 84111
Telephone: (801) 521-3680

IN THE THIRD JUDICIAL DISTRICT COURT OF SALT LAKE COUNTY

STATE OF UTAH

CHERYL HARDY,	:	
Plaintiff	:	AFFIDAVIT OF MARK ITH
vs.	:	
THE PRUDENTIAL INSURANCE COMPANY OF AMERICA; WAYNE L. RIGBY, Insurance Agent,	:	Civil No. C83-7195
Defendants	:	

STATE OF UTAH)
: ss.
COUNTY OF SALT LAKE)

MARK ITH, being first duly sworn, deposes and states that:

1. He is the step-son of LYNN HARDY and the son of CHERYL HARDY.

2. He makes this affidavit on the basis of his personal, first-hand knowledge.

3. He was present in the home of Lynn Hardy when Agent Wayne Rigby was there going over the questions on a life insurance application.

4. He heard Lynn Hardy tell Agent Rigby that he had had a heart attack seven years before.

5. He heard Agent Rigby respond that the heart attack did not matter because the application was concerned with medical history for only the past five years.

DATED this 12 day of February, 1985.

MARK ITH

SUBSCRIBED AND SWORN TO before me this 12th day of February, 1985.

Notary Public

Residing in Salt Lake County, Utah

My commission expires:

9/15/87

quifax services **LIFE REPORT—ADVANCED**

This report contains information pertinent to Life Insurance Underwriting and was prepared for that purpose only.

Account No. 17 Dist., Agcy. or Br. G Salt Lake Office: Salt Lake City

Policy No. ns

Date 8/13/81-6-5

Name HARDY, LYNN.

Address SLC, Utah, 1650 W. Southgate

Occupation and Employer on Inq. Self-employed

Date of Birth 4/26/39

Amt. Appl. 300M

Insurance History: Date	Acct. No.	Amt. or Type Coverage	Fam. or Indv.
2/13/78	12486	50M	Indv.

	(No)	(Yes)
Date(s) Inspection Made 8/10/81		
Identity		
Interview (applicant, spouse, other adult family member): In person		
By phone Wife		
Other sources (Yrs. known to each) In person 2½ years, 4 years		
By phone		
Prev. Rpts. 7 years (no. reports—longest time known)		
How many days since you or sources have seen or talked to applicant? (If not within 2 weeks, explain.) 1 day		
Is date of birth on inquiry incorrect?	X	
Marital status? (M S Sep. Wid. Div.) M		
Number of children in household: 3		
Reside with someone other than an immediate family member?	X	
Is beneficiary someone other than an immediate family member? (If yes, cover relationship & reason.)	X	
Occupation		
Occupation, job, or employer differ from that given on inquiry?	X	
Part-time or off-season occupation? (Describe fully.)	X	
Change jobs frequently?	X	
Plan to work or travel in foreign countries?	X	
Aviation—Sports—Avocations		
Flown as pilot or student pilot? (If yes, cover Handy Guide.)	X	
Hazardous sports or avocations (racing, skin or scuba diving, sky diving, snowmobiling, hang gliding, etc.)?	X	
Driving Record		
Driver's license number: 004653871		
and state or province: Utah		
Moving traffic violations? (Cover at least past 3 yrs.)		X
Traffic accidents? (Cover at least past 3 yrs.)	X	
Driver's license suspended or revoked?	X	
Own or drive motorcycle, motorbike, dune buggy, or high performance car?	X	
Appearance—Impairments		
Unusual build? (If yes, describe appearance.)	X	
If interview, give: ht. 6'1 wt. 185		
Deformity, amputation, blindness, deafness or other impairments?	X	
Health (Amplify as necessary on reverse.)		
Personal Physician: Name Dr. Peterson		
Address		
City & State or Province SLC, Utah		
1. Date last seen: ns		
2. Why?		
3. Results:		
Illness, injury, operation, past or present, not covered in 6A? (If yes, see reverse.)	X	
Use medication regularly?	X	
Family member (parents, brothers and sisters) had diabetes, cardiovascular disorder, or cancer?		X

	(No)	(Yes)
7. Smoking		
A. Smoke cigarettes?		X
If yes, how long? years # pkgs. a day 1 - 2 cigs		
B. Stopped smoking?	X	
If yes, when?		
Why?		
8. Interview Information (Alcohol-Drugs)		
Alcohol (Amplify as necessary on reverse.)		
A. 1. Use alcohol? (If no, see "B.")		X
2. How often? Occasionally		
3. What? Mixed (Cover additional alcoholic beverages in narrative.)		
4. How many? 1 - 2		
5. When? Evenings		
6. Where? Home		
7. Drive after drinking?	X	
8. Any noticeable effects from alcohol use?	X	
9. How long drinking?		
10. Drinking pattern changed?	X	
11. Received counseling or treatment for alcohol use?	X	
B. 1. Used alcohol in past?	X	
2. What?		
3. How many?		
4. How long?		
5. When stopped?		
6. Why stopped?		
7. Received counseling or treatment for alcohol use?	X	
Drugs (Amplify as necessary on reverse.)		
C. Use(d) or experiment(ed) with marijuana, LSD, or non-prescribed stimulants, depressants or narcotics?	X	
9. Other Source Information (Alcohol-Drugs) (Amplify as necessary on reverse.)		
A. 1. Does applicant use alcohol? (If no, see "B.")	X	
2. Any personal observation of noticeable effects from drinking?	X	
3. Drive after drinking?	X	
4. Any known financial, job or personal problems caused by drinking?	X	
5. Received counseling or treatment for alcohol use?	X	
B. Used alcohol in past?	X	
C. Use(d) or experiment(ed) with marijuana, LSD, or non-prescribed stimulants, depressants or narcotics?	X	
10. Personal		
A. Except for traffic violations, ever been arrested?	X	
B. Any comments about reputation, life style, or home environment?	X	
11. Interview Information		
A. Ever rated or declined for insurance?	X	
B. Individual life insurance in force at this time?	X	
C. Group life insurance in force at this time? (If 11 B-C answered "Yes," give name of carrier and amount(s) in Insurance History paragraph.)	X	
12. Answer only if Family Policy: Illness, injury or operation of other family members? (Past or present)		
13. If Family Life requested, complete & attach Family Life Supplement, Form 18008.		

F 00208

(OVER) Report Transferred on .... To .... (date) (branch office)

Recd 8/25

uifax Services Inc.
uifax Services Ltd.

Finances:	Worth
Cash in banks	$ 2,000
Real estate	$ 70,000
Car(s)	$ 10,000
Stocks/bonds	$
Business equity	$ 150,000
Personals	$ 20,000
	$
	$
Total assets	$ 252,000
Accounts payable	$
Mortgages	$ 30,000
Secured Loans	$ 50,000
Personal notes	$
	$
	$
	$
	$
Total Liabilities	$ 80,000
Net Worth	$ 170,000

Income	
Salary	$ 25,000
Self-employed (Unincorporated)	
Gross Income	$
Expenses	$
Net income (adjusted gross)	$
Bonus	$
Commission	$
Total Earned	$ ~~28,000~~
Dividends	$
Interest	$
Net rentals	$
	$
	$
	$
Total Unearned	$
Total Income (Earned and Unearned)	$ 25,000

How was worth acquired? Accumulated

Who gave worth/income figures? Wife

Insurance: If 11 A-C answered "Yes," comment.

Sources: Show type of source, e.g., banker, business associate, neighbor. If applicant not interviewed, state why.

Business: Name of employer, line of business, approximate number of employees, how long employed. Describe business history for last 3 years. If fluctuations in business/profession, what are reasons? Describe business record for last 3 years when applicable.

Duties: Answer Handy Guide questions.

Finances: Amplify as needed.

Aviation—Sports—Avocations: Comment if question 3 A-B answered "Yes." Cover Handy Guide questions.

Driving: If 4 B-E answered "Yes," give details.

Health: Give details of "Yes" answers to questions 6 B-D.

Alcohol—Drugs: Give details of: noticeable effects of alcohol; any known related financial, job or personal problems; changes in usage; treatment. Cover use of other alcoholic beverages. Describe in detail present or past usage of marijuana, narcotics, sedatives, depressants, stimulants or hallucinogens.

Personal: Describe associates, home life, living conditions and neighborhood. Comment on social/club life if developed.

SOURCES: Applicant's wife, neighbor known for 2½ years, neighbor known for 4 years, previous report for 7 years.

BUSINESS: The applicant, Lynn Hardy, is presently self-employed as a trucker. The subject owns 5 trucks and will rent four of these trucks out to other people. He will drive one of the trucks himself. The trucks are all used to haul asphalt products primarily during the summer months and lumber products during the winter months. The subject has been employed as a trucker for over 15 years and is stable. He will work in the local area and will work on a contract basis with various companies. He will generally not do long-haul driving, however, will occasionally if necessary. The subject currently has a contract with the Clark Tank Lines to haul asphalt products.

DUTIES: The applicant's duties are those of a truck driver. He will work primarily in the local area and will maintain his own trucks and will haul asphalt and lumber products.

Field Representative—Use Continuation of Report Form 5166 for additional remarks.

DRIVING: The applicant has received one speeding violation in the past 10 years.

HEALTH: The applicant is in good health and is 6'1 and weighs 185 pounds. We learned that his brother has some heart problems, however, is still living.

PERSONAL: The subject is married and resides with his wife and three children in a middle-class surroundings. He is well regarded.

042:cp

P 00210

MEDIC/ 'EPARTMENT ——X—ray and Electrocardiog ; Section

REQUEST FOR EXAMINATION

PRUDENTIAL INS. CO. OF AMERICA, W.H.O. LOS ANGELES, CAL.

NAME Lynn Hardy

SIGNATURE

X RAY NO. Date D.B.

Height Weight Age Pol. No.

( ) X—RAY OF

E) ECG No.

( ) METABOLISM

I) Insurance ( ) Field

( ) Disability ( ) Other Cl. No.

CASE HISTORY (Give briefly significant records):

( ) H.O. Case

( ) Borrowed

(¢ Credit

( ) Photo—Copy $13.00

M.D.

Hi Amount

REPORT OF EXAMINATION

Date 8-17-81

X-RAY DATE FROM

ECG DATE 8-7-81 FROM Exam. Mgmt. Services Salt Lake City, UT

Rate 60 PR 0.22 sec, QRS sec, QT sec

Normal ECG showing a first degree AV heart block.

Pd 8/25

I. T. Wilson, CPT

CREDITED

AUG 18 1981 CO..1

Code 340

( ) X—ray returned

( ) Film filed

(U ECG to Underwriting

( ) ECG copied and returned by X--ray

ITW/vcm

Comb 16600—A ED 5/81 (W) CAT. # 4005W5G

Member of
THE HEALTH SERVICES CORPORATION
OF THE CHURC[redacted]SUS CHRIST OF LATTER DAY SAI[redacted]
COTTO[redacted]WOOD HOSPITAL[redacted]
5770 South 300 East, Murray, Utah 84107

EMERGENCY ROOM RECORD

Soc. Sec. No. [redacted] 68 7934 (wife[redacted]

Drivers Lic. No. ____

NOTIFIED PARENTS ☐ YES ☐ NO | NOTIFIED DR. ☐ YES [redacted] ☐ NO

CLOTHING & VALUABLES ☐ WITH PT. ☐ HOME ☐ CHECKED — Signed for — Witness:

1-5-74 Time 6:24 PM Patient Log Number 430

…f Patient HARDY, LYNN F. (Last, First) Age 34 Birth Date 4-26-39 Comp. No. 544482

…s of Patient 3717 S. 3200 W. SLC 84119 (Street, City — State — Zip) Phone 298-2693 Sex M S M D W Sep.

…er of Patient McKinley Trucking Occupation ____

…sible Party Wanda Relationship wife Employer of R.P ____ (Name of business — Firm — Address)

…ce: Industrial: Yes No—Medicare: Yes No Other Travelers (Name of Insurance Carrier — Group No.)

…an: V.Sundwall REFERRED E.R. Doctor on Call: Taylor/Burton

…t in By: wife Charge Nurse: S. Rager Manner Received: walking

…gating Officer: ____ (Name) Dept.: ____ Murray, Highway Patrol, S.L. County, Midvale

…f …nt ____ Time ____ Location ____ Date ____

…s or Complaint poss coronary X-Ray No. ____

Orders Chest

…s (Final) Diagnosis ____

NURSE'S NOTES	Time	T	P	R	BP
… side Chest pain – O2 started per mask @ 5 l	6:30 p	97.4	64	22	172/1…
…t EKG done. Skin warm & dry			reg		
… per Dr. Burton					
…ray. Continues to c/o "dull like					
…est pain"	8:15 p		68 reg		158/9…
…Sundwall notified					
…cc 5D/W @ #18 angiocath (L) arm. P. Jones	8:40 p				
…work drawn.					

DISPOSITION (CIRCLE ONE) EMR ☐ Out Admit Rm. REC ☐ Time 9:25 Nr. Signature P. Jones RN

…Report: Call 9 pm

…r's Orders

…ian's Report:

AUTHORIZATION AND GUARANTEE OF PAYMENT: I hereby consent to any medical, surgical and anesthetic procedure which the physician may consider or advise in the treatment of my case and guarantee payment of the charges incurred. In case this account is placed in the hands of an attorney for collection, the undersigned agrees to pay a reasonable attorney's fee with all costs and expenses incurred. I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED. This office will not accept the responsibility for filing or collecting your insurance claim or for negotiating a settlement with your insurance company. Should you have insurance benefits due you for this hospital service, we will provide you with a copy of your bill which you may forward to your insurance company for re-imbursement. You are responsible for payment of your account within the limits of the above policy. I hereby agree to pay a service charge at the rate of 1½% per month (18% per year) on the unpaid balance.

Signed Wanda Hardy Relationship wife

Witness S Bird Date ____

S: Strong FH heart disease. Tonight gradual onset of non exertional chest pain in (R) & (L) precordial area c rad → both arms. No SOB, not diaphoretic. No N, V or syncope. Pain persistent now x 2½ hrs. No hx of phlebitis.

O: JVP = 5–6 cm Nl venous wave. Carotids Nl ↑ & vol. & bruit. Chest – Clear. Cor S1 S2 phys no S3 or S4. No MR. Abd – non-tender. Ext – no edema Good pulses.

EKG – … (P) … ST …V4 … written

DATE	LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH
	HARDY	Lynn		

9/4 Dr. ~~Ketchum~~

Pls note, 42 yr old male applying for 300,000.

ECG indicates 1st degree AV block

Strong FH of circulatory disorder.

No credits available.

Suggest we accept at a SPCL-1

Pls advise.

Tom J. [signature]

RECEIVED MEDICAL DEPT. SEP 8 '81

9/8/81 Tom Shaw:

ECG shows PR interval of .21 to .22 sec — not ratable per our guidelines. FH noted - we don't know age of CV deaths but assume under 60. However, absent other ratable impairment feel he's standard physically.

[signature]

9/9 Mrs Reed,

Pls note above. Finances appear minimal, however noting he is self employed feel amt can be justified.

Pls advise.

Tom J. [signature]

P 00217

DATE	LAST NAME FIRST NAME MIDDLE INITIAL	DATE OF BIRTH

9/8 Tom Shaw - Mother died of a stroke, Dad of heart attack in 1944. 2 brothers died early from heart attacks. Would follow family hx rules for 3 or more cases in the family and get X ray.
You can explain ~~that~~ "due to info just rec'd" its necessary.
M. Reed

P 00218

HARDY LY'

APPLICANT

HARDY CHERYL

426395 RC

WRITING REPRESENTA

RIGBY, W L

75 707664632? 1008 G-SLC

THIS APPLICATION HAS BEEN APPROVED, STANDARD.

POLICY SHOULD BE DELIVERED BY 11 05 81

POLICY DATE 09 17 81 ISSUE DATE 10 08 81
PREMIUM 161.65 MODE M PRODUCTION CR 300000
CONTRACT # TQ9993 COMM 71.13 (12) WHO
ADV PAY 161.65
1650 W SOUTHGATE SALT LAKE CTY UT 84119

PAGE 1 OF 1 UND-J C WICZEK

COMB 81069A ED 1-79 PART II - REPRESENTATIVE'S COPY

COMB 9280 ED 6-81 (W)

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

LIFE & HEALTH CLAIM DIVISION, W.H.O.

RECEIVED
JAN 14 1983
H.O.R. CONTROL DESK
W.H.W.H.

INSPECTION REPORT
Richard S. Stelzner
RSS/jg

INSURED: Lynn Hardy

January 10, 1983

DIVISION		POLICY NOS.	DATE OF APPS.	TYPE OF INV.
L & H Claim		~~70 766 463~~		~~Death Contest.~~
Underwriting				
CHIP/EBP CLAIM				
GSP Claim				

SETTLEMENT OF CASE

	Amount		Funds From:	
R.P.			Advance	
Comp.			Draft	
Settle.			Dist. Off.	
District Office Notified?				

Date of Death ____________________ **SUPPLEMENTARY REPORT TO FOLLOW?** Yes ☐ No ☐

This Report Requested By Vicki Lavetts **, Division** L&H Clm.

January 6, 1983

Visited the Exam Center, 1735 South Redwood Road, Salt Lake City. The Medical Secretary informed me that there were no copies of our Insured's Medical Records kept by them.

Visited our Beneficiary at her place of employment, Lynn Hardy Trucking Company, 2717 South Redwood Road. Our Beneficiary told me that our Insured became ill at about 3:00 a.m. with chest pains and pain in one of his arms. She drove him to St. Marks Hospital. His condition worsened and he died at approximately 5:00 a.m. that same morning, December 4, 1982.

Our Beneficiary said that our Insured has never had any heart problems in the past. He and our Beneficiary had been married for 5 years and she is unaware of any medical history prior to their marriage. She said she could not recall any specific medical history, however, she said that he had seen Dr. Sundwall.

I asked about our Insured's prior physical examinations for his driver's license. Our Beneficiary went to the file cabinet in her office and removed copies of a January 7, 1977 examination and an August 7, 1981 examination. She gave me copies of these reports. All of the categories were within normal limits. A signed Medical Authorization was obtained from our Beneficiary.

Visited the office of Dr. Val Sundwall, 4815 Center Street, Murray. The only items in our Insured's medical folder was a visit on September 30, 1980 for ocass Nocheria. I asked the Medical Receptionist if there was other medical history perhaps in another folder. She stated that 4 or 5 years ago, all of the records for patients who had not been seen within 5 years were destroyed.

The only records that they have for our Insured is the 1980 visit, which I had obtained from them. I learned that there is also a Dr. David Sundwall, who at one time, practiced at the Utah Medical Center. I was told that he is now in Washington, D.C., working with Senator Hatch.

Visited the Utah Medical Center. Initially, I was not allowed to inspect nor obtain copies of our Insured's Medical Records, by the Medical Secretary. I asked to speak to the Director of Medical Records, Mr. Tohenaka. With much persistence, I was able to obtain copies of our Insured's only admission, which was on March 9, 1974. The final clinical impression for that visit was, organic heart disease. Etology, ASHD, secondary to hyerlipidemia. Anatomy high grade obstruction of the midcircumflex and right coronary arteries, inferior wall, myocardial infarction.

Our Insured was referred to Dr. Thorne, in the Cardiac Clinic. Our Insured had also been seen by Dr. Huckleberry, a Urologist, for prostatitis.

Mr. Tohenaka would not allow me to inspect our Insured's Medical Records. With reluctance, he personally obtained copies of the records for me. He said the Records Department was undergoing an audit and they were being extremely cautious in releasing records. I asked about our Insured's Clinic Records. I learned that Dr. Thorne had moved his practice to another location. After searching the files, Mr. Tohenaka informed me that there had been no Clinic Records in the files. He said that had there been Clinic Records, they would have been in the file.

Visited the Cottonwood Hospital, Salt Lake City. Obtained copies of our Insured's Medical Records. Our Insured was seen on December 6, 1965 with left hip pain, Etology, unknown. On March 28, 1967 he was treated for recurrent genito urinary tract infection, probably recurrent prostatitis. On January 4, 1974, our Insured was admitted for pain in his chest and down both arms. A discharge diagnosis was (1) Arteriolsclerotic heart disease with an apparent acute myocardial infarction. (2) Mild hypercholesteresolemia. (3) Strong family history for early coronary death. I obtained medical leads to Dr. Val and David Sundwall, Dr. C. A. Natoli and Dr. W. T. Black.

A call is made to the office of Dr. W. T. Black, 870 East 94th South, Sandy. The Medical Secretary was unable to locate any Medical Records for our Insured.

An attempt was made to locate Dr. C. A. Natoli, however I was unable to locate any evidence of this physician.

Visited St. Marks Hospital, Salt Lake City. Obtained copies of our Insured's Autopsy and Medical Records. Our Insured was seen in the Emergency Room on December 4, 1982, complaining of chest pains. He expired that same day.

The Autopsy Report states both severe arteriolsclerosis causing 70% to 80% luminal narrowing. I obtained leads to Dr. Adamson and Thorne.

I learned that Dr. Adamson is a staff physician at St. Marks Hospital and he does not have a private practice.

Visited the office of Dr. J. L. Thorne, 1200 East 3900 South, Suite 3 F, Cardiovascular Disease. The Medical Receptionist would not permit me to review our Insured's medical records. She did however, make copies of the records for me. The records include a January 2, 1980 visit in the records of our Insured's March 9, 1974 visit at the University of Utah Medical Center for organic heart disease. I was told that there were no other visits to the doctor's office. There were no referring physicians.

Visited the County Courthouse in Salt Lake City. Criminal and Civil Records were checked. There was no criminal record for our Insured. Civil Records revealed a law suit case #80-CV4934, A. J. Dean & Sons Ready Mix & Concrete versus Lynn & Cheryl Hardy, for the amount of $946.26. This case involved non-payment for services rendered. There were no medical leads.

A call was made to Dr. Neel Huckleberry, M.D., a Urologist, at 1002 East South Temple Street. I learned that our Insured had been seen for urinary tract infections on June 6, 1967, July 1, 1967, July 8, 1967, September 27, 1967, December, 1969 and May, 1972. There were no medical leads obtained. No Medical Reports obtained.

A call was made to the SLCX Agency. I spoke with Wayne Rigby, the Writing Representative. Mr. Rigby first met our Insured approximately one month prior to the date of application. Rigby had been at a booth which had been set up at a local fair. He met our Insured's son and wife and they had a conversation about insurance. Our Insured's name and business had been obtained from the son as a possible lead. Mr. Rigby went to our Insured's place of business and attempted to interest our Insured in a Group Policy. Instead, our Insured applied for Life Insurance for himself. He requested $300,000 coverage for himself, because he had 3 or 4 semi-truck and trailers which he still owed money for.

Mr. Rigby is unaware of any medical history pertaining to our Insured which is not on the application form.

CONCLUSIONS:

All medical leads were followed. Medical evidence was obtained which shows that our Insured had a prior history of heart-related problems, which was not admitted to on the application.

Please find all of the Medical Reports obtained, inside the jacket of this file.

This concludes the handling of this file.

hospitalization to the application date? Who initiated the negotiations for insurance? What other insurance did our insured have? (These factors are not conclusive, but may help to evaluate good faith)

- What factual information can we prove?

- What is the probable underwriting significance?

Given information that an insured had incorrectly answered question 7 a. on the application because he had a physical two years ago at which time his blood pressure was found to be a "little high", we would have insufficient information to determine whether the insured had given us a "no" answer in good faith. Did he give us the date and name of the doctor in questions 4, 9, or 11? What were the actual Blood Pressure Readings? What was he told? Was medication prescribed? Were there subsequent visits or treatment? The answers to these and other questions would have to be obtained before good faith could be evaluated and probable underwriting significance judged.

Even though an insured omitted information from the application, common knowledge or a review of the Underwriting Manual may disclose that the information would not have had underwriting significance. The file should be noted to reflect this unless the information relates to treatment so old or a condition so minor that it would obviously be of no significance. Question 9 on our application - the "Other than as disclosed in the answers to the preceding questions have you..." is limited to treatment, tests, etc. within five years of the application date. Although the other questions on the application do not have any time limitation; it has been our practice to disregard treatment more than five years old.

Occasionally the reverse of the Part 2 Medical Application or our investigation will disclose that our Examining Physician was also the insured's attending physician. In such cases the law will generally imply that any knowledge the physician has about his patient will be imputed to us under general rules of Agency. Therefore, given a misrepresentation which results from our own examiner's failure to record treatment he rendered to our insured there is generally little we can do other than pay the claim and refer the file to our Medical Department for appropriate action such as removing the examiner from our list.

Partial admissions present particular difficulties for Claim because the question then becomes whether the insured in good faith told us what he believed to be true, or whether deliberately tried to mislead us. For example, if the insured admits hospitalization for 10 days for "pneumonia" when in fact he was hospitalized three weeks for surgery to remove a tumor from his lung, this would have to be viewed as an admission deliberately designed to mislead us in the absence of conclusive proof that he was never told anything other than that he had pneumonia.

The majority of questions on Part 2 of our application are objective ("When

DATE	LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH
	Hardy	Lynn		

1/25/83 Mrs. S. Frankel:

Note reply from New Bus. Div. regarding this contestable death claim. By the way, Marilyn Reed also reviewed the file and she concurs with C. Young's evaluation of the matter.

While we generally cannot use significant medical history over five years from the date of the Part 2 as a basis for a misrep reject, I believe consideration should be given to the history in this instance. We could also ask Dr Thorne to reconstruct the missing clinic history however think it would be questionable as to whether it would be acceptable.

M Burke

P 00124

TE	LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH
	Hardy			

1-31-83 Mr. Zevin,
Believe you should review this $300,000 claim before it is referred to CORP.
The ins was carefully examined due to family history of heart trouble. He admitted to KC exams, prostate infection, and rheumatic fever as a child. He did not admit to a 1-74 M.I. A 1-2-80 note states he is "doing very well." Records between 1-74 and 1-80 (if any) have been destroyed. Based only on the 1974 history, we would have rated minimum SC4, which, under CORP guidelines, calls for rejection.
However, CORP guidelines state we "generally disregard" history over 5 years old.
I believe we should question CORP on this point since it appears that the 1974 history was material to the risk.

Frankel

2/2/83 M Zevin

2-2-83 Miss Burke -
Refer to CORP. Frankel

B 24263 ED 8-81 (W)

P 00123

CAT. #4057W81

MEMORANDUM FOR: MARY BURKE
ASST. CLAIM CONSULTANT
LIFE AND HEALTH CLAIM
WHWH

February 4, 1983

You've referred this large amount contestable claim for review. For our files, these are the details.

On 8-4-81, Lynn Hardy, age 42, applied for a 5 yr. term policy for $300,000, naming his wife, Cheryl, as beneficiary.

Based upon his age and the amount applied for, the insured was required to take an exam and an EKG. Upon questionning on 8-17-81 by the paramedic, Mr. Hardy indicated that his father had died of a heart attack, his mother of a stroke and two brothers of a heart attack. The only other medical history furnished by the insured was an examination in 9-79 for his truck drivers license. The ECG was reported as normal "showing a first degree AV heart block".

Because cardiovascular disease is heredity and because the insured's family demonstrated a high incidence of young age coronary deaths, the underwriters were concerned about Mr. Hardy's cardiovascular status. They requested an attending physician's statement from the only doctor the insured had admitted to seeing (the doctor who did his truck driver's physical) and ordered another examination - by a physician - and a chest x-ray.

This time, Mr. Hardy indicated "unknown" to all questions regarding his family history. Additional medical history was furnished which included another truck drivers exam, a history of prostatitis ten years ago and rheumatic fever as a child. Questions 7a (Have you ever been in a hospital . . . for observation, rest diagnosis or treatment?), 8b (Have you ever been treated by a doctor for or had any known sign of chest pain, pressure or discomfort?) and 9b (. . . had any known sign of a disease or disorder of the heart, arteries or veins?) were all answered "No". The APS which was pursued verified the department of transportation exam.

The file was submitted to the medical department because of the family history and the AV block in the current ECG. The doctor decided that the case could be issued standard "absent other ratable impairment".

Mr. Hardy died on 12-4-82 of a myocardial infarction. A contestable investigation was conducted. The investigation revealed that the insured was hospitalized at Cottonwood Hospital on 1-5-74, at the age of 34, with chest pain. He remained in the coronary care unit for ten days with a diagnosis of acute myocardial infarction, ASHD, and multiple episodes of ventricular tachycardia and ✓ venticular extrasystoles. On 3-9-74, he was admitted to Utah Medical Center for cardiac catherization. The results showed the insured had a 92% occlusion of the right coronary artery and moderate occlusion of the circumflex coronary artery. He was discharged on digoxin,quinidine sufate and atromed and was followed in a Dr. Thorne's cardiac clinic.

Unfortuantely Dr. Thorne's clinic records have been either lost or destroyed. The only subsequent medical record we have obtained is a 1-2-80 visit to Dr. Thorne which Dr. Thorne had in his possession as the visit was after Dr. Thorne left the cardiac clinic 3 years ago. The clinic would not allow him to take his records on patients he saw there.

On. 1-2-80 the insured was not suffering from any cardiac symptoms and was doing very well. This visit, however, establishes that the insured was still being seen periodically by this cardiologist.

Generally medical history over five years old can be disregarded in a claim investigation because medically it would have been of no significance at underwriting time. This is not always true,particularly in a case of myocardial infarctions and severe arteriosclerosis at a very young age.

You referred the case to the underwriters who advised that had they had the 1974 information the case would have been a minimum Special Class 4 with a sizeable temporary extra. This information therefore clearly meets Utah's requirement that any misrepresented information be material to the hazard assumed by the insurer.

It also appears that there was a deliberate concealment of the facts by the insured. He furnished medical history of a genitourinary infection three years prior to his coronary as well as the childhood episode of rheumatic fever. I doubt he could have forgotten his myocaridal infarction and subsequent catherization. Each of the questions answered incorrectly was asked twice since the applicant had two exams.

In addition Utah law stipulates that an insurer cannot void the policy on the grounds that it relied on the misrepresentation of a material fact by applicant if the insurer had "sufficient indications that would put a prudent man on notice and would have caused him to start an inquiry which if carried out with reasonable thoroughness, "would reveal the truth . . ."

In this instance the family history provided such indications. Underwriting thoroughly investigated all given possible leads to information but was prevented from discovering the history because the insured did not furnish the names of any physicians who had knowledge of his history (namely, Dr. Thorne) or mention being confined to Utah Medical Center.

It is therefore my recommendation that liability be denied on the grounds of material misrepresentation.

Jan

Jan Drosendahl
Senior Claim Consultant
General Actuarial and Claim Division
9 Gib - CORP

JD/gh

P 00118

IS IS CARBONLESS PAPER-DO NOT USE CARBON AFTER YOU COMPLETE ...

lephone 533-7900

89 01 28

STATE OF UTAH INSURANCE DEPARTMENT
326 South 500 East Street
Salt Lake City, Utah 84102

INSURANCE REPORT FORM

This Insurance Report Form is sent in response to your recent request for assistance.
Upon completion return both copies to the above address.
Approximately 30 days is required to review and take appropriate action.

File No 13906

PLEASE TYPE OR PRINT FIRMLY TO MAKE A CLEAR COPY

ur Name Cheryl Hardy
eet 1650 W. Southgate Ave
y, State West Valley City Zip 84119
ur Telephone - Home 9726562
Work SAME
ployer's Name
group policy)
APPROXIMATE AMOUNT OF MONEY INVOLVED
$ 300,000

Insurance Company Prudential
(Against which complaint is directed)
Agent's Name Wayne Rigby
Adjuster's Name
Insured's Name & Address Lynn Hardy
(If not your own)
Type of Insurance LifE
Policy # 70766463 Policy Date 9/17/81
Company Claim # Date of Loss 12/4/82

ase indicate which of the following is applicable:

My complaint is against: ☑ Company ☐ Agent ☐ Adjuster

Briefly and in your own words, describe your problem. If more space is needed, please add additional sheets in duplicate. Enclose copies of papers and other correspondence relative to this problem. (Do not send policy.) A copy of this form may be forwarded to the insurance company involved.

The insurance company resinded the policy. They SAID that they hadn't Known of my husbands Complete medical record. Their agent Knew, or was told that Lynn had been in the hostipal back in 1974 with a clogged artery. AND when the policy was issused he was surprized that it never had a waiver included in it.

The insurance company had Lynn examined by Their doctors. There he was given an EKG, chest x-rays and an examination. The doctors were Dr Joseph Evans a cardiovasior ~~disease~~ specialist.

I Know when my husband and I first took out the policy, I asked the agent if the question pertain only to the last 5yrs and this was the understanding that we had.

F 0076

COTT M. MATHESON
Governor

STATE OF UTAH
INSURANCE DEPARTMENT

160 East 300 South
P.O. Box 5803
Salt Lake City, Utah 84110-5803
Phone: (801) 530-6400

ROGER C. DAY
Commissioner of Insurance

RECEIVED
JUL 12 1983
7.00
CONSUMER AFFAIRS

July 5, 1983

Mr. Ernest A. Long
Vice President and Counsel
Prudential Insurance Company of America
P. O. Box 9247
Van Nuys, CA 91409

RE: Policy No. 70766463
Insd: (Deceased) Lynn F. Hardy
Beneficiary: Cheryl Hardy
Our File 13906

Dear Mr. Long:

Enclosed is a complaint concerning your company. We request that the problem described in this report form be subject to an independent review in your office to ascertain the validity of this complaint.

We also request that you reconsider or review your decision to rescind the policy, paying particular attention to the evidence of insurability. It appears an error may have occurred in the underwriting department regarding questions 5, 8c, 10a and 10b of the application. If any of these questions had been reviewed more thoroughly the policy may not have been issued; but the policy was issued and the insured and beneficiary believed they would be protected if a loss did occur.

I would appreciate receiving at your earliest convenience a report in duplicate. Please attach to the report copies of any material that supports your decision.

Thank you for your cooperation.

Sincerely,

ROGER C. DAY
Commissioner of Insurance

Marjorie J. Pierce
Marjorie J. Pierce
Consumer Service Division

MJP:lm

cc: Ms. Cheryl Hardy

3407u

Dan S. Bushnell - # 0522
Merrill F. Nelson - # 3841
KIRTON, McCONKIE & BUSHNELL
Attorneys for Plaintiff
330 South Third East
Salt Lake City, Utah 84111
Telephone: (801) 521-3680

IN THE THIRD JUDICIAL DISTRICT COURT OF SALT LAKE COUNTY

STATE OF UTAH

CHERYL HARDY, Plaintiff, vs. THE PRUDENTIAL INSURANCE COMPANY OF AMERICA; WAYNE L. RIGBY, Insurance Agent, Defendants.	)	AFFIDAVIT OF DR. JOSEPH L. THORNE Civil No. C83-7195

STATE OF UTAH)
: ss
COUNTY OF SALT LAKE)

Dr. JOSEPH L. THORNE deposes and states that:

1. He is a physician engaged in the exclusive practice of cardiology since 1965.

2. He was an Associate Professor of Cardiology at the University of Utah College of Medicine from 1965 until 1980.

n, McConkie
Bushnell
ssional Corporation
S 300 EAST
T LAKE CITY
TAH 84111

3. He is currently a member of the cardiology staff at St. Marks Hospital in Salt Lake City, Utah.

4. He followed and monitored Lynn Hardy in his Cardiac Clinic through annual check-ups from 1974 until 1980. During that time, Lynn Hardy's physical condition steadily improved, his heart condition was totally asymptomatic, and he carried on a totally active and normal life. Between 1976 and 1980, Lynn Hardy received no special therapy for heart disease.

5. Between 1974 and 1980, Dr. Thorne prescribed no medication for Lynn Hardy. The only medication that Lynn Hardy may have been taking at that time is atromid-S. Atromid-S is not a medication for heart disease, but is prescribed only to regulate the cholesterol and triglyceride level. Atromid-S has no direct physiological function or effect on the heart.

6. Dr. Thorne referred Lynn Hardy to the Multidisciplinary High Risk Corornary Consultation Clinic at the University of Utah, not to receive special treatment for heart disease, but to participate in a study of the effect familial relationships have on cardiac disorders.

7. The Electrocardiography Request Form, completed at Lynn Hardy's August 1, 1979, check-up, shows "angina with exertion." This notation is a reference to Lynn Hardy's medical history, and does not represent a current angina problem.

8. The facts that Lynn Hardy's father and two brothers had died prematurely of heart disease, that another living brother also had heart disease, that Lynn had smoked at least one package of cigarettes per day for over twenty years, and that a recent EKG exam revealed a first degree AV heart block, taken together, constitute significant external indications of potential cardiac abnormalities.

Dated this 28 day of February, 1985.

Joseph L. Thorne

Dr. Joseph L. Thorne

SUBSCRIBED AND SWORN to before me this 28th day of February, 1985.

Merrill E. Nelson

Notary Public
Residing: Salt Lake County

My Commission Expires:

9/15/87

VEK
CR

Kindred Number 26
Individual ID Number 020
Subjects Name Hardy Lynn
Last First Initial

Visit: 3 / 24 / 79
Month Day Year

Time: 2 30 a.m./p.m.

SKINFOLD MEASUREMENTS

Triceps skinfold 15.2 cm.
14.6 cm.
15.1 cm.
Average ____ cm.

Subscapular skinfold 13.2 cm.
14.2 cm.
14.2 cm.
Average ____ cm.

Ulnar skinfold 5.5 cm.
5.2 cm.
5 9 cm.
Average ____ cm.

Suprailiac skinfold 17.4 cm.
16.8 cm.
16 6 cm.
Average ____ cm.

Abdominal girth 96 cm.

Percent body fat ____

71.25 inches

Height [ ][ ][ ] [ ][ ] (cm to nearest .1 inch)

Weight [ ][ ][ ] [ ] (round kg to nearest .1 kg)

175.0 lbs

Is there a diagonal ear lobe crease?
1) Yes, right ear only
2) Yes, left ear only
3) Yes, both ears
4) No
5) Can't tell

Which of the following is the ear lobe?
1) Connected
2) Lobulated

BLOOD PRESSURE MEASUREMENTS

Cuff Size:
1) Regular Adult
2) Large Arm
3) Thigh
4) Pediatric
5) Infant

Pulse Regular 1) Yes
2) No

Beats in 30 Sec. 34

x 2 = 068 Beats/Minute

Pulse Obliteration Pressure 120

+30

Peak Inflation (std.) 150
Max Zero (R-Z) 42
Peak Inflation (R-Z) 192

SITTING BLOOD PRESSURE

		Systolic	Diastolic Muffle	Diastolic Disappear
(1)	Std.	120	070	068
	R-Z Uncorr.	140	110	098
	Zero	36	36	36
(2)	R-Z BP	104	074	062
(3)	Automated (disk attached) BP	107	075	070
	R-Z uncorr.	132	100	090
	Zero	26	26	26
(4)	R-Z BP	106	074	064

BLOOD PRESSURE STANDING (2 MIN.)

	R-Z uncorr.	152	110	108
	Zero	38	38	38
(5)	R-Z BP	114	072	070

Follow-up need for HBP?
1) No
2) Yes .. Referral made 1) No 2) Yes ____/____/____
mo day yr

Screener Number NF

56

1/16/78

VENTILATORY FUNCTION

Forced vital capacity ______

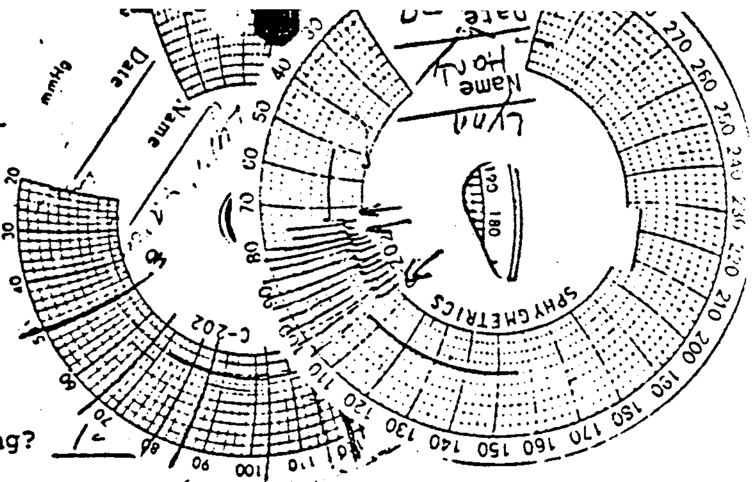
FEV_1 ______

$Fev_{25-75\%}$ ______

Hair color auburn

Male hair pattern 2

For how many hours have you been fasting? 1



How long ago did you have your last cigarette? 1/2

Have you taken any special dietary precautions in preparing for this visit? No

If so, please describe ______

COMMENTS: ______

JAN 28 1980

ersity of Utah
State Division of Health

PHYSICIAN HISTORY & EXAMINATION

Date 3/24/79

Family Number 2 6

Name Hardy Lynn
Last First

Patient Number 0 2 0

A. CURRENT SYMPTOMS

1. Symptom Summary
1) None (Skip to #9)
2) Some (Check below)

2. Chest Pain (if yes, list onset mo/yr)
1) None
2) Non-anginal pain
3) Atypical angina
4) Typical angina
5) Unstable angina

3. Dyspnea
1) None
2) Class I (with marked exertion)
3) Class II (with ordinary exertion)
4) Class III (with minimal exertion)
5) Class IV (at rest)

4. Orthopnea
1) Absent
2) Present

5. PND
1) Absent
2) Present

6. Cough
1) Absent
2) Present

7. Fatigue or Decreased Exercise Tolerance
1) Absent
2) Present

8. Intermittent Claudication
1) Absent
2) Present

Other ______

B. CARDIOVASCULAR HISTORY

9. C-V History Summary
1) No abnormalities (Skip to 19)
2) Some findings (checked below)

10. Coronary Artery Disease (clinical onset)
1) No
2) Yes Onset: JAN '74
month year

11. Myocardial Infarction (suspected)
1) No
2) Yes Onset: JAN 4 1974
month year

12. First Myocardial Infarction (definite)
1) No
2) Yes Onset: JAN 4 1974
month year

Other Myocardial Infarctions
Onset: ______ ______
month year
Onset: ______ ______
month year

13. Coronary Angiogram
1) No
2) Yes Date: Feb-Mar 1974
month year

Dr. Thom
Uuwe

month year

month year

14. Coronary Artery Surgery
1) No
2) Yes Date: ______ ______
month year

15. Valvular Heart Disease
1) Absent
2) Present (circle) MS MR AS AR Other

16. History of CHF
1) Absent
2) Present ______ ______
month year

17. History of Cardiac Arrhythmias
1) Absent
2) Present ______ ______
month year

18. History of Heart Block
1) Absent
2) Present ______ ______
month year

Other Heart Disease: ______

C. CARDIOVASCULAR RISK FACTOR HISTORY

19. Risk Factor Summary
1) None (skip to 28)
2) Some (checked below)

20. Hypercholesterolemia
1) Absent
2) Present
3) Not known (never measured)

21. Hypertriglyceridemia (including history cloud serum)
1) Absent
2) Present
3) Not known (never measured)

22. Cigarette Smoking
1) Never
2) Past smoker: Quit ______ ______
month year
After smoking: ______ years Average ______ pks a day
3) Current smoker for: 23 years
Average 2 pks a day

23. Known Hypertension
1) No
2) Yes (on treatment)
3) Suspect (no therapy)

24. Family History of Pre[illegible] CHD
1) No
2) Yes Bro's - self < 30's
3) Suspect

25. Diabetes Mellitus
1) No
2) Yes, non-insulin
3) Yes, insulin
4) Yes, dietary therapy

D. ASSOCIATED CO-MORBID CONDITIONS

26. Summary of Co-Morbid Conditions
1) Absent (skip to #33)
2) Present (check below)

27. Peripheral Vascular Disease
1) Absent
2) Present

28. Cerbral Vascular Disease
1) Absent
2) Present

29. Kidney Disease
1) Absent
2) Present

30. Chronic Pulmonary Disease
1) Absent
2) Present

31. Peptic Ulcer Disease
1) Absent
2) Present

32. Gout
1) Absent
2) Present

Other: ______________________

E. PRESENT THERAPY

33. Therapy Summary
1) No therapy (skip to #50)
2) On therapy (check below)

34. Nitroglycerine
1) No
2) Yes

35. Long-Acting Nitrate
1) No
2) Yes

36. Propranolol
1) No
2) Yes

37. Bile Sequestrant
1) No
2) Yes

38. Atromid
1) No
2) Yes

39. Antiarrhythmics
1) No
2) Yes

40. Digitalis
1) No
2) Yes

41. Diur[illegible]
1) [illegible]
2) Yes

42. Antihypertensive
1) No
2) Yes

43. Anticoagulants
1) No
2) Yes

- - - - - - - - - - - - - -

44. Birth Control Pills
1) No
2) Yes

45. Aspirin
1) Rarely (less than 2/month)
2) Occasionally (3-8/month)
3) Frequently (9-15/month)
4) Regularly (at least one a day or one every other day)

46. Insulin
1) No
2) Yes

47. Oral Diabetes Medication
1) No
2) Yes Name: ______________________

48. Special Diet
1) Low fat
2) Low salt
3) Low calorie
4) Diabetic
5) None

49. Exercise Program
1) No
2) Yes

Other ______________________

50. Summary
1) Totally normal (skip to 86)
2) Some findings (checked below)

51. Xanthoma
1) Absent
2) Present
a) Planar
b) Palmar
c) Tuberous
d) Tendenous
e) Eruptive

52. Xanthelmasma
1) Absent
2) Present

EYES:

53. Arcus Cornea
1) Absent
2) Partial annulus early
3) Complete annulus

FUNDUS:

54. Fundus Summary
1) Not done
2) Normal (skip to #64)
3) Abnormal (note below)

55. Areriolar Narrowing
1) Absent
2) Present

[illegible]
1) Absent
2) Present

57. Silver-wire Changes
1) Absent
2) Present

58. Flame-Shaped Hemorrhages
1) Absent
2) Present

59. Round Hemorrhages
1) Absent
2) Present

60. Hard Exudates
1) Absent
2) Present

61. Lipemia Retinalis
1) Absent
2) Present

62. Cotton-Wood Patches
1) Absent
2) Present

63. Microaneurisms
1) Absent
2) Present

Other: ______________________

LUNGS

64. Lung Summary
1) Normal (skip to #68)
2) Abnormal (note below)

65. Basilar Rales
1) No
2) Yes

66. Wheezes
1) No
2) Yes

67. Dullness
1) No
2) Yes

CARDIOVASCULAR

68. CV Summary
1) All findings normal (skip to #86)
2) Some findings (checked below)

69. Carotid Arteries: upstroke/volume
1) Normal
2) Decreased unilateral
3) Decreased bilateral

70. Carotid Bruits
1) None
2) Unilateral (right or left)
3) Bilateral

71. LVH by Palpation
1) No
2) Yes

72. RVH by Palpation
1) No
2) Yes

1) Absent
2) Pres

74. Heart Sounds
1) Normal (skip to #86)
2) Some abnormality (check below)

75. S3 Gallop
1) Absent
2) Present

76. S4 Gallop
1) Absent
2) Present

77. Paradoxically Split S2
1) Absent
2) Present

78. Mid-Systolic Click
1) Absent
2) Present

Other ______________________

79. Heart Murmur Summary
1) Absent (Skip to #86)
2) Present

80. Systolic Ejection
1) No
2) Yes

81. Holosystolic Ejection
1) No
2) Yes

82. Late Systolic
1) No
2) Yes

83. Early Diastolic Blow
1) No
2) Yes

84. Diastolic Rumble
1) No
2) Yes

85. Peripheral Pulses
1) Normal
2) Abnormal (describe below)

	Brachial	Radial	Femoral	DP	Pt
R					
L					

(Grade 0-4, 3+ being normal)

Other Abnormalities and Comments (Bruits) ______________________

86. Other Findings and Comments: ______________________

C DEC 17 1979

SECTION 8 PRESCRIPTION MEDICATIONS TAKEN NOW OR IN THE PAST FOR A YEAR OR MORE

158. Have you ever taken a prescription for a year or more, now or in the past?
1) No 2) Yes (please list below)

Name of Medicine	Age Started	Years Taken	Reason
1. Atromid	34	5	Cholestrol
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

SECTION 9 HOSPITALIZATION, INCLUDING DELIVERIES

159. Have you ever been a patient in a hospital?
1) No 2) Yes (please list below)

Month/Year	Hospital Name	City/State	Reason for Hospitalization
1. Jan 1974	Cottonwood Hospital	SLC	Heart Attack
2. 1974	UUMC	SLC	Tests
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

If more space is needed, use back of page

CLINIC NOTE

LYNN HARDY

January 2, 1980

Lynn is doing very well, he lives an active physical life, he has not had any symptoms to suggest coronary artery insufficiency and has not had anything to suggest angina pectoris. His physical capacity is good, he has not had orthopnea or PND and he is not aware of palpitation. Over the past several weeks he has had an upper respiratory tract infection with myalgia, malaise, sore throat, hoarseness and a cough.

Physical examination reveals abundant post nasal drainage, he has no evidence of lymphadenopathy. His neck is supple with no venous distension. The chest is symmetrical. There are no rales or rhonchi, and the breath sounds are normal. The heart is in a regular sinus rhythm, no cardiomegaly, no extrasystoles. The abdomen is not remarkable and the extremities are normal with no evidence of edema.

We have given Lynn 1.2 mil units of Wycillin, he will take Turpin Hydrate 1 tsp Q4 hr. PRN for cough and Afrin nasal spray BID daily for four days and he will return in one day for follow up penicillin.

J.L. Thorne, M.D.

From the office of Dr J L. Thorne

P 00155

31-27-22. Discrimination between risks of same class prohibited—Preference based on fictitious grouping prohibited—Revocation of certificate of authority.—(1) No insurer shall make or permit any unfair discrimination in favor of particular individuals or persons between insurants or subjects of insurance having substantially like insuring, risk and exposure factors or expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premiums charged therefor, or in the dividends or other benefits payable thereunder.

31-1-8. Governmental regulation—Business affected with public interest—Moral obligations of persons concerned.—Within the intent of this code the business of insurance is one affected with the public interest, requiring that all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters. Upon the insurer, the insured, and their representatives rests the duty of preserving inviolate the integrity of insurance.

31-27-1. Unfair competition, or deceptive acts or practices prohibited—Commissioner to define unfair acts or practices—Effective date of regulation—Penalties for violations.—(1) No person engaged in the business of insurance shall engage in unfair methods of competition or in unfair or deceptive acts or practices in the conduct of such business as such methods, acts or practices are defined in this chapter.

Section 2. Purpose

The business of insurance is a public trust assumed by persons accepting licenses to operate in this State and inherently includes a duty to treat claimants equitably and in good faith. The breach of such duty is considered to be an unfair or deceptive business practice and, if generally engaged in, an unfair method of competition. Such a practice is detrimental to free competition and injurious to the insuring public. The purpose of this regulation is to respond to the volume of complaints arising from claims settlement practices by affirmatively establishing standards of equity and good faith to guide licensees in the settlement of claims. This regulation defines and provides notice of such minimum standards which, if violated knowingly, or with such frequency as to indicate a general business practice, will be considered to constitute unfair claims settlement practices. The promulgation of this regulation is done in recognition of the limited jurisdiction of the Utah Small Claims Court, and the practical unavailability to the public of other legal remedies to handle common claims disputes. It is intended that this regulation will help to establish parity between the public and professional insurance licensees and facilitate the prompt and fair settlement of insurance claims.

Section 5. Unfair Methods of Competition and Unfair or Deceptive Acts and Practices Defined

The following are hereby defined as unfair methods of competition and unfair or deceptive acts and practices in the business of insurance:

(a) misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) refusing to pay claims without conducting a reasonable investigation;

(e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative;

(f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds when claims or demands have been made for amounts reasonably similar to the amounts ultimately recovered;

(h) attempting to settle a claim for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material reasonably related to the insurance contract;

(i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

Harrison's

PRINCIPLES OF INTERNAL MEDICINE

Tenth Edition

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of the ASTZ test is in *ruling out* rheumatic fever when the titer is low in patients with isolated polyarthritis. To date, the specific antigens involved in the ASTZ test remain unidentified and therefore the test has not yet been adequately standardized. A rise in titer of two dilution tubes or more can be demonstrated for at least one of the streptococcal antibodies in almost all recurrent as well as primary attacks of rheumatic fever (Table 257-2). Increased streptococcal antibodies, however, do not reflect rheumatic activity per se, and their rate of decline is independent of the course of the rheumatic attack.

Isolation of group A streptococci Some patients continue to harbor group A streptococci at the onset of acute rheumatic fever, but these organisms are usually present in small numbers and may be difficult to isolate by a single throat culture. The administration of penicillin or other antibodies may also result in failure to isolate the infecting organism. In addition, a significant number of *normal* individuals, particularly children, may harbor group A streptococci in the upper respiratory tract. For these reasons, throat cultures are less satisfactory than antibody tests as supporting evidence of recent streptococcal infection.

Acute phase reactants These tests offer objective but nonspecific confirmation of the presence of an inflammatory process. *The erythrocyte sedimentation rate* (ESR) and the test for *C-reactive protein* (CRP) in serum are used most commonly. Unless the patient has received corticosteroids or salicylates, these reactions are almost always abnormal in patients presenting with polyarthritis or acute carditis, whereas they are often normal in patients with chorea. Other laboratory findings which reflect inflammation include reactions such as leukocytosis, and increases in serum complement, mucoproteins, and $alpha_2$ and gamma globulins. Prolongation of the PR interval of the electrocardiogram, although neither specific for rheumatic fever nor diagnostic of serious cardiac involvement, is frequent in acute rheumatic fever (about 25 percent of all cases), and other nonspecific electrocardiographic changes are also common. Anemia, due to the suppression of erythropoiesis characteristic of chronic inflammatory diseases, is another feature of rheumatic activity.

COURSE AND PROGNOSIS The course of rheumatic fever varies greatly and is impossible to predict at the onset of the disease. In general, however, approximately 75 percent of acute rheumatic attacks subside within 6 weeks, 90 percent within 12 weeks, and less than 5 percent persist more than 6 months. The latter usually consist of severe, intractable forms of rheumatic carditis or stubborn, prolonged attacks of Sydenham's chorea, both of which may persist for as long as several years. Once acute rheumatic fever has subsided and more than 2 months have elapsed after withdrawal of treatment with salicylates or adrenal corticosteroids, rheumatic fever does not recur in the absence of new streptococcal infections. Recurrences are most common within the first 5 years of the initial attack and tend to decline with increasing duration of freedom from rheumatic activity. The frequency of recurrences is dependent upon the frequency and severity of streptococcal infection, the presence or absence of rheumatic heart disease following an attack, and the duration of freedom from the last attack.

Approximately 70 percent of patients who develop carditis do so within the first week of the disease, 85 percent within the first 12 weeks of the disease, and almost all within 6 months from the onset of the acute attack. Thereafter, if significant murmurs have not appeared, the prognosis for a patient in whom recurrences are prevented is excellent.

Chronic rheumatic carditis and the course of rheumatic heart disease The remarkable variability in the course of rheumatic carditis and rheumatic valvular disease stems from several factors: (1) the variability in the duration and severity of the rheumatic inflammation; (2) the amount of scarring of the valves and myocardium following the abatement of the acute inflammation; (3) the location and severity of the hemodynamic lesion due to valvular insufficiency or stenosis; (4) the frequency of recurrent bouts of carditis; and (5) the progression of valvular calcification and sclerosis, which occurs as a secondary phenomenon in a deformed or injured valve without recurrent or persistent rheumatic inflammation (as seen in congenital valvular disease or following healed acute bacterial endocarditis). These factors, and possibly others not yet appreciated, produce striking variations in the clinical syndromes of rheumatic heart disease.

Chronic rheumatic myocarditis In this syndrome, the presenting picture is one of chronic heart failure in a patient with a markedly dilated heart and with physical, roentgenographic, and electrocardiographic findings of mitral regurgitation. The differentiation of this syndrome from other forms of chronic myocarditis may be very difficult, if not impossible, when the associated extracardiac features of rheumatic fever (chorea, polyarthritis, and so forth) are not present (Chap. 263). Although rheumatic fever does not produce *isolated* myocarditis, and is almost invariably a pancarditis, the pericardial inflammation may not be clearly evident, and the mitral valvulitis may not be distinguishable from mitral regurgitation due to dilation of the mitral ring. In such cases one must search diligently for an evanescent friction rub, evidence of pericardial effusion, appearance of a soft aortic regurgitation murmur, and extracardiac clues such as fever responding promptly to salicylates, arthralgias, transient subcutaneous nodules, evanescent erythema marginatum, and subtle signs of chorea.

The course of chronic rheumatic carditis may be intractable and end fatally after months or even several years. Often, however, the patient improves rather suddenly and even recovers cardiac reserve dramatically in association with the disappearance of systemic manifestations of the inflammatory process. The heart may remain large, may decrease somewhat in size, or in occasional instances may return to normal size with varying degrees of residual valvular deformity. Such a course signals the termination of the "toxic" phase of the rheumatic process, and thereafter the course of rheumatic heart disease depends on the variables in healing cited above.

DIFFERENTIAL DIAGNOSIS Early cases of rheumatic fever may be confused with other diseases which begin with acute polyarthritis. It is wise to exclude *bacteremia* by blood cultures, particularly because such infections may be masked by penicillin given for presumed acute rheumatic fever. Polyarthritis due

TABLE 257-2
Serologic results in patients with streptococcal disease

	Percent of patients whose serums were "positive"				
Patient group (no.)	*ASO*	*AH*	*Anti-DNase B*	*At least 1 of 3*	*ASTZ*
Acute rheumatic fever (20)	90	65	85	95	100
Acute glomerulonephritis (22)	50	63	72	91	95
Convalescent pharyngitis (11)	81	54	54	91	91
Convalescent pyoderma (23)	35	35	91	96	91
Total (76)	61	54	79	93	95

SOURCE: *AL Bisno, I Ofek, Am J Dis Child* 127:676, 1974.

to *infective endocarditis* in a patient with preexisting rheumatic heart disease may be mistaken for a recurrence of acute rheumatic fever. If streptococcal antibodies are not increased, polyarthritis should be attributed to some cause other than rheumatic fever. Gonococcal polyarthritis may be distinguished from rheumatic fever by the dramatic response of the former to a therapeutic trial of penicillin. In rheumatoid arthritis, joint involvement will persist and characteristic joint deformities may appear. The latter are not seen in rheumatic fever. The rheumatoid factor so characteristic of rheumatoid arthritis is not present in rheumatic fever. Antibodies against nuclear components and other autoantibodies are absent in rheumatic fever. Rheumatic pericarditis and myocarditis, associated with cardiac enlargement and heart failure, are both almost invariably associated with valvular lesions which produce significant murmurs.

Overdiagnosis of rheumatic fever should be avoided. Unless ill-defined febrile syndromes are clearly associated with a major manifestation of rheumatic fever, the diagnosis of rheumatic fever should not be made. A common error is the premature, vigorous administration of corticosteroids or salicylates before the signs and symptoms of rheumatic fever are unmistakable. In the absence of a curative agent, one should not suppress the signs and symptoms of rheumatic fever until they are clearly expressed.

Particularly confusing in the differential diagnosis of rheumatic fever is the drug sensitivity with fever and polyarthritis which may occur after administration of penicillin for a previous pharyngitis. Urticaria or angioneurotic edema, if present, helps differentiate penicillin sensitivity in such cases. The abdominal pain of rheumatic fever may be mistaken for appendicitis, and the crisis of sickle-cell anemia may also be associated with joint pain, enlargement of the heart, and cardiac murmurs. The rapidity with which the arthritis symptoms of rheumatic fever are controlled with salicylates is characteristic of this disease. Dramatic response to salicylates does not in itself, however, establish a diagnosis of rheumatic fever.

In order to help clarify the diagnosis of rheumatic fever, the American Heart Association has accepted and modified criteria usually referred to as the *Jones criteria* (Table 257-1). They are not to be used as a substitute for good medical judgment but are recommended as a guide for careful study of questionable cases. The finding of two major criteria, or of one major and two minor criteria, indicates a high probability of the presence of rheumatic fever if supported by evidence of a preceding streptococcal infection. The absence of the latter should always make the diagnosis questionable, except in the situation in which rheumatic fever is first discovered after a long latent period from the antecedent infection (Sydenham's chorea or low-grade carditis). Because the prognosis may differ according to the major manifestations, for recording purposes the diagnosis of rheumatic fever should be followed by a list of the major manifestations present, e.g., rheumatic fever manifested by polyarthritis and carditis. An indication of the severity of carditis in terms of presence or absence of congestive heart failure and cardiomegaly is also advisable.

TREATMENT There is no specific cure for rheumatic fever, and no known measures change the course of the attack. Good supportive therapy, however, can reduce the mortality and morbidity of the disease.

Chemotherapy After rheumatic fever is first diagnosed, a course of penicillin should be given to eliminate group A streptococci. This is advisable even if bacteriologic examination yields throat cultures negative for streptococci, since the organisms may be present in areas inaccessible to swabs. It is preferable to administer penicillin parenterally. An effective course is a single injection of 1.2 million units of benzathine penicillin intramuscularly or 600,000 units of procaine penicillin intramuscularly daily for 10 days. Attempts to reduce ultimate heart damage by administering penicillin early in the acute rheumatic attack in larger doses have not been successful. After completion of the therapeutic course of penicillin, continuous protection from reinfection with streptococci should be provided by instituting one of the prophylactic regimens described below.

Suppressive therapy For patients without carditis treatment with adrenal corticosteroids is unnecessary. Acute arthritis can be relieved with codeine or with salicylate, the latter being preferable to reduce fever and joint inflammation. When salicylate is used in the therapy of rheumatic fever, the dosage should be increased until the drug produces either a clinical effect or systemic toxicity characterized by tinnitus, headache, or hyperpnea. A starting dose of 100 to 125 mg/kg per day in children and 6 to 8 g in adults given in four or five divided doses is recommended. Of the various salicylate preparations ordinary aspirin is cheapest and most effective. Gastric intolerance can usually be diminished by administering aspirin after meals or by giving antacids 15 to 30 min after each dose of aspirin.

Many physicians prefer corticosteroids to salicylates for the treatment of carditis, despite the lack of a demonstrated advantage of these adrenal hormones in controlled clinical trials. Corticosteroids are more potent anti-inflammatory agents but are more likely to be followed by posttherapeutic "rebounds," and they have the additional disadvantage of more frequent side effects, particularly acne, hirsutism, and cushingoid changes in facies and habitus. For this reason it is preferable to begin treatment of patients who have carditis with salicylates; if these drugs fail to reduce fever and to ameliorate heart failure, therapy with corticosteroids may be initiated promptly. Prednisone is administered in doses of 60 to 120 mg or higher when necessary in four divided doses daily. After the inflammation has been brought under control by either salicylates or corticosteroids, treatment should be continued until the sedimentation rate approaches near-normal values and should be maintained for several weeks thereafter. To prevent poststeroid rebounds, an "overlap" course of salicylate therapy may be added when steroids are tapered off over a 2-week period. A useful method for tapering steroids is outlined in Chap. 112. Salicylates may then be continued for an additional 2 to 3 weeks. Rebounds of rheumatic activity are usually of short duration and, when mild, are best managed without resuming anti-inflammatory treatment, because a second or even a third rebound may occur when suppressive therapy is discontinued. About 5 percent of rheumatic attacks persist for 6 months or longer, either in the form of spontaneous acute recrudescences or as posttherapeutic rebounds. These "chronic" attacks are most likely to occur in patients with cardiac damage and with previous rheumatic episodes. Weekly tests for C-reactive protein in blood and for erythrocyte sedimentation rate are useful in following the healing process, particularly while treatment with corticosteroids or salicylates is gradually withdrawn.

Treatment of chorea The signs and symptoms of chorea usually do not respond well to treatment with antirheumatic agents. Because the patient with chorea is frequently emotionally unstable and because the manifestations of chorea may be exaggerated by emotional trauma, complete mental and physical rest is essential. Patients with chorea should be kept in a quiet room and cared for by sympathetic attendants. Corticosteroids or salicylates have little or no effect on chorea. Sedatives and tranquilizers, particularly diazepam and chlorpromazine, are useful. If the chorea is severe, large doses of phenobarbital rather than tranquilizers alone are usually necessary to control purposeless movements. Padded sideboards for the bed may be necessary to avoid injury to the patient. In the absence of other evidence of acute rheumatic disease, it is advisable to allow gradual resumption of physical activity when improvement is apparent rather than waiting for all choreiform movements to disappear, which may require many months.

Because of the great variability in the course of chorea, evaluating the effectiveness of various therapeutic measures is difficult. It is well to remember that chorea is a self-limited disease which is usually not followed by significant neurologic sequelae and that good results are almost invariably obtained by patient, attentive nursing care and by conservative medical management.

PREVENTION OF RECURRENCE The most efficient regimen for continuous prophylaxis against group A streptococci is a monthly intramuscular injection of 1.2 million units of benzathine penicillin. The disadvantages and discomfort of this regimen have to be weighed against the individual patient's susceptibility to recurrences. Those with rheumatic heart disease, recent rheumatic fever, and exposure to an environment in which the incidence of streptococcal infection is frequent deserve the most effective protection. As a second choice, prophylaxis may be administered orally with either 1 g sulfadiazine daily in a single dose or 200,000 units of penicillin given twice daily on an empty stomach. The duration of continuous prophylaxis cannot be fixed arbitrarily for all patients, although the safest generalization is that it be continued indefinitely. Certainly, those under the age of 18 years should receive a continuous prophylactic regimen. A minimum period of 5 years is recommended for patients who develop rheumatic fever without carditis over the age of 18 years. The decision to continue prophylaxis beyond this period should take into account a number of variables. Patients with rheumatic heart disease are more susceptible to reactivation of rheumatic fever if they contract a streptococcal infection. Moreover, patients who have had carditis in a previous attack are much more likely to suffer carditis again in a subsequent attack. Climate, age, occupation, household situation, cardiac status, and length of time since the previous attack are all significant variables which influence the risk of recurrence. The decline in recurrence rates with increasing age is due to (1) decreased rate of streptococcal infection and (2) decrease in the rate of rheumatic reactivation following streptococcal infection in older rheumatic subjects. Despite this decreased rate, however, the risk of rheumatic recurrence in adults remains relatively high when the streptococcal disease encountered is severe or epidemic.

PREVENTION OF INITIAL RHEUMATIC ATTACKS Early and adequate treatment of pharyngeal infection due to group A streptococci will prevent initial attacks of rheumatic fever. If clinical streptococcal disease were properly detected by throat cultures and adequately treated, the spread of infection in a given population would be prevented, the epidemiology of streptococcal disease would be modified markedly, and the incidence of rheumatic fever in the community would be diminished. In communities where group A streptococcal disease has been diagnosed early and treated well and where socioeconomic standards are high, the group A organisms cultured frequently from schoolchildren's throats may be of relatively low virulence and may cause rheumatic fever less frequently than do more virulent strains prevalent in many epidemics.

Streptococcal pharyngitis is adequately treated by a single intramuscular injection of 600,000 units of benzathine penicillin in children less than 10 years of age or 1.2 million units in older children and adults. Any alternate plan of parenteral therapy or combined parenteral and oral therapy should provide for treatment over a period of 10 days. If oral penicillin is employed, at least 800,000 units per day in four divided doses must be given for no less than 10 days to achieve results comparable with a single injection of benzathine penicillin. Erythromycin in daily doses of 1 g for 10 days may be substituted in penicillin-sensitive individuals. Tetracycline is not recommended because some strains of group A streptococci have acquired resistance to it. All group A streptococci have so far remained extremely sensitive to penicillin.

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258
VALVULAR HEART DISEASE

EUGENE BRAUNWALD

The role of physical examination in the evaluation of patients with valvular disease is considered in Chap. 248; of echocardiography, phonocardiography, and other indirect graphic techniques in Chap. 250; and of cardiac catheterization and angiography in Chap. 251.

MITRAL STENOSIS

PATHOPHYSIOLOGY In normal adults the mitral valve orifice is 4 to 6 cm^2. In the presence of significant obstruction, i.e., when the orifice is less than one-half of normal, blood can flow from the left atrium to the left ventricle only if propelled by an abnormally elevated left atrioventricular pressure gradient, the hemodynamic hallmark of mitral stenosis. When the mitral valve opening is reduced to 1 cm^2, a left atrial pressure of approximately 25 mmHg is required to maintain a normal cardiac output. The elevated left atrial pressure in turn raises pulmonary venous and capillary pressures, reducing pulmonary compliance and causing exertional dyspnea. The first bouts of dyspnea are usually precipitated by clinical events which increase the rate of blood flow across the mitral orifice, which results in further elevation of the left atrial pressure. In order to assess the severity of obstruction, it is essential to measure both the transvalvular pressure gradient and the flow rate. The latter is dependent not only on the cardiac output but on the heart rate as well. An increase in heart rate shortens diastole

VOLUME ONE

ANDERSON'S PATHOLOGY

Edited by

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ment; and a surrounding zone of edematous connective tissue in which some degree of nonspecific, chronic inflammation may be seen (Fig. 16-34). Within the outer zone, there may be proliferation of blood vessels, but this is not a conspicuous feature.[291] Foci similar to Aschoff bodies sometimes are noted. The subcutaneous nodules usually occur in association with evidence of rheumatic carditis.[289] A lesion has been described in apparently nonrheumatic children that simulates the rheumatic nodule but is believed to represent an unusual reaction to trauma.[285]

Arterial lesions

Rheumatic arteritis is present in many instances of rheumatic fever. The lesions are not confined to the coronary arteries but may be seen in arteries in various organs of the body. They are described in the discussion of coronary artery diseases earlier in this chapter (Fig. 16-33). When the aorta is involved, the lesions are found predominantly in the proximal part of the vessel.

Polyarthritis

The rheumatic changes in the joints are not as well known as those in the heart. The synovial membrane and the periarticular connective tissues are the sites of hyperemia, edema, neutrophilic infiltration, fibrinoid change, and foci of necrosis of connective tissue, followed by proliferative changes of a granulomatous character. Focal lesions similar to Aschoff bodies are observed. Serous or serosanguineous fluid may be present in the joint cavity. This usually subsides, without leaving a residuum.[284]

Pleural and pulmonary lesions

Pleuritis may develop in association with polyarthritis or carditis. Pleural effusion usually is present, and the pleural surfaces appear slightly opaque as a result of a fine film of fibrin. No definite Aschoff bodies are described in the pleura. Rheumatic pneumonia has been described, but there is a question about its specificity. There is no pathognomonic picture. Grossly, the lungs are large, bluish or purplish, firm, and rubbery. Microscopic changes include edema, capillary hemorrhages, and a patchy fibrinous exudate in the alveoli. The fibrin is in the form of globular masses or hyaline-like membranes and often is associated with monocytes.[290] Organization of the fibrinous masses occurs with formation of so-called Masson bodies. Fibrinoid changes and angiitis may be seen, but Aschoff bodies are not evident.

Lesions of central nervous system

One of the major manifestations of rheumatic fever is chorea minor (Sydenham's chorea, St. Vitus' dance), although this entity has been reported in association with other clinical states. The word chorea (Greek *choreia*, "dance") refers to the disordered and involuntary movements of the trunk and extremities that are characteristic of the disease. Chorea minor, often associated with or preceded by acute rheumatic fever, is seen in childhood and early adolescence, more commonly in girls. It has been shown to be associated most frequently with a benign form of rheumatic fever.[295]

Chorea minor must be differentiated from Huntington's chorea, a chronic hereditary disorder occurring usually in adults. The cerebral lesions in chorea minor consist of a diffuse meningoencephalitis of mild degree that is not pathognomonic. Grossly, changes are not striking, but there may be evidence of edema, hyperemia, and petechiae. Microscopically, lesions have been described in the cerebral hemispheres, the brainstem, and, most frequently, the basal ganglia. Small hemorrhages, edema, and perivascular exudation of lymphocytes are commonly seen. The ganglion cells may show some changes, but these are not specific.

Late sequelae of rheumatic heart disease in the brain include chronic obliterating endarteritis and embolism. Rheumatic obliterating endarteritis and other vascular changes, including thrombosis, involve particularly the meningeal and cortical vessels, with subsequent gross or microsopic softenings in the brain.[286,287] Cerebral embolism results especially from thrombi in the left atrium or its appendage, most frequently in patients with mitral stenosis and atrial fibrillation. Other sources of emboli may be the vegetations of nonspecific, nonbacterial thrombotic endocarditis and bacterial endocarditis, either of which may be superimposed on the deformed valves.

Prognosis and causes of death

The outlook today for patients with acute rheumatic fever is much better than it was several decades ago. In one study of children admitted to the hospital with presumably initial attacks, exclusive of chorea, a comparison was made of the number of fatalities among the first 100 consecutive patients seen during the first year of each of four decades. The percentages of deaths were as follows: 1920-1921, 24%; 1930-1931, 20%; 1940-1941, 8%; 1950-1951, 3%.[294] The 3% mortality represents an eightfold decrease since the beginning of the study. Other observations in this investigation were a modest decline in the incidence of cardiac involvement and a twofold improvement in the severity of carditis.

The decline in incidence and severity of rheumatic fever was noted even before the advent of antibiotics in the 1940s. Among the factors that contributed to the favorable state was improvement in standards of living for the poorer classes of urban areas after the extreme privation and crowded quarters of the depression years. There also was an awareness of the role of streptococcal infections in the first and succeeding attacks of the disease, so that the medical profession instituted measures to protect the patient and to isolate carriers. Natural mutation of the disease as a result of a new generation of more resistant hosts and less vigorous organisms also may have been a factor.[294] With the development of antimicrobial prophylactic programs and the use of potent antirheumatic agents, there was acceleration of the decline in mortality and lessening severity of the disease.[294]

Certain factors, such as the nature of the attack of rheumatic fever and the cardiac status at the time the patient is first seen by the physician, have been shown to influence the subsequent course of the disease. Many patients who initially had arthritis or chorea but no significant murmurs remain free of rheumatic heart disease.[296] The frequency, duration, and severity of recurrences (the last being most significant) affect the prognosis.[295] The more frequent and more severe the recurrences, the greater are the disability and mortality. In patients who have evidence of rheumatic heart disease when first observed, there is a greater likelihood that the cardiac damage will disappear during subsequent years (1) in those who had no previous attacks of rheumatic heart disease than in those who had previous attacks, (2) in those without diastolic murmurs, and (3) in those with no cardiomegaly.[296] Patients who have considerable cardiomegaly or congestive heart failure at the onset of rheumatic fever do poorly, and it is unusual for the ones who survive adolescence to reach 30 years of age.[295] Patients with little or no cardiac enlargement early in the disease are relatively free from serious recurrences and have a longer life.[295]

The chief causes of death in patients with rheumatic heart disease [295,298,299] are cardiac failure with or without associated rheumatic activity, bacterial endocarditis, and embolism. Death also may be attributed to other complications, such as bronchopneumonia.

Cardiac failure is the most frequent cause of death from rheumatic heart disease, and it often coexists with and is caused by active rheumatic fever, particularly in early life. In young or middle-aged adults, heart failure is likely to be caused by various valvular deformities. In older patients, other types of lesions, such as coronary heart disease, often are superimposed on old rheumatic heart disease and may be the cause of death. Patients with heart failure are more susceptible to the development of other lesions (pulmonary infarcts).

Bacterial endocarditis, usually of the subacute type, shows a downward trend as a cause of death in rheumatic heart disease, probably because of the use of antibiotics and chemotherapeutic agents in the treatment of the disease and their use in prophylactic programs in the management of patients with rheumatic heart disease. The peak incidence of bacterial endocarditis in rheumatic patients occurs at about 20 to 39 years of age.[298] Older patients are more likely to have the acute type of bacterial endocarditis.[298]

Embolism as a cause of death in rheumatic heart disease shows a substantial increase, in contrast to the downward trend of deaths caused by bacterial endocarditis.[298] The organ most frequently affected is the brain, followed by the kidneys, spleen, and lungs. The majority of emboli are bland, but occasionally they may be septic, the latter arising from superimposed bacterial endocarditis. Most of the emboli originate in mural thrombi within the left atrium or its appendage, particularly in association with mitral stenosis and atrial fibrillation. Another possible source of emboli is a concomitant, nonspecific nonbacterial thrombotic endocarditis on a valve.[298] In contrast to emboli from the atrium or its appendage, emboli from nonbacterial thrombotic endocarditis are not dependent on atrial fibrillation, for they may occur whether the rhythm is regular or not. [298,299] At times the source of the emboli cannot be identified in the heart at autopsy. In such instances it has been suggested that mural thrombi or vegetations of nonbacterial thrombotic endocarditis were washed away completely. If roughened surfaces from which they were dislodged cannot be found, one may assume that the areas healed. Because of the high frequency of occurrence of thrombosis of the left atrial appendage, there is a danger of causing an arterial embolism during the course of mitral commissurotomy for mitral stenosis by inadvertently dislodging a fragment of a thrombus. [293] Occasional cases have been reported in which death was caused by emboli arising from calcific fragments of a greatly calcified mitral valve during valvulotomy.[292] Calcific emboli also have been reported to occur spontaneously, as well as in association with surgical procedures on the aortic valve, in patients with calcific aortic stenosis.[297] Another source of embolism, particularly pulmonary, is a thrombus in the veins of the lower extremities.

Sudden death may occur as a result of obstruction of a stenotic mitral orifice by a ball thrombus in the left atrium or as a result of coronary insufficiency associated with aortic stenosis.

Heart in rheumatoid arthritis

The possible relationship of rheumatic fever to rheumatoid arthritis has long been a subject of discussion in the literature. Many pathologic investigations have shown that rheumatic heart disease and rheumatoid arthritis frequently coexist. The reported proportion of patients with rheumatoid arthritis who have postmortem evidence of associated rheumatic heart disease varies from 7% to 65.7%.[309] There is, of course, the possibility that use of less rigid criteria of what constitutes rheumatic heart disease may account for the high incidence of this disease in some of the investigations. In a comparative study, one investigator observed that the incidence of rheumatic heart disease was somewhat higher (12.2%) in the group with rheumatoid arthritis than in the general population, in whom the incidence was 6.1%.[309] These data, together with those in the other published cases, suggest that coexistence of the two diseases is not merely

THE HEART

Arteries and Veins

Fifth Edition

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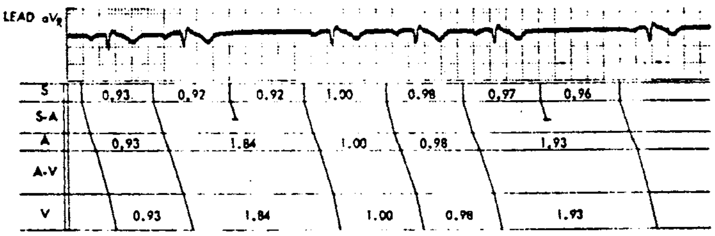

FIGURE 28-34 SA block. In each pause the entire P-QRS-T sequence is missing, and the long cycle is approximately equal to two of the sinus cycles.

pause is equal to two sinus cycles (Fig. 28-34): if an existing sinus rate exactly halves, 2:1 SA block is diagnosed.

It is important to recognize SA Wenckebach periods because they invariably indicate an abnormality of the sinus node, yet they are usually overlooked and called sinus arrhythmia—a normal mechanism. Their recognition is discussed further on in this chapter. If P waves are entirely absent, complete SA block may be diagnosed, but it is well to keep in mind that there are four possible explanations for absent P waves: (1) failure of the sinus node to form impulses (generator failure); (2) failure of the impulse to emerge from the node (exit block); (3) atrial paralysis, as in potassium intoxication; and (4) a sinus impulse that is too weak to activate normally responsive atria (inadequate stimulus). Block should be diagnosed only when a mathematical relationship can be demonstrated between the P waves, or when the cycle sequence of Wenckebach conduction is recognized.

Any abrupt pause produced by failure of one or more sinus impulses to occur on time, and failure to satisfy the mathematic relations of recognizable block, may be called *sinus pause* and its duration specified.

Atrioventricular (AV) Block

AV block is usually classified into three degrees (Table 28-7). In *first-degree*, AV conduction time is prolonged, but all impulses are conducted to the ventricles. *Second-degree* means that more or less frequent impulses are blocked and fail to reach the ventricles. This is usually subdivided into type I, type II, and high grade (or advanced). *Third-degree* is complete block, in which no impulses can reach the ventricles.

The current classification of AV block has serious shortcomings because its categories fail to correlate with prognosis or with indicated therapy. This is because two decades ago there was no consistently effective treatment for AV block, and consequently it mattered little how blocks were graded. Pacemakers then entered the picture and revolutionized the therapy of block, while nothing was done to renovate its taxonomy. It is regrettable that, in the days before pacemakers muddied the prognostic waters, a careful assessment of the many and various patterns of AV conduction disturbance was not attempted. There is no doubt that, to correlate realistically with prognosis and the need for therapy, a classification expanded by several additions and subcategories is needed (Table 28-7, bottom).

One of the many factors that have helped to maintain the unsatisfactory status quo is the consistent failure of almost all authors to define terms such as complete, high-grade (or advanced), and type II AV block. An extreme example of the unfortunate result of not defining these terms is that disturbances as different as spontaneous ventricular asystole and AV dissociation, at least partly due to block but in the company of an independent junctional rhythm at a rate of 45 per minute or more—a combination which, for want of a better term, we have called *block/acceleration dissociation*—are often lumped under the heading of "complete AV block." Yet, in acute myocardial infarction transient spontaneous ventricular asystole (Fig. 28-35*A*) is associated with a mortality (whether paced or not) of about 90 percent, while block/acceleration dissociation (Fig. 28-35*B*) in our experience is associated with a mortality of less than 10 percent.

Another factor is that "degrees" as they are cur-

TABLE 28-7 Classification of AV Block

Common Classification of AV Block
First degree (prolonged PR interval)
Second degree:
Type I (Wenckebach periodicity)
Type II
High grade (advanced)
Third degree (complete)
Categories of AV Block Requiring Consideration
Prolonged PR interval
Block/acceleration dissociation
Occasional "dropped" beats:
Type I (Wenckebach periodicity)
Type II
2:1 AV block:
Type I
Type II
High-grade block:
Type I
Type II
Complete block:
Junctional escape
Ventricular escape
Transient ventricular asystole:
Spontaneous
Phase 4 (?)
Vagal

A B


FIGURE 28-35 *A.* Spontaneous ventricular asystole lasting for over 7 s and due to the abrupt development of AV block at a time when no escaping pacemaker is active. From a patient with acute anteroseptal infarction. *B.* Complete AV dissociation due to a combination of *some* degree of AV block with an accelerated junctional rhythm (rate 68 per minute). From a patient with acute inferior infarction.

rently defined do not necessarily correlate with the severity of the conduction disturbance—definitions are predicated mainly on conduction ratios to the neglect of atrial rate. Thus 2:1 block, which some classify as high grade, may represent anything from a disaster (2:1 block at an atrial rate of 60) to a blessing (2:1 block at an atrial rate of 140). Again, if the sinus rate is 70 and, despite a slow independent ventricular rate of 30, no impulses are conducted to the ventricles, complete AV block can be diagnosed; but if the rate of an independent accelerated AV junctional pacemaker is 85, complete absence of AV conduction in these circumstances may represent only a minor degree of block. In fact, mere delayed AV conduction (prolonged PR interval) associated with an accelerated subsidiary pacemaker may be responsible for this form of complete AV dissociation. It is therefore obvious that in any meaningful consideration of AV block the respective rates of the involved pacemakers must be taken into account.

In fact, with definitions and misconceptions as they presently exist, a patient with "first-degree block" may have a worse conduction disturbance than another erroneously labeled as having "high-grade block."

The recipe for confusion is complete if we add the following widespread misconceptions to the lack of precise definitions and the fact that "degrees" are not really degrees: 2:1 AV block is necessarily high-grade;[79] 2:1 AV block is necessarily type II block;[80,81] the block is necessarily high-grade when most, but not all, atrial impulses are not conducted to the ventricles;[82] and total absence of conduction, as in Fig. 28-35*B*, is necessarily evidence for complete block.[83] In view of these deficiencies in current usage, it seems desirable that the following three remedial measures be implemented: (1) "degrees," as presently used, should be eliminated or at least deemphasized; (2) the inclusion of stated atrial and ...

diagnoses of AV conduction disorders; and (3) the AV blocks should be reclassified into a realistic set of sufficient and *defined* categories, including at least those listed in Table 28-7. Only then will the current confusion be remedied and indications for therapy clearly limned.

Since most reports concerned with AV block fail to define their terms, and since basic terms are variably used, some of the following observations on etiology and incidence must be accepted with appropriate reservation.

Prolonged PR intervals are occasionally found in apparently normal subjects.[40] In their survey of over 67,000 asymptomatic Air Force personnel, Johnson et al.[84] found 350 examples of first-degree block (5.2 per 1000). Twenty percent of them had PR intervals that were over 0.24 s. Of 19,000 young aircrew applicants, 59 had PR intervals of 0.24 s or greater.[85]

In both normal and diseased hearts, atropine, standing, exercise, and isoproterenol tend to shorten the lengthened PR interval. There is a widespread belief that the PR interval tends always to shorten with an increase in heart rate. Though this is true in normal hearts with natural acceleration, when the rate is increased with artificial atrial pacing, the PR lengthens even in normal hearts; in diseased hearts a natural increase in rate is frequently associated with lengthening of the PR interval. AV block with Wenckebach periods may occur in normal hearts[40] and was found in 3 of the 67,000 Air Force personnel screened by Johnson.[84]

Prolonged AV conduction (PR interval) and dropped beats can be caused by vagal stimulation and by a variety of drugs, including digitalis, quinidine sulfate, procainamide, propranolol, and potassium. Diseases that most commonly produce AV block are rheumatic fever, chronic ischemic heart disease, and myocardial infarction, especially inferior infarction. Any infectious disease that produces myocarditis may have this effect. Some patients with hyperthyroidism have prolonged PR intervals.

Causes

TEXTBOOK OF
Clinical cardiology

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Textbook of Clinical Cardiology, Emanuel Goldberger (1982)

disorder using pharmacologic means. In the usual event of this variety of ventricular tachycardia not being hemodynamically tolerated, cardioversion is performed as an emergency procedure, and generally several hundred watt seconds are required for conversion to sinus rhythm. Occasionally this rhythm disturbance will convert to sinus rhythm following a sharp blow on the chest, but the authors do not recommend this as the usual approach to correcting it. There are many different causes of extrasystolic ventricular tachycardia, but acute myocardial ischemia and infarction, digitalis excess, severe hypoxia and/or acidosis, hypokalemia, hypercalcemia, hyperkalemia, systemic infection, viral myocarditis, and hypotension need to be emphasized in particular. Occasionally this rhythm disturbance occurs in apparently normal individuals; the reason for this is not known.

Idioventricular Tachycardia

The two major reasons for the development of this rhythm disturbance are digitalis excess and acute myocardial infarction. This rhythm is common in the setting of acute myocardial infarction and is generally benign. It may be present in as many as 30-40 percent of patients with acute myocardial infarcts, and it is usually so benign that it goes unnoticed by patient, nurse, and physician. Even when discovered it generally requires no treatment as long as the patient is hemodynamically well compensated and there are no other foci of ventricular ectopic activity and no bursts of more rapid ventricular tachycardia as described above. When this rhythm disturbance is due to digitalis excess, the medication should be discontinued. This possibility should be suspected in any patient on digitalis who develops the rhythm disturbance. When pharmacologic treatment is necessary, either atropine or xylocaine are preferred. If xylocaine is utilized, one needs to be careful that one does not suppress the only pacemaker rhythm a patient has, and one probably should remain by the bedside of the patient as xylocaine is administered, ready to insert a temporary pacemaker should that be necessary. The administration of atropine is based on the recognition that this rhythm disturbance generally occurs by default, i.e., the accelerated ventricular rhythm usurps pacemaker control from a slower sinus or AV junctional pacemaker.

Bedside examination of the patient may be very helpful in correctly identifying ventricular tachycardia. Clinical manifestations are those produced by the A-V dissociation. The physical findings include cannon A waves in the jugular venous pulse, varying intensity of the first heart sound, and variations in systemic peak systolic blood pressure. Atrial gallops, ventricular filling gallops, and summation gallops that may be of constant or variable intensity may also occur as a manifestation of the A-V dissociation. Wide splitting of both the first and second heart sounds is also frequently noted. Another helpful clue of A-V dissociation may be obtained from the electrocardiogram itself if one can identify the presence of Dressler or fusion beats which represent a "hybrid beat" between a partially conducted supraventricular impulse and a ventricular ectopic beat. The presence of fusion beats identifies independent supraventricular and ventricular pacemakers and, in the opinion of the authors, helps to prove the presence of ventricular ectopy. Occasionally AV junctional tachycardia may also be characterized by A-V dissociation and demonstrate the same clinical signs, but this phenomenon occurs infrequently. As a practical point, the presence at the bedside of signs of A-V dissociation in association with a rapid regular tachycardia with bizarre QRS complexes indicates the presence of ventricular tachycardia.

Atrioventricular Block

The different types of atrioventricular block (AV block) are ordinarily classified into three degrees. First degree AV block represents that situation in which there is a delay in atrioventricular conduction manifest by a prolonged PR interval on the electrocardiogram (generally one longer than 0.20 sec) but each atrial impulse is conducted into the ventricles. Second degree heart block represents that situation in which some atrial impulses are not conducted into the ventricles. Third degree heart block represents complete inability to conduct atrial impulses into the ventricles and the existence of a totally independent ventricular pacemaker. Third degree heart block needs to be differentiated from complete A-V dissociation in which instance independent atrial and/or AV junctional and ventricular pacemakers do exist but only for temporary periods of time since the mechanism of the A-V dissociation is an accelerated AV junctional or idioventricular pacemaker, slowing the sinus rate, digitalis excess, ischemia, etc. Third degree heart block implies complete inability to conduct supraventricular impulses into the ventricles while complete A-V dissociation suggests conduction would be possible if physiologic circumstances were appropriate.

First degree heart block. As previously discussed, first degree heart block is recognized by identifying a prolonged PR interval on the resting electrocardiogram. In both normal and diseased hearts atropine, exercise, and catecholamines tend to shorten PR intervals. In addition, in normal hearts physiologic increases in heart rate tend to shorten PR intervals although in diseased hearts physiologic and artificial increases in heart rate may result in PR prolongation. Prolonged PR intervals in first degree heart block may be caused by vagal stimulation, a number of different pharmacologic interventions, including importantly digitalis and disease processes, such as ischemic heart disease, infiltrative myocardial diseases, acute myocardial infarction (especially acute inferior or diaphragmatic myocardial infarcts), myocarditis, Addison's disease, congenital heart disease (especially atrial septal defect and Ebstein's anomaly), rheumatic fever, and streptococcal infections. Prolonged PR intervals are occasionally found in apparently otherwise normal subjects and in well-trained athletes.

The presence of first degree heart block generally does not constitute an indication for any particular form of therapy. In children the development of first degree heart block may represent digitalis excess, and cardiologists usually decrease the amount of digitalis a child

MEMORANDUM SHEET

NAME OF INSURED Emma Harris

POLICY NUMBER D82-029-158

CLAIM NUMBER

DATE

8-17-81 Mr Help: Liability: $5000

We have received a statement from agent Ricci Thompson regarding his knowledge of the insured's health history at the time of application for GLIP.

Mr Thompson was aware that the insured was undergoing dialysis three times a week, although he had no knowledge of her receiving ASSI payments due to her disability.

Based on the agent's knowledge of the insured's kidney disease, which legally can be imputed to the Company, would suggest making payment of death benefits to Mable Lewis. Agent's knowledge would seem to estop us from claiming reliance on a material misrepresentation.

Erickson

Agree. Make up AR card on agent.

E. Help

77

MEMORANDUM FOR E. A. GOULET
DIRECTOR
UNDERWRITING AND INSURANCE SERVICES

March 29, 1983

Re: Agent's Responsibility
Don C. Painter, FTSA
Detroit Agency

Insured: Barbara Sullivan
Policies: 34 986 134
34 998 589

This case involves two Whole Life insurance policies on the life of Barbara G. Sullivan written by Full Time Special Agent, Don Painter. Policy 34 986 134 is a Life Paid-Up at Age 65 plan for $12,000 applied for on January 22, 1981. Policy 34 998 589 is a Modified Whole Life policy for $35,000 applied for on March 16, 1981.

The Insured died on June 14, 1982, within the two year contestable period on both policies. The cause of death was cardiopulmonary arrest due to scleroderma. A routine contestable investigation was conducted and we determined that the scleroderma had been diagnosed in 1978. This history was not included in the answers to the Part II health questions on either application. Had this health history been admitted, both applications would have been rejected at Underwriting time. On August 11, 1982 we informed the Co-Conservators of the minor beneficiary that because of material misrepresentations in the applications for insurance, our only liability was the return of premiums paid plus interest ($909.03).

We subsequently received a letter dated February 5, 1983 (copy enclosed) from an attorney representing the Guardian of the minor beneficiary. This letter contained serious allegations about Agent Painter's knowledge of the Insured's poor health as well as allegations that the Prudential policies replaced coverage the Insured had obtained from Agent Painter when he had been an agent for Equitable. These allegations were subsequently investigated by Home Office Representative Marsano. A copy of his March 11, 1983 report is attached.

Because it is apparent that Agent Painter not only did not follow replacement regulations and Company guidelines but was also cognizant (and had been for some time) of the Insured's poor health at the time he took the applications, we have dropped our misrepresentation action and are accepting full death claim liability of $47,000.

In addition to a $47,000 claim loss, Agent Painter's actions made the Company highly vulnerable to an expensive lawsuit.

MEMORANDUM SHEET

NAME OF INSURED/EMPLOYEE Josephine Oertel CONTROL/POLICY NUMBER 77-024-315

NAME OF DEPENDENT CLAIM NUMBER

DATE 10/29/82 EFFECTIVE DATE (POLICY)

Mr. Rupert,

I would appreciate your input + opinion on this contestable death claim.

This 64 yr old female applied for a $5000 WL@88 policy on 8/6/81 (C.O.D.). She admitted high blood pressure onset in 1976 + continues treatment with good results. She was examined by our medical examiner + found to be in fairly good health. Based upon the health information supplied + the good Bp reading in the exam our underwriter acted appropriately by issuing the policy at standard rates.

The contestable investigation revealed a long history of coronary artery disease. However, she had not undergone specific treatment for such in recent years. Our underwriters state they would have required an APS because of the h+ of an old MI. + would have issued a Sp. Cl. 3.

Wisconsin has a statute which presumes good health when insured is examined by a Co. medical examiner. Insurer would be estopped from denying for misrep, except in a case of fraud or deceit.

It does not appear fraud would be a good defense in this case. The applicant gave a partial admission + considering the date of her last MI (1967 + no specific ongoing treatment for this, she in all likelihoo

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[redacted]

may have believed she was giving truthful answers. She probably did not recognize the ongoing nature of her heart disease but rather her main health concern was her weight + b/p problems.

I'm inclined to approve the claim. Your opinion please

B.A. Moon

10/29/82 Ms. Moon :- Agree. Underwriter's comment on reverse of Part I indicates that there was a basis for requesting an APS, but he opted not to. Thus we waived the APS and accepted the risk with our eyes open.

J. Rupert

CONTROL/POLICY NUMBER 77-024-315

CONFIDENTIAL

[redacted] 15036 F402-70785063

1-4-82 31 28
FLOYD, IDA G.
Grays Harbor, WA—1104 E McBride
Retired

REQUESTER Mary Burke 213-992-2

Address any additional instructions to Tacoma, WA BRANCH C

If you wish to discuss on phone, call 206-752-4695
(Area code & Branch Office phone no.)

Type Report SPECIAL CONTESTABLE I

Date of birth or age 7-29-20 Date(s) of this investigation 12-31-81

1. STATUS:

A. ☐ ACKNOWLEDGEMENT: Your .... Claim request dated .... was rec on .... If possible, final report will be sent on or before ....
(Explain below any mail or other irregular delay encountered thus far.)

B. ☐ PARTIAL REPORT: A partial report is included covering our findings to date. If possible, final report will be sent you on before ....

C. ☐ CASE IS STILL PENDING: An Acknowledgement or Partial Report was last sent you on .... If possible, final rep will be mailed to you on or before .... (Give reason for delay below.)

D. ☒ FINAL REPORT: Investigation by this office is being closed with this report.

E. ☒ TRANSFER CASE: You will receive (or may have already received) report(s) from our Olympia Sub Office Office(s).

2. CIRCUMSTANCES: Give brief resume of pertinent information such as date of issue or loss, date of disability, amount & nature of disabili or loss. (If circumstances previously given, so state; do not repeat. If customer request contained in letter, refer to date of letter & writer with out repeating entire letter. Do NOT repeat any special attention points here.)

- Please refer to report from this office dated 12-18-81.

3. CLAIM HISTORY (Give all Claim History. If already given, so state; do NOT repeat.)

	Date	Name & Address of Company	Type Report	Claim, Pol. #, etc.
☐ Yes				
☒ No				

INVESTIGATION

This case was transferred to our Aberdeen Sub Office for further handling at the St. Joseph Hospital in Aberdeen and Dr. M.C. Lindell of Montesano, WA.

Attached are out-patient emergency room record, in-patient admitting form, and doctor Reed's summary, as well as EKG tracing and nurses constant care record.

Note Dr. Reed's comments on Mrs. Floyd's past health history. In view of our good relations with Dr. Lindell's office, as well as to expedite handling, field representative first telephoned Dr. Lindell's office in Montesano 10 miles east of our Aberdeen sub office. There was no record of recent treatment of Mrs. Floyd by Dr. Lindell. A check was then made of past files in storeroom where it was found that Dr. Lindell last saw Mrs. Floyd as a patient in October 1973. Since this is well beyond the five year limit, we did not contact Dr. Lindell's office in person.

Our Aberdeen sub office is closing handling with foregoing.

ROY HOVILA, Claim Specialist, Aberdeen Sub Office

RXH/ces 2cc

fax Inc.
fax Services Inc.

phone message

o:

rom: Date of {Death / Disability / Maturity}

ddress: Date of Birth:

Policy No.:

hone:

nsured's Name: Memo for file Cupp

Message: Spoke with Jim Strawser regarding ECG in app. The low voltage refers to the machine used. He said their decision is based on the reading by D. T. Wilson. Even though it appears there was an

Message: old inferior myocardial infarction, there was no need to pursue it, based on Mr Wilson's interpretation. App was handled correctly

Called By/
Call Taken By: Cindy Date: 12/3/82

Comb 38767 ED 2-80 (W)

DATE	LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH
7-7-82	Garza,	Marcelino		9-26-26

Vicki Lovetts,

Contestable

Please review the attached death claim less than 2 years. Application was accepted and rated SC 4 due to insured's history of high blood pressure and had previously been rejected in 1975 according to app. Medical records in file reveal no unadmitted medical history of any significance. Recommend we accept liability and pay claim and refer claim to New Business after payment for review for future reference. Please advise.

Mary Butler
7-14-82

7-14-82 Mary Butler,

Agree to accept liability. Dr Majewski's records which we had at issue state emergency room visit 6-29-80. Had we followed on that information Underwriting would have been aware of chest pain & admission of old MI by insured. Agree to refer to Underwriter for review. Vicki Lovetts

DATE	LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH
	Mandelbaum	Manfred		

6/2 Mr. Ketchum,

Pls note, 52 yr old male applying for 300,000.

Past hx of vague chest pain, elevated triglycerides, abnormal stress test, and PVC's.

Noting 40 N.S. and 20 family hx. credit, suggest we accept at a special class 2. No W.P.

Please advise,

Tom J Shaw

RECEIVED MEDICAL DEPT. JUN 2 '81

6-2-81 Tom J Shaw

WITH FAVORABLE HOME OFFICE EXAMINATION AND CURRENT EKG, FEEL WE MAY BE LIBERAL. THE CHEST PAIN HISTORY IS VAGUE AND THE POS. TREADMILL STUDY IS REMOTE. ELEVATED SERUM LIPIDS OFFSET BY NON-SMOKER CREDITS. FEEL WE MAY ACCEPT STANDARD (WOULD HAVE APPRECIATED IT IF H.O. WOULD HAVE DONE TREADMILL STUDY AT TIME OF EXAM - HATE TO HAVE HIM RETURN FOR THIS STUDY.) [signature]

The Prudential Insurance Company of America

Western Home Office
P O Box 9028
Van Nuys, Ca 91409

Prudential

Mr. Lennox F. Pruitt, CLU
Director, Claims
General Actuarial and Claim Division
9 Gib - CORP

July 16, 1982

Insured: Manfred Mandelbaum
Policy: 70 743 521

Dear Len:

We are referring this $300,000 death claim to you in accordance with existing Corporate authority limits.

On April 4, 1981, this 52-year old drapery store owner completed Part I of the application for a 5-year R&C policy with a face amount of $300,000 on a COD basis. It is interesting that the agent noted Policyholder Service as the source of the sales lead. On April 10, 1981, the insured completed the required physical exam; the application reflects treatment at Kaiser Foundation, Cadillac and Sunset locations, for annual physicals, a URI, a right inguinal hernia for 15 years, and a kidney stone in 1966. The underwriter obtained the records of Kaiser-Sunset, which reflected a history of vague chest pain, an abnormal stress test, and PVCs. The underwriter recommended issue at Special Class 2, which our Medical Dept. liberalized to standard, and the policy was issued June 3, 1981. It was not placed until August 19, 1981, when the agent visited the insured at his place of business and collected the initial premium. The agent confirms that he asked the insured the usual "placement" questions.

The insured died on May 2, 1982, of ASHD, and the death certificate was certified by Dr. Jerry Drexler of Kaiser-Cadillac, who had been the AP since 1974. (An irrelevant note to this is that Dr. Drexler is the husband of our Associate Counsel Ruth Drexler.) We received the proofs on May 25 and immediately began our investigation. The HOR (whose investigation was unfortunately delayed and, we feel, pretty sketchy) obtained the records from Kaiser-Cadillac and a Dr. Alpern, who the insured consulted in February 1981 for exertional angina and a stress test (abnormal). The records reflect that the insured consulted Dr. Drexler on July 6 -- during the COD period -- with a request for a hernia repair, and complaints of angina after dancing. Coincidentally, the insured was dancing when his fatal attack occurred.

Marilyn Reed, Mike Zevin, and our Dr. Ketchum have all reviewed this file and agreed that, had the underwriter gotten the completed Kaiser records, Special Class 3 would have been an appropriate rating. Given that we waived a recommendation for Special Class 2 on the information we did have, which included references to the cardiac abnormalities, Tom Potter and I feel that we would have no basis now for declaring a misrepresentation to either the Part II information, or the COD placement, and that we should pay the claim.

As well as the subject policy file, we are also enclosing the files for policy 33 917 120 and 70 924 993 (both descended from 33 586 892). These policies totalled $160,800 and were cash surrendered in November and October 1981, respectively. The subject of insurance replacement was not taken up with the agent (who has been the servicing agent since the 1960's), and under the circumstances, I don't think we need do so now. It is interesting to note that in connection with a 1978 reinstatement we obtained the records from both Kaiser Cadillac and Sunset, showing the insured's lengthy history of angina pain.

Policy H9 274 546 is a 2-year S&A policy issued in 1968, for which we have no record of ever receiving a claim. We enclose it just to complete the package.

Please feel free to call if you would like to discuss this case any further. As always, I look forward to hearing from you.

Sincerely,

Susan Frankel

Susan A. Frankel (Mrs.)
Senior Claim Consultant
Life and Health Claim Division
(213) 992-2127

MEMORANDUM FOR: SUSAN FRANKEL
SENIOR CLAIM CONSULTANT
LIFE AND HEALTH CLAIM
WHWH

S. A. F.
JUL 23 1982

July 21, 1982

Insured: Manfred Mandelbaum

For our records, these are the details of the large amount claim you sent for our review.

Manfred Mandelbaum, 4-13-28, applied on 4-4-81 for a 5 yr. R&C for 300,000 naming his wife, Nili, as beneficiary. On the exam taken on 4-10-81 the insured gave a medical history of 1) annual physical exams by Kaiser-Permanente the last being 11-80 2) a kidney stone in 1966 and 3) a right inguinal hernia still present. The exam and ECG taken for the policy were within normal limits.

Medical records were requested from Kaiser-Permanente at the Sunset location. The insured had stated that annual exams were done at either of two locations, Sunset or Cadillac. The records sent by Kaiser-Sunset only contained records through 1976. These included a 12-4-74 stress ECG interpreted by our medical department as abnormal. Kaiser had also interpretated the ECG as abnormal and indicative of ischemic heart disease.

In addition, underwriting attached and reviewed two older policies on the insured - 33 917 120 and 70 924 993. As you mentioned, during underwriting of a long form reinstatement in 1978, records were obtained from Kaiser-Cadillac through that date which revealed that the insured occasionally had anginal symptoms after exertion.

The case was referred for acceptance at Special Class 2 rates based on the abnormal stress ECG. It was decided, however, to issue the policy at standard rates based on the recent normal resting ECG. The policy was issued on June 3, 1981 and was placed on August 19, 1981.

Mr. Mandelbaum died on 5-2-82 of an acute myocardial infarction.

The HOR obtained the medical records from Kaiser-Cadillac which included details of medical visits through 2-82. They revealed that the insured had anginal pain with exertion for several years and that in July 1981 he had requested a hernia repair.

Based on this underwriting advised that had they had these records the policy would have been issued at Sp Cl 3 rates for the angina and the hernia. Because it was decided at issue to waive a Special Class 2 rating based on the insured's cardiac abnormalities you are recommending that we pay the claim.

I agree. As I see it, there is no basis for a misrepresentation defense. At underwriting time we were on notice that 1) the insured suffered from anginal paid on exertion, 2) his stress ECG's were abnormal and 3) ischemic heart disease had been diagnosed. The insured stated on the application that he had annual physicals with the last one only four months before the application date. Underwriting received records only through 1976 and, in spite of his medical history, did not pursue obtaining his medical records for the period between 1976 and 1981. In addition, the fact that the insured had an inguinal hernia present for 15 years was stated on the application and the medical records obtained referred numerous times to the hernia and the symptoms and treatment of it. His physical condition did not change significantly during the placement period.

Full proceeds may be paid to the beneficiary, Nili Mandelbaum.

I also agree that, since we are paying full benefits of this policy, the question of whether this policy is a replacement of the previous two is a moot one. It is questionable since policy loans were taken to pay premiums on those two policies after this one was issued and it is unlikely that this would have been done if replacement and cash surrender were contemplated when this coverage was applied for.

Jan

Jan Drosendahl
Claim Consultant
General Actuarial and Claim Division
CORP

JD/gh

DATE	LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH
9/21/82	Klug			

Memo for file.

Insured was 54 years old when policy was issued. Policy was rated sc-3 due to hypertension & diabetes. Insured died of same condition. Medical records were obtained from USAF Hospital & B/P readings from VA Hosp. In view of the fact that we knew of insd condition, policy was rated & insd died of same condition we'll approve claim & waive contestability.

Lottie Tolen

DATE	LAST NAME Colwell	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

Memo for file

Insured died of acute myocardial infarction. I obtained the not taken app on policy 79 039 767 which contained the APS from Dr Brodie and records from St Francis Hospital relating to his heart condition to which he was ~~[illegible]~~ rated Spec Class 5.

Since the Insured died of the same condition he was rated for and there were no other leads to follow, I am approving this claim

Cindy Ramirez
11/29/82

CLAIMS GROUP

MEMORANDUM SHEET

ME OF INSURED Katherine Opgaard POLICY NUMBER D44-866-890

CLAIM NUMBER

TE	
9-3	Memo:
	Investigative report received & reviewed.
	$3000.00 Contestable benefits due.
	Equifax contacted Dr. Heppner at
	Fargo - we have all available rec's
	already in app file - Fargo clinic was
	Insureds clinic - any other care was
	with Dr Agnew (July (81) coronary by-pass)
	and Dr Duval (cardiologist) The dr's notes
	were obtained from St Lukes (by-pass info)
	& Dakota (fatal coronary).
	Found no unadmitted health hx - Insureds
	hx of heart problems were already known
	to Underwriters - in fact - policy was rated
	for such -
	Would pay benefits at this point w/no
	further delay
	L Hunt

CLAIMS GROUP
MEMORANDUM SHEET

NAME OF INSURED John W. Richardson POLICY NUMBER 34 930 49

CLAIM NUMBER

DATE

3/24/81 Ms. Martell:

This is a Missouri case. Misrep must contribute to the loss. While I believe it did in this case that may be hard to establish since D/C is equivocal and no autopsy was performed.

I am also concerned about the effect of the app. admission on a misrepresentation defense. We are dealing with a 10 day hospital confinement. That's a bit extended for an acute gastritis. Insured appears to have given an essentially accurate description of his symptoms to our examiner. The Company had an opportunity to obtain clarification of dx and prognosis, etc. from the source (A.P.) and opted not to do so. These factors would substantially weaken a misrepresentation defense. I believe we would have to clearly and unequivocally establish that this layman was fully advised and fully understood the actual diagnoses from his 10/79 confinement. That could prove extremely difficult. We would also be vulnerable to a contention that we were "re-underwriting" at time of claim and thus be exposed to a damages action.

On balance, I am reluctant to resist liability in this

FORM 17707- ED. 7-78 Litho in U.S.A.

case. Pay death benefits. Have Jim Rupert record this as a case that would have been a i.p. were it not for mitigating circumstances.

After payment refer file to Mr. Borgstrom for his information. He might also want to refer it Pension underwriters.

E. Helo

CERTIFICATE OF SERVICE

I hereby certify that four true and correct copies of the foregoing Brief of Appellant were mailed to the Respondent by depositing them in the United States Mail on this 15th day of August, 1985, to the following counsel of record:

Richard Ferrari
WATKISS & CAMPBELL
Attorneys for Defendants/Respondents
310 South Main Street - Suite #1200
Salt Lake City, Utah 84101

Merill F. Nelson