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Chapter 17: Insurance

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CHAPTER 17

Insurance

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A. COURT DECISIONS

§17.1. Life insurance: Accidental death benefits: Proximate cause. In *Vahey v. John Hancock Mutual Life Insurance Co.*,[1] plaintiff, the beneficiary, sued on two life insurance policies containing certain provisions for additional benefits payable in the event of the accidental death of the insured. Specifically, the policies provided that recovery of the benefits could be had upon notice to the company and a showing "that the death of the insured was caused directly and independently of all other causes by a bodily injury sustained solely by external, violent and accidental means. . . ."[2] However, no benefit was payable if the death of the insured resulted "directly or indirectly, or wholly or partially, from . . . any infection or bodily or mental infirmity or disease existing before . . . the accidental injury. . . ."[3] The insured, an epileptic, had fallen during a seizure, fracturing his skull and suffering an epidural hemorrhage, as a result of which he died two days later. The trial court judge, sitting without a jury, found the benefits to be due plaintiff under the policy. On appeal, the issue was whether the death of the insured was "accidental" within the policy definitions and qualifications. The plaintiff contended that it was essential to draw a distinction between the cause of the accident or injury from which death resulted and the cause of death itself, stating that "if an accident is the sole cause of death, then the death cannot be said to have been the indirect result of anything else,[4] and that the policies in question properly excused payment only if the *death* resulted from the pre-existing infirmity, not if the *accident* or *injury* causing the death so resulted. Rejecting plaintiff's argument, the Supreme Judicial Court reversed the decision below, in effect refusing to dichotomize the situation into one in which the sole cause of the death of the insured could be said to have been the accident. Instead, the Court held that whenever a pre-existing disease or infirmity either "proximately causes or substantially contributes to the death"[5] of the insured, "such a death is not covered by that por-

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§17.1. [1] 1969 Mass. Adv. Sh. 359, 245 N.E.2d 251.
[2] Id. at 360 n.1, 245 N.E.2d at 252.
[3] Ibid.
[4] Id. at 360, 245 N.E.2d at 252.
[5] Id. at 361-362, 245 N.E.2d at 253.

tion of the policy which insures against death by accident or accidental means independently of all other causes. . . ."[6] Finding that the death of the insured here resulted from a fall caused by his epilepsy, the Court denied plaintiff recovery.

§17.2. Life insurance: Condition of insurability: Condition precedent. In *Warren v. Confederation Life Assn.*,[1] the court of appeals affirmed the decision of the district court[2] denying plaintiff recovery as beneficiary on a policy of life insurance. The facts, essentially undisputed, revealed that the applicant, plaintiff's son, had signed an application for insurance which contained a proviso that "[the] policy . . . [would] not take effect until . . . the policy has been delivered to the Applicant while the facts concerning the insurability of . . . [the] insured are the same as described in this application. . . ."[3] In the application, which became a part of the policy, the plaintiff's son had stated that he was "in first class health and free from all symptoms of disease. . . ."[4] However, during the period from the date of application to the date of delivery of the policy (approximately three months), the deceased son had been hospitalized several times for epilepsy and drug ingestion.

Defendant pressed its contention that the recital of "first class health" in the application, in conjunction with the proviso language of the application, combined to establish a "condition precedent" to the policy's taking effect. Defendant argued that the fact that the decedent was not in good health immediately prior to delivery of the policy was conclusive as a violation of the condition precedent so that the policy never became effective. Plaintiff contended that certain knowledge possessed by the defendant at the time of application that the decedent son was not in first class health constituted a waiver of the proviso in the application. The court of appeals, noting that "[t]he distinction between a misrepresentation on an application . . . which may or may not be fatal, and a condition precedent, where substantial truth is an absolute requirement . . . is well recognized by . . . Massachusetts courts,"[5] held that the decedent's failure to maintain first class health until the date of delivery of the policy was an absolute bar to plaintiff's recovery. As to a waiver of the health requirements, the court found that, although defendant's knowledge at the time of application could possibly constitute a waiver until that date, the defendant could not be held to have waived the provision as to subsequent events of which it was ignorant. A further claim by plaintiff of waiver or estoppel because the soliciting agent

[6] Id. at 362, 245 N.E.2d at 253.

§17.2. [1] 401 F.2d 487 (1st Cir. 1968). For further discussion of the Warren case see §17.5 *infra*.

[2] Warren v. Confederation Life Assn., 282 F. Supp. 375 (D. Mass. 1968), noted in 1968 Ann. Surv. Mass. Law §15.3.

[3] 401 F.2d at 489.

[4] Ibid.

[5] Ibid.

of defendant did not read the proviso in the application to the decedent was rejected by the court on the familiar contract ground that his acceptance of the policy bound him to its provisions absent fraud or misrepresentation, of which there had been no allegation by plaintiff.

Significantly for insurance law practitioners, the court in this case stated that, notwithstanding the propriety of using condition precedent language, such language "should be construed against the company at least to the extent of not permitting it to rely upon the literal wording to achieve a result not disclosed."[6] Such a statement may signify some judicial intent to diminish the efficacy of the condition precedent defense.

§17.3. Casualty insurance: "Crime" insurance: Interpretation of policy language. *Western Massachusetts Theaters, Inc. v. Liberty Mutual Insurance Co.*[1] involved the interpretation of certain words in a so-called "crime policy" issued by defendant to plaintiff to cover plaintiff's theater in Fall River. At a time when the theater was not open to the public, two young boys forced a rear exit door and, having gained entrance, proceeded to break into a candy and ice cream freezer, taking a substantial amount of the contents; they also slashed the theater's picture screen. Plaintiff grounded its right to recovery on that portion of the policy in which defendant undertook to "*pay for damage to the premises caused* by robbery . . . or *by or following burglarious entry into the premises, or attempt thereat.*"[2] "Premises" was defined in the policy to be "those portions of the interior of any building which are occupied and controlled" by the insured; although "burglarious" was not defined, "burglary" was stated to be "the wrongful abstraction of merchandise, furnishings, fixtures and equipment by any person . . . making felonious entry into the premises." The Supreme Judicial Court, in affirming an appellate division reversal of the trial court, with one minor exception hereinafter to be considered, found it necessary to consider first, whether there was a "burglarious entry" in the face of defendant's contention that, because no evidence was introduced to support a finding that the boys had in fact removed any candy or ice cream from the theater, there was no "wrongful abstraction" giving rise to a burglary, and that the conduct of the boys was properly to be classified as vandalism. The Court viewed defendant's construction of the facts as unduly restrictive, noting that " '[a]bstraction' is not a word of settled technical meaning such as 'embezzlement' or 'larceny.' "[3] Thus, the Court found there to be a "burglarious entry" within the meaning of the policy.

Next, the Court considered the question of whether the damage

[6] Id. at 490.

§17.3. [1] 1968 Mass. Adv. Sh. 1159, 241 N.E.2d 826.
[2] Id. at 1160, 241 N.E.2d at 827.
[3] Id. at 1161, 241 N.E.2d at 828.

to the picture screen, candy and ice cream was within the coverage of the policy as constituting "damage to the premises." Pointing out "[t]he word 'premises' may have different meaings, depending upon . . . [its] content. . . ,"[4] but finding that only in a peculiar context could it be said to include personal property, the Court found that recovery for these elements of damage was not within the proper purview of the policy language. In so finding, the Court conceded that the picture screen was a "fixture," but found that another section of the policy revealed an intent to differentiate between "premises" and "fixtures." Because the Court had held there was "burglarious entry," the Court modified the opinion of the appellate division granting recovery to plaintiff of the cost of repairing the exit door of the theater, which had been damaged in the course of the boys' gaining entrance. The defendant had conceded the correctness of this modification if a "burglarious entry" were found, presumably on the basis that the doors were clearly a part of the "premises."

Although it cannot be doubted that the Court's decision is technically correct, it is questionable whether it does substantial justice. It seems clear that, unless such "fixtures" as the picture screen (valued at $675 for replacement)[5] were to be included in a crime policy, such a policy would be effectively of no value to the plaintiff, as it is usually the case that fixtures are the only items worthy of insurance in buildings dedicated to theater use, exclusive of personal property. It is felt that sufficient ambiguity was present in the language of the policy to justify a different conclusion as to the status of the picture screen, and hence the propriety of recovery for its damage.

§17.4. Accident insurance: Damage to goods: Interpretation of policy language. The question before the Court in *Beacon Textiles Corp. v. Employers Mutual Liability Co.*[1] was the proper interpretation to be afforded the word "accident" in an accident insurance policy issued to plaintiff by defendant. The facts of the case indicated that plaintiff had sold a substantial amount of yarn to a customer, which later turned color in sweaters knit by the customer, causing the customer damage of approximately $3700. Defendant denied coverage for the loss, for which plaintiff was otherwise liable, on the basis of an exception to the general obligation of defendant to cover "all sums which the insured shall become legally obligated to pay as damages because of injury . . . caused by accident."[2] The exception provided that the policy was inapplicable "to injury . . . of . . . any goods . . . thereof manufactured . . . by the . . . insured . . . of which the accident arises."[3] The defendant contended both that no "acci-

4 Ibid.
5 Id. at 1161 n.1, 241 N.E.2d at 827.

§17.4. 1 1969 Mass. Adv. Sh. 599, 246 N.E.2d 671.
2 Id. at 600, 246 N.E.2d at 672.
3 Ibid.

dent" had occurred and that, in any event, the injury was to "goods . . . manufactured . . . by the . . . insured."

The Court held that the change in color of the yarn, due to an unexplained latent defect, was an "accident," since "[t]he term 'accident' is to be broadly construed in a policy insuring damage against accident."[4] It rejected, however, plaintiff's theory that the damage was to the sweaters, and hence not to plaintiff's goods, by adopting an analysis which viewed the sweaters as injured by the accidental injury to the yarn, a product of plaintiff, and within the exception to coverage. The Court therefore concluded that the extent of plaintiff's compensable loss was only that loss to the customer in having to sacrifice the sale of the sweaters which was independent of the yarn. Such a loss could be calculated because although "in the sweaters the yarn had ceased to have independent significance as a physical product . . . it remained yarn, and the dollar effect of the injury thereto [was] . . . separately ascertainable."[5]

§17.5. Fire insurance: Notice of loss: Warranty policy. The plaintiff in *Romanos v. Home Insurance Co.*[1] purchased certain fire insurance policies from the Home Insurance Company (Home) and Underwriters at Lloyd's of London (Lloyd's) incident to a purchase of Boston real estate. The one policy issued by Home contained a provision requiring the insured to render "forthwith" a statement in writing containing certain information on any asserted loss. Of the three policies issued by Lloyd's, two were classified as so-called "cover notes" in that Lloyd's "[w]arranted the same terms and conditions as and to follow the settlement of Home. . . ."[2] The third Lloyd's policy contained no such "warranty clause."

Although substantial damage was done to plaintiff's property by fire on November 30, 1958, it was not until January 29, 1959, that plaintiff forwarded to Home a sworn and written proof of loss. Prior to this latter date, Lloyd's had appointed an insurance adjuster to review the matter; but Home appointed no one. In March of 1959, Home rejected the claim of the plaintiff on the basis that the policy provision of "forthwith" report of loss had not been honored. Lloyd's also rejected plaintiff's claims against it on the basis of its "warranty clause."

In affirming the decision of the trial court denying liability of the defendants Home and Lloyd's, the Supreme Judicial Court held, first, that Home's right to stand on the prerequisite of "forthwith" notice of loss was not waived, and second that the failure of plaintiff to send such a statement "as soon as 'the exercise of reasonable diligence . . . (enabled) the assured to send it. . . .' "[3] was fatal to its

[4] Id. at 601, 241 N.E.2d at 673.
[5] Ibid.

§17.5. [1] 1969 Mass. Adv. Sh. 451, 246 N.E.2d 173.
[2] Id. at 454, 246 N.E.2d at 176.
[3] Id. at 453, 246 N.E.2d at 176.

claim. The interesting aspect of the case, however, pertains to the Lloyd's defense. Against plaintiff's claim that the assignment of an adjuster by Lloyd's must have constituted an implied waiver of any notice of loss,[4] the Court responded by pointing out that Lloyd's was not relying "upon lateness of notice in connection with its refusal to settle the two policies containing the warranty clause. . . ."[5] Rather, it was Lloyd's position — a position which "commended itself" to the Court — that the warranty clause in the two policies effectively vested Lloyd's with an absolute derivative liability, so that any defense of Home sufficient to avoid liability would, ipso facto, free Lloyd's from liability as well, notwithstanding any action on the part of Lloyd's which, if taken by Home, would have constituted an estoppel or waiver of Home's defenses. In holding Lloyd's not to be liable on its two "warranty clause" policies, the Court regarded compliance with the warranty as a condition precedent to recovery. Although conduct on the part of an insurer in Lloyd's position in the instant case can be envisioned to be so grossly inequitable as to constitute fraud on an insured, the reasoning of the Court in *Romanos* would seem to compel a finding of nonliability of such an insurer under its policy. It is not, therefore, unreasonable to expect that the Court will, if such a case should come before it, retreat significantly from the position adopted in *Romanos* that the presence of a warranty clause in the policy of an insurer has the effect of placing that insurer in the shoes of a principal insurer for the purpose of obtaining the benefits of the principal insurer's defenses to an asserted claim.

§17.6. Motor vehicle insurance: Interpretation of policy language. In *F. W. Woolworth Co. v. Lumbermen's Mutual Casualty Co.*,[1] the Supreme Judicial Court had occasion to reconsider the proper scope of the words "use" and "loading and unloading" in motor vehicle liability insurance issued to a common carrier. Defendant had issued such a policy to its insured, Hopkins Transportation, Inc. (Hopkins), in which policy coverage was extended to include "loading and unloading" of the vehicle as constituting an insured "use of the motor vehicle."

On the day in question, Hopkins' servant was delivering certain merchandise to the Arlington store of plaintiff F. W. Woolworth Company (Woolworth), which premises were covered by a public liability policy issued by the plaintiff Travelers Insurance Company (Travelers). After all the merchandise had been removed from Hopkins' truck by employees of Woolworth, who had taken each piece from the tailgate of the truck as it was placed there by Hopkins' servant, one Miss Ervin, a lady approximately 80 years old, fell into

[4] This is in substance the provision of G.L., c. 175, §102.
[5] 1969 Mass. Adv. Sh. at 454, 246 N.E.2d at 176.

§17.6. [1] 1969 Mass. Adv. Sh. 121, 243 N.E.2d 919.

an open chute in the sidewalk. The chute had its covers removed and was being utilized by Woolworth employees to send the merchandise to Woolworth's storeroom. At the time of the accident, all the merchandise was either already in the storeroom or on the sidewalk shortly to be sent to the storeroom via the chute, and Hopkins' servant had already received both a signed receipt for the merchandise and payment of his charges from Woolworth employees.

In a suit by Woolworth and Travelers seeking to require defendant to reimburse them for a part of sums paid Miss Ervin in settlement of her claim, the trial court decreed that the accident to Miss Ervin "was caused by and arose out of the use and unloading of (Hopkins') truck"[2] by Woolworth and its employees, and defendant was ordered to pay $3,566.66 each to Woolworth and Travelers, with interest. All parties appealed.

In reversing the decision of the trial court, the Supreme Judicial Court placed great emphasis on the fact that all merchandise had been removed from Hopkins' truck at the time of the accident so that Hopkins' employee "had nothing left to do except to remove the Hopkins truck from the curb."[3] Thus, the case was distinguishable from an earlier Massachusetts case, *August A. Busch & Co. v. Liberty Mutual Insurance Co.*[4] The Court nevertheless considered the principles established in that case controlling. In the *Busch* case, the Court had held that language essentially similar to that contained in the Lumbermen's Insurance Company policy

> . . . was intended to extend the coverage of "use of the . . . vehicle" to include "unloading" in the sense of delivery to the . . . consignee rather than the more restricted doctrine that the unloading has ended when the goods have come to rest.[5]

The Court thus adopted "the so-called 'complete operation' rule and rejected the 'coming to rest' doctrine."[6] The Court further stated that "for Busch, the insured hirer of the vehicle there unloaded, 'unloading would mean a continuous transaction ending with the deposit of the goods in the hands of the purchaser.' "[7] In *Busch*, the Busch employees were still significantly engaged in the process of unloading and storage when the accident occurred, and for this reason the Court held Busch's insurer liable under the "unloading" provision of the applicable policy. As the process of unloading the Hopkins truck had been completed, and the trucker and its employees "[had] made the delivery they were reasonably expected to make and . . . [had] ceased to participate . . . ,"[8] the Woolworth employees

2 Id. at 121, 243 N.E.2d at 920.
3 Id. at 124, 243 N.E.2d at 921.
4 339 Mass. 239, 158 N.E.2d 351 (1959).
5 339 Mass. at 242-243, 158 N.E.2d at 353.
6 1969 Mass. Adv. Sh. at 123, 243 N.E.2d at 921.
7 Ibid.
8 Id. at 125, 243 N.E.2d at 922.

could not be said to be "using" the Hopkins truck at the time of the accident. The Court therefore concluded that the trial judge had incorrectly concluded that unloading had not ceased, and held that a decree was to be entered absolving defendant of liability for the injuries sustained by Miss Ervin.

§17.7. Motor vehicle insurance: Cancellation: Estoppel of insurer. Plaintiff in *Caravan v. Hanover Insurance Co.*[1] sought to reach and apply proceeds of a motor vehicle insurance policy issued by defendant and covering one Graves, against whom plaintiff had obtained a judgment in a tort action arising when plaintiff was struck by an automobile owned and operated by Graves. Graves was insured by defendant as a result of a referral by an independent insurance agent, which agent had filled out the appropriate rating form and application for registration. Defendant's agent subsequently completed the application and accepted the premium payment, which payment was made by a finance company, a fact so noted in the file at defendant's office. In the process of completing the application form the independent agent had incorrectly typed Graves' address as 35 D Street, South Boston, instead of 35 B Street. When defendant mailed the policy to Graves, the envelope was therefore returned marked "No such number." After a second unsuccessful attempt to mail the policy, defendant sent a statutory notice of cancellation pursuant to G.L., c. 175, §113A(2), again to the incorrect address, which notice was also returned marked "No such number." No notice of cancellation was ever received by Graves. The trial court made rulings that (1) the mere sending of notice of cancellation with no effort to ascertain the correctness of the address after knowledge of the incorrectness of the address used was ineffectual to cancel the policy, and (2) defendant was estopped to avail itself of the fact of cancellation against the plaintiff.

In affirming the decree of the trial court, the Supreme Judicial Court noted that, notwithstanding a number of documents in defendant's files which, if consulted, could have afforded means to ascertain Graves' correct address, defendant at no time had made any effort to ascertain the correct address of its insured. Such conduct, the Court held, was sufficient to constitute an estoppel. The argument of the defendant to the effect that the typographical error was the mistake of Graves' agent (the independent insurance agent), and not that of defendant or its agents, thus distinguishing the case from prior precedent cited favorably by the Court,[2] was not accepted by the Court; nor could the Court accept defendant's contention that its failure to utilize information in its possession to ascertain the true address of its insured was not effective to create an estoppel in view

§17.7. [1] 1969 Mass. Adv. Sh. 873, 248 N.E.2d 271.

[2] In Greenberg v. Flaherty, 306 Mass. 95, 27 N.E.2d 683 (1940), where the insured's application was incorrectly filled in by agents of the insurer with the result that the insured never received notice of cancellation, it was held that the cancellation was effective but that the insurer was estopped to avail itself of that fact.

of the fact of defendant's compliance with Section 113A of the General Laws. The Court found it unnecessary to consider the provisions of Section 113A, since it could be conceded that the notice of cancellation might have been effective in view of the fact that the Court found an estoppel to have been created by defendant's conduct. Defendant's contrary contention the Court found to be in disregard of the purpose of the compulsory motor vehicle law: to protect travelers on the public ways by providing compensation for their injuries when inflicted through operation of automobiles insured by the owners.[3]

§17.8. Motor vehicle insurance: Classification of risks and establishment of premium charges: Insurance rate "freeze." In one of the most publicized decisions of the Supreme Judicial Court in the 1969 SURVEY year, *Insurance Rating Bd. v. Commissioner of Insurance*,[1] the Court was called upon to consider the authority of the Commissioner of Insurance (commissioner) to "freeze" certain automobile insurance rates. The plaintiffs, Insurance Rating Board (board), Mutual Insurance Rating Bureau (bureau), and several insurance companies argued that the attempted "freeze" was both illegal as a result of a mistaken interpretation of statutory directive, and unconstitutional as a violation of the legal protection clause of the Fourteenth Amendment to the United States Constitution. By Acts of 1968, Chapter 643, the commissioner was directed, in Section 2A, to "fix . . . the same classifications of risks and the same basic premium charges . . . in connection with the issue of motor vehicle liability policies or bonds . . . as he fixed . . . for . . . (1967)."[2] By Section 3 of Chapter 643, G.L., c. 175, §113C, was amended to require insurance companies authorized to issue compulsory bodily injury liability ("compulsory") policies or bonds

> . . . to issue to any person purchasing such policy or bond, at his option, additional coverage of property damage . . . to a limit of at least five thousand dollars . . . [t]he rates for such additional coverage . . . [to be] subject to the approval of the commissioner, under the provisions of [§113B].[3]

On November 25, 1968, approximately one month after the board and bureau had filed with the commissioner approved rating rules covering the rating of the additional property damage liability coverage described by Chapter 643,[4] the commissioner filed a "Memorandum" in his office purporting, in effect, to reaffirm — or "freeze" — all classifications of risks, premium charges and other regulation ap-

[3] Caravan v. Hanover Ins. Co., 1969 Mass. Adv. Sh. 873, 876, 248 N.E.2d 271, 273.

§17.8. [1] 1969 Mass. Adv. Sh. 967, 248, N.E.2d 500.
[2] Id. at 968, 238 N.E.2d at 502.
[3] Ibid.
[4] The rules were filed on October 14, 1968, also the effective date of Chapter 643.

plicable to all motor vehicle policies or bonds, including the classifications applicable to property damage liability insurance under the amended G.L., c. 175, §113C, on the basis of the 1967 classifications. Subsequent to the filing of the memorandum, the commissioner returned to the board and bureau purported filings regarding property damage liability insurance on the ground that these filings were "inconsistent with . . . [his] Memorandum . . . of November 25, 1968."[5] It was the contention of the commissioner that the rate "freeze" provision of Chapter 643, Section 2A, was applicable to property damage liability insurance because the legislature, in using the words "policies or bonds," as opposed to the word "coverage," must have intended to include *all coverage* contained in policies or bonds containing "compulsory" coverage, and not merely the "compulsory" coverage. The Court rejected the rationale of the commissioner, noting that the interpretation given by the Court to the phrase "motor vehicle liability policy," in prior cases[6] dealing with the proper scope of that phase as it appears in G.L., c.175, §113A, had been limited to "compulsory" coverage and that substantially the same wording was used by the legislature in Chapter 643. The provisions of Chapter 643, the Court therefore concluded, neither required nor authorized the commissioner to "freeze" automobile property damage liability insurance rates.

The board and the bureau also argued that the provision of Chapter 643, Section 3, requiring insurance companies "to issue to any person purchasing . . . ['compulsory'], *at his option*, additional coverage . . . of property damage . . . ," (emphasis added) applied only to those persons who were not "voluntarily" offered property damage coverage by the companies in conjunction with "compulsory" since a voluntary offering would negate the exercise of any "option" by the insured. Such a labored construction of legislative intent was summarily rejected by the Court, which stated:

> . . . We believe that the words "at his option" signify nothing more than a desire by the Legislature to make clear that, although the insurance companies issuing . . . ["compulsory"] are required to offer certain . . . [property damage coverage], the insured is not required to purchase it.[7]

The board and the bureau advanced its "equal protection" argument in the guise of a contention that a requirement forcing the in-

[5] Insurance Rating Bd. v. Commissioner of Ins. 1969 Mass. Adv. Sh. 967, 969, 238 N.E.2d 500, 503.

[6] Benoit v. Fisher, 341 Mass. 386, 388, 169 N.E.2d 905, 907 (1960) (requirements of §113A not applicable to property damage coverage); Lodge v. Bern, 328 Mass. 42, 43-44, 101 N.E.2d 748, 749 (1951) (provisions of §113A forbidding exclusions from compulsory coverage said to have "no application to the coverage in excess of the required $5000").

[7] Insurance Rating Bd. v. Commissioner of Ins., 1969 Mass. Adv. Sh. 967, 971, 238 N.E.2d 500, 504.

surance companies to issue such additional property damage coverage as is mandated in Chapter 643, Section 3, was unconstitutional as making "unreasonable distinctions among insurance companies writing . . . [property damage coverage]."[8] The Court was unpersuaded, however, that the statutory directive in Chapter 643, Section 3, constituted an infringement of the constitutional rights of the companies. The Court stated that no distinction was drawn between companies; the only distinction was between policies issued by the companies.[9] The companies were not prohibited from issuing property damage coverage in conjunction with "compulsory"; nor were they required to seek approval of the commissioner for property damage coverage in excess of the required amount of $5000 in Chapter 643, Section 3. The companies were free to file under G.L., c. 175A, with respect to any excess over the $5000.

In addition to the considerations discussed above, the Court resolved, in favor of the commissioner, two further issues involving the propriety of the commissioner's actions in fixing rates subsequent to the September 15 deadline set forth in G.L., c. 175, §113B. Although the Court found there to have been certain technical abnormalities in the procedure adopted by the commissioner, it noted that absolute compliance with the statute would have been rendered not feasible in view of the lateness of the rate filings by the board and bureau — December 26, 1968 — and the consequent inadequacy of the time in which the commissioner might have acted under Section 113B.

B. Legislation

§17.9. Liability insurance. Chapter 143[1] of the Acts of 1969 permits the insured under a policy of liability insurance written to cover losses in excess of those covered by an underlying policy — such as, for example, the insured under a typical motor vehicle policy — to include both his spouse and unmarried dependent children under the age of 23 in the policy coverage with respect to medical expenses greater than a "stated deductible amount." Stated deductible amount is defined to be the greater of (1) the minimum deductibles shown in the declaration of the policy or (2) the amount of benefits available for eligible medical expenses under other medical expense coverage.

§17.10. Automobile insurance. Chapter 147[1] of the Acts of 1969 provides that a policy of insurance covering a motor vehicle being transferred shall continue to cover that motor vehicle in the hands of the new owner until the expiration of two business days after the date

[8] Ibid.
[9] Ibid.

§17.9. [1] G.L., c. 175, §111G.

§17.10. [1] G.L., c. 175, §113A.

of transfer within the period for which the transferred vehicle was registered; provided that the number plates issued upon registration of the transferred vehicle are attached to the newly acquired vehicle. Chapter 147 thus alters a previous amendment to Chapter 175, Section 113A, of the General Laws[2] which had provided that such coverage was effective only if the two business days fell within the same calendar year as the date of transfer. Under the present Section 113A, as amended by Chapter 147, vehicles whose registration periods straddle two calender years suffer no discrimination because of this fact.

§17.11. Group life insurance. Possibly the most important change in Massachusetts insurance legislation during the 1969 SURVEY year was effected by Chapter 156[1] of the Acts of 1969. By this statute an insured under a policy of group life insurance may, subject to policy restrictions, assign any and all incidents of ownership of such policy, including the right to designate a beneficiary thereunder, to have an individual policy issued him upon termination either of employment or of the group policy, and to pay premiums. By Section 3 of Chapter 156, this new statute is to be construed as declaratory of the law prior to its enactment, and not as modifying, altering or amending any law.

As enacted, Chapter 156 represents an effort by the legislature to deal with the implications of the *Landorf* decision,[2] which held, inter alia, that although the question of retention of incidents of ownership in a group life insurance policy which a decedent had assigned to his wife was a federal question, the question could turn on state law.[3] Looking to the insurance and property law of the state of New York, stipulated by the parties to be applicable, the court ultimately determined that, while "[n]either the courts of the State . . . nor its legislature has directed itself to these specific questions . . . ,"[4] local law neither prohibited nor approved assignment of group policies. The court therefore concluded that group life insurance policies were no less assignable under New York law than ordinary life insurance policies,[5] which are, of course, fully assignable.

Because the increased flexibility offered by *Landorf* in estate planning could be insured with relative certainty by a statute declaring that group policies are assignable under the law of Massachusetts, the legislature promptly enacted Chapter 156. Other jurisdictions will undoubtedly enact variants of the Massachusetts statute to insure the same benefits for their citizens.[6]

2 Acts of 1961, c. 568, §2.

§17.11. 1 G.L., c. 175, §134C.
2 Landorf v. United States, 408 F.2d 461 (Ct. Cl. 1969).
3 Id. at 466.
4 Ibid.
5 Id. at 468.
6 New York, for example, approved and enacted such a statute shortly after Massachusetts had done so. Laws of New York 1969, c. 843, amending N.Y. Ins. Law §161 (McKinney 1966).

§17.12. Fire insurance. By Chapter 425[1] of the Acts of 1969, the number of days of written notice of cancellation of a fire insurance policy required to be given an insured by a company has been increased from 10 to 20. This new provision, however, applies only to policies issued on or after January 1, 1970.

§17.13. Fire insurance. By the terms of Chapter 528[1] of the Acts of 1969, the provisions of the Urban Area Insurance Placement Facility Act[2] have been amended to insure that property owners in urban areas can obtain needed fire insurance policies and extended coverage endorsements from the insurance companies. Under Chapter 528, the extent of the coverage which the companies are required to offer is made subject to the determination of the commissioner of insurance after public hearing or a rule of the secretary of the United States Department of Housing and Urban Development in accordance with the Urban Property Protection and Reinsurance Act of 1968 (Pub. L. No. 90-448).[3]

§17.14. Life insurance. Chapter 747[1] of the Acts of 1969 increases from 5 to 6 percent the rate of interest which insurance companies are allowed to charge on loans against any policy of life insurance. By Section 2 of Chapter 747, this new rate of interest is not available to the companies on policies issued before the effective date of the Act, which, by virtue of emergency declaration filed by the governor, was August 20, 1969.

C. Student Comment

§17.15. Condition precedent: The "good health" clause: Warren v. Confederation Life Assn.[1] Deceased, a citizen of Massachusetts, applied for a life insurance policy in which plaintiff was named beneficiary. The policy was applied for on May 5, 1966, from the defendant, a Canadian corporation. The first premium was paid on August 5, 1966, with the effective delivery of the policy considered to be on August 1, 1966.

In the application the deceased disclosed that he had been treated by a Dr. Drachman in 1963 for fainting spells. He failed to disclose treatment by that physician for subsequent seizure disorders in 1964 and 1965. The deceased also disclosed that from 1963 to 1965 he had been treated by another physician, a Dr. Reusch. Dr. Reusch, unaware of the seizure disorders being treated by Dr. Drachman, was contacted

§17.12. [1] G.L., c. 175, §99.

§17.13. [1] G.L., c. 175C, §§1-4, 8.
[2] G.L., c. 175C.
[3] 12 U.S.C. §17015.

§17.14. [1] G.L., c. 175, §142.

§17.15. [1] 401 F.2d 487 (1st Cir. 1968).

by the defendant insurance company. Dr. Drachman was not. Before and after the application on May 5, 1966, the deceased was treated for seizure disorders and ingestion of drugs.

One of the questions asked in the application was: "Are you now in first-class health and free from all symptoms of disease?" The deceased answered "yes." The application, which became part of the policy, also provided, in part, as follows:

> The Applicant declares that the above answers are full and true and agrees that: . . . any policy issued pursuant to this application will not take effect until the first premium has been paid and the policy has been delivered to the Applicant while the facts concerning the insurability of any person whose life is thereby insured are the same as described in the application. . . .[2]

Between the time of application (and also the medical examination by defendant insurance company) in May, and the date of delivery in August, the deceased was twice treated in June for seizure disorders; once in July for a disorder diagnosed as epilepsy; and once more in July for an overdose of medication. None of these postapplication treatments were reported to the defendant. The insured died on October 24, 1966.

At the trial in the district court, the defendant contended that because the deceased had, in the application, stated that he was in "first class health" and free from all symptoms of disease," and as he was not in such "good health" on August 1, the policy never took effect. The trial judge entered a judgment n.o.v. for the defendant.[3]

On appeal the plaintiff beneficiary argued that the defendant knew or should have known that the deceased was not "in first class health" on the date of the filing of the application, May 5, and therefore waived any condition precedent which may have been established by the above quoted statement from the application. The First Circuit Court of Appeals, in affirming the lower court, HELD: The statement in the application, which is deemed part of the policy, created a condition precedent, effective between the application date and the delivery date, which was violated by the deceased's hospitalization during that period. The company did not waive, nor was it estopped from enforcing, this condition.

Warren involves the area of representations and conditions in insurance policies that deal with "good health" clauses.[4] It turns upon the decedent's answer in the application that he was "in first class health

[2] Id. at 489.

[3] Warren v. Confederation Life Assn., 282 F. Supp. 375 (D. Mass. 1968).

[4] The term "good health" clause is used to describe various types of clauses in insurance policies whereby the companies attempt to protect themselves by conditioning the coverage provided in the policies on the existence of the insured's good health at the time of payment of the first premium. The interpretation of these clauses in the various jurisdictions varies widely.

and free from all symptoms of disease." The law in this area, characterized by a conflict of opinion, is susceptible to change in interpretation.

In Massachusetts, answers in insurance applications are considered representations if unaltered by other clauses in the policy or application.[5] This being the case, they would normally fall under the law of misrepresentations if they were false in content. A representation is a written or oral statement of fact made by the applicant to induce the insurer to contract, being collateral to the contract once formed.[6] A warranty is a written or oral fact which constitutes a part of the contract between the parties.[7]

At common law a warranty demanded exact and literal truth as a necessary condition of the right to recover, however immaterial the statement may have been.[8] It was considered to be a part of the contract itself,[9] defining the limits of obligation.[10] If the terms of the warranty were not met exactly then no contract resulted.[11] The burden was on the party claiming recovery to show exact compliance with all waranties.[12] A representation at common law, however, was treated differently. It did not, like a warranty, require strict and literal compliance. That is, only substantial compliance was required in those particulars which were material to be disclosed to the insurer in order to enable them to determine whether they would enter into the contract.[13] Its relation to the contract was usually described by the term collateral.[14] The burden was on the defendant, attempting to void the policy, to prove a material misrepresentation.[15] In neither warranty nor representation, however, was good faith or intention a

[5] Giannelli v. Metropolitan Life Ins. Co., 307 Mass. 18, 29 N.E.2d 124 (1940); White v. Provident Savings Life Assurance Society of New York, 163 Mass. 108, 39 N.E. 771 (1895); Barre Boot Co. v. Milford Mutual Fire Ins. Co., 89 Mass. 42 (1863); See Kappes, Misrepresentation as it Relates to Policies of Ordinary Life Insurance, 1965 ABA Section of Insurance, Negligence and Compensation Law 65, 74.

[6] 1 MacGillivray on Insurance Law §795 (5th ed., D. Browne, 1961).

[7] Id. §805.

[8] Metropolitan Life Ins. Co. v. Burno, 309 Mass. 7, 8, 33 N.E.2d 519, 520 (1941); White v. Provident Savings Life Assurance Society of New York, 163 Mass. 108, 39 N.E. 771 (1895); See, Note, Misrepresentation and False Warranty under the Illinois Insurance Code: Recent Developments, 54 Nw. U.L. Rev. 275 (1959–1960) (hereinafter cited as Recent Developments).

[9] Campbell v. New England Mutal Life Ins. Co., 98 Mass. 381 (1867).

[10] Ibid.

[11] White v. Provident Savings Life Assurance Society of New York, 163 Mass. 108, 39 N.E. 771 (1895); Vose v. Eagle Life & Health Ins. Co., 60 Mass. 42 (1850).

[12] Barker v. Metropolitan Life Ins. Co., 198 Mass. 375, 84 N.E. 490 (1908); Campbell v. New England Mutual Life Ins. Co., 98 Mass. 381 (1867).

[13] Metropolitan Life Ins. Co. v. Burno, 309 Mass. 7, 33 N.E.2d 519 (1941); White v. Provident Savings Life Assurance Society of New York, 163 Mass. 108, 39 N.E. 771 (1895); See Taylor, The Life Insurance Law of Massachusetts, 19 B.U.L. Rev. 53 (1939).

[14] 98 Mass. at 390.

[15] 98 Mass. at 390; Daniels v. Hudson River Fire Ins. Co., 66 Mass. 416, 426 (1853).

factor in the decision.[16] In both cases concealment, as well as misstatement, would suffice to void the policy.[17]

In reaction to the harsh effects of the common law of warranties, the Massachusetts legislature, as did many other legislatures, altered by statute the law of representation and warranty as applied to insurance policies.[18] This statute, in effect, eliminated any distinction in law between a representation and warranty.[19] The scope of materiality in misrepresentations was increased by allowing fraud alone to avoid a policy.[20] The statute created a common rule as to the burden of proof. That burden was placed upon the party trying to void the policy, by showing either intent to deceive or a material increase of the risk assumed, by a preponderance of the evidence.[21] It should be noted that the courts have held that the misrepresentation does not have to be germain to the death of the insured to be material,[22] and that the questions of intent and increase of risk are normally ones for the jury.[23] The courts have, on occasion, however, ruled that misstatements about certain diseases increase the risk as a matter of law. Included are misrepresentations about cancer,[24] Hodgkins disease,[25] diabetes,[26] tuberculosis,[27] age of the insured,[28] and chronic excessive drinking.[29]

Not only false statements, but failure to disclose one's medical

16 98 Mass. at 396.

17 Clark v. Manufacturers' Ins. Co., 49 U.S. 235, 247 (1850); Daniels v. Hudson River Fire Ins. Co., 66 Mass. at 425.

18 G.L., c. 175, §186. "No oral or written misrepresentation or warranty made in the negotiation of a policy of insurance by the insured or in his behalf shall be deemed material or defeat or avoid the policy or prevent its attaching unless such misrepresentation or warranty is made with actual intent to deceive, or unless the matter misrepresented or made a warranty increased the risk of loss."

19 Nonantum Ins. Co. v. Maryland Casualty Co., 56 F.2d 329 (1st Cir. 1932); Giannelli v. Metropolitan Life Ins. Co., 307 Mass. at 22, 29 N.E.2d at 126; Barker v. Metropolitan Life Ins. Co., 198 Mass. 375, 84 N.E. 490 (1908).

20 Taylor, The Life Insurance Law of Massachusetts, 19 B.U.L. Rev. 53 (1939).

21 New York Life Ins. Co. v. Simons, 60 F.2d 30 (1st Cir. 1932); Schiller v. Metropolitan Life Ins. Co., 295 Mass. 169, 171, 3 N.E.2d 384, 385 (1936); Foss v. Mutual Life Ins. Co. of New York, 247 Mass. 10, 141 N.E. 498 (1923).

22 Lennon v. John Hancock Mutual Life Ins. Co., 339 Mass. 37, 157 N.E.2d 518 (1959).

23 Schiller v. Metropolitan Life Ins. Co., 295 Mass. at 178, 3 N.E.2d at 388; Foss v. Mutual Life Ins. Co. of New York, 247 Mass. 10, 141 N.E. 498 (1923); Kelly v. Mutual Life Ins. Co. of New York, 207 Mass. 398, 93 N.E. 695 (1911); Barker v. Metropolitan Life Ins. Co., 198 Mass. 375, 84 N.E. 490 (1908); Levie v. Metropolitan Life Ins. Co., 163 Mass. 117, 39 N.E. 792 (1895).

24 Lennon v. John Hancock Mutual Life Ins. Co., 339 Mass. 37, 157 N.E.2d 518 (1959).

25 Pahigian v. Manufacturers' Life Ins. Co., 349 Mass. 78, 206 N.E.2d 660 (1965).

26 See DeGuzzi v. Prudential Ins. Co. of America, 242 Mass. 538, 136 N.E. 617 (1922).

27 Brown v. Greenfield Life Assn., 172 Mass. 498, 53 N.E. 129 (1899).

28 See Dolan v. Mutual Reserve Fund Life Assn., 182 Mass. 413, 65 N.E. 798 (1903).

29 The Merchants National Bank of Newburyport v. New York Life Ins. Co., 346 Mass. 745, 196 N.E.2d 201 (1964); Rainger v. Boston Mutual Life Assn., 167 Mass. 109, 44 N.E. 1088 (1896).

history,[30] and failure to disclose new developments occurring before delivery of the policy have been held to be misrepresentations that act to void the policy.[31] In Massachusetts, "the representations . . . must be regarded in law as though they were made at the time the policy was delivered."[32] Also, "a failure by the insured to disclose conditions affecting the risk, of which he is aware, make the contract voidable at the insurer's option."[33] The emphasis in the representation area is on a willful concealment by the insured,[34] or at least the concealing of information critical to the insurer's decision of which the insured was aware.[35]

When the insurer seeks to void the policy by reason of a misrepresentation which allegedly increased the risk, it is necessary to demonstrate a degree of materiality of the misrepresentation.[36] The degree of materiality in Massachusetts is stated as "every such fact . . . must be regarded as material, the knowledge or ignorance of which would naturally influence the judgment of the underwriter in making the contract at all, or in estimating the degree and character of the risk, or in fixing the rate of the premium."[37]

A distinction is made as to representations of "good health" by an insured in an application which sets them apart from the ordinary representations of facts. The Court in *Rappe v. Metropolitan Life Insurance Co.*[38] stated the Massachusetts view that:

> . . . Such a question as this, as well as the question whether the insured ever had an 'illness,' is so indefinite that a wide allowance must be made for difference of opinion or judgment as to what

[30] New York Life Ins. Co. v. Simons, 60 F.2d 30 (1st Cir. 1932); Pahigian v. Manufacturers' Life Ins. Co., 349 Mass. 78, 206 N.E.2d 660 (1965); See also Kaffanges v. New York Life Ins. Co., 59 F.2d 475 (1st Cir. 1932), where the decision could possibly be read to make the effect of epilepsy a material increase of the risk by law. For a discussion of disclosure, see Witherspoon, What is the Ultimate Effect of the "Good Health" Clause? Federation of Insurance Quarterly 22 (Summer 1967).

[31] Aetna Life Ins. Co. v. Hub Hosiery Mills, 74 F. Supp. 599 (D. Mass. 1947); Lennon v. John Hancock Mutual Life Ins. Co., 339 Mass. 37, 157 N.E.2d 518 (1959); Gabbett v. Connecticut General Life Ins. Co., 303 Mass. 433, 21 N.E.2d 950 (1939); See 1959 Ann. Surv. Mass. Law §16.3.

[32] Gabbett v. Connecticut General Life Ins. Co., 303 Mass. at 435, 21 N.E.2d at 952.

[33] Ibid.

[34] New York Life Ins. Co. v. Simons, 60 F.2d 30 (1st Cir. 1932); Aetna Life Ins. Co. v. Hub Hosiery Mills, 74 F. Supp. 599 (D. Mass. 1947).

[35] Pahigian v. Manufacturers' Life Ins. Co., 349 Mass. 78, 206 N.E.2d 660 (1965); Lennon v. John Hancock Mutual Life Ins. Co., 339 Mass. 37, 157 N.E.2d 518 (1959); see Witherspoon, What is the Ultimate Effect of the "Good Health" Clause? Federation of Insurance Quarterly 22, 28 (Summer 1967).

[36] For a discussion of the standard used in judging materiality, see Comment, Material Misrepresentation as a Requirement for Rescission of Insurance Contracts, 73 Dick. L. Rev. 250 (1968-1969); 12 J. Appleman, Insurance Law and Practice §7294 (1943).

[37] Daniels v. Hudson River Fire Ins. Co., 66 Mass. at 425.

[38] 320 Mass. 376, 69 N.E.2d 584 (1946).

> constitutes good or bad health or an illness. These questions cannot be construed as calling for more than opinion, or a statement to the best of the applicant's knowledge and belief.[39]

The emphasis is placed on the good faith of the insured in an effort to make the situation as equitable as possible, the purpose of the insurance application being to place the insurer in as good a position to judge the risk as is the insured.[40] The *Rappe* rule is an attempt to prevent the insurer from gaining an unfair advantage on a good faith applicant. In this attempt, "[t]he courts are inclined to construe a representation or warranty as one of opinion whenever it is possible to do so, in order to prevent the forfeiture of policies by reason of innocent mistake."[41]

This would then be the law applicable to the decedent's answer in *Warren* that he was "in first class health" if it were not for the clause included in the application which made the truth of the representations a condition for recovery. This clause was deemed to be a condition precedent by the court of appeals.[42] In Massachusetts the view is that:

> The distinction between a warranty and a condition precedent, though sometimes narrow, is nevertheless plain. Such a condition is one without the performance of which the contract, although in form executed by the parties and delivered, does not spring into life. A warranty does not suspend or defeat the operation of the contract, but a breach affords either the remedy expressly provided in the contract or those furnished by the law.[43]

Other differences, in addition to this basic distinction, are also important. One of the major distinctions is that G.L., c. 175, §186, does not apply to conditions precedent.[44] This means that, unlike representations, a condition precedent demands absolute fulfillment with no test of materiality to soften its effect.[45] If the representations covered by a condition precedent clause are false in any way, the policy is void ab initio.[46] In addition, the burden of proof, like the common law ap-

[39] Id. at 380, 69 N.E.2d at 586.

[40] Recent Developments, 54 Nw. U.L. Rev. 275 (1959-1960).

[41] Id. at 278.

[42] Warren v. Confederation Life Assn., 401 F.2d at 489 n.4.

[43] Everson v. General Accident, Fire & Life Assurance Corp., of Perth, Scotland, 202 Mass. 169, 173, 88 N.E. 658, 660 (1909).

[44] Charles, Henry & Crowley Co. v. Home Ins. Co., 349 Mass. 723, 212 N.E.2d 240 (1965); Krause v. Equitable Life Ins. Co. of Iowa, 333 Mass. 200, 129 N.E.2d 617 (1955); Lopardi v. John Hancock Mutual Life Ins. Co., 289 Mass. 492, 194 N.E. 706 (1935); Ballard v. Globe & Rutgers Fire Ins. Co. of New York, 237 Mass. 34, 129 N.E. 290 (1921).

[45] Paratore v. John Hancock Mutual Life Ins. Co., 335 Mass. 632, 141 N.E.2d 511 (1957); Lopardi v. John Hancock Mutual Life Ins. Co., 289 Mass. 492, 194 N.E. 706 (1935); Ballard v. Globe & Rutgers Fire Ins. Co., 237 Mass. 34, 129 N.E. 290 (1921).

[46] "No contractual duty arises under such a policy unless there has been com-

plicable to warranties, is placed upon the insured to demonstrate that he met the condition.[47] He must prove, by a preponderance of the evidence, that he has fulfilled the requirements of the condition.[48] If he is unable to do so, a judgment is required by law in the insurer's favor.[49] If evidence is presented, however, it is usually a question for the jury.[50]

Recognizing the harshness of the law applicable to conditions precedent, the courts normally limit the scope of the conditions, as well as demand that for conditions to be effective they must be created clearly and expressly.[51] The courts have established the criterion that

> . . . a statement made in application for a policy of insurance may become a condition of the policy rather than remain a warranty or representation if: (1) the statement made by the insured relates essentially to be insurer's intelligent decision to issue the policy; and (2) the statement is made a condition precedent to recovery under the policy, either by using the precise words "condition precedent" or their equivalent.[52]

It has been ruled that medical treatment between the time of medical examination and the delivery of the policy could be material in the insurer's entry into the contract and is therefore an appropriate subject to be made a condition precedent.[53] In addition it has been held that the "good health" of the insured is of suitable character to be made a condition precedent to the policy.[54]

> . . . That an insured is in sound health at the date of the policy is clearly a proper subject of a condition precedent . . . . And the matters dealt with in the clause entitled "Policy When Void," though of secondary rather than of primary importance, cannot be pronounced so immaterial in their bearing on the health of the insured . . . that they cannot reasonably be made conditions precedent . . . .[55]

These decisions affirm the validity of the ordinary "good health"

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pliance with conditions precedent thereto." Lopardi v. John Hancock Mutual Life Ins. Co., 289 Mass. at 496, 194 N.E. at 708.

47 Kramer v. John Hancock Mutual Life Ins. Co., 336 Mass. 465, 146 N.E.2d 357 (1957); Fondi v. Boston Mutual Life Ins. Co., 224 Mass. 6, 112 N.E. 612 (1916).

48 Connolly v. John Hancock Life Ins. Co., 322 Mass. 678, 79 N.E.2d 189 (1948); Fondi v. Boston Mutual Life Ins. Co., 224 Mass. 6, 112 N.E. 612 (1916).

49 Connolly v. John Hancock Life Ins. Co., 322 Mass. 678, 683, 79 N.E.2d 189, 192 (1948).

50 Lee v. Prudential Life Ins. Co., 203 Mass. 299, 89 N.E. 529 (1909); Gallant v. Metropolitan Life Ins. Co., 167 Mass. 79, 44 N.E. 1073 (1896).

51 Pahigian v. Manufacturers Life Ins. Co., 349 Mass. 723, 212 N.E.2d 240 (1965).

52 Id. at 726, 212 N.E.2d at 242.

53 Krause v. Equitable Life Ins. Co. of Iowa, 333 Mass. 200, 129 N.E.2d 617 (1955).

54 Lopardi v. John Hancock Mutual Life Ins. Co., 289 Mass. 492, 194 N.E. 706 (1935).

55 Id. at 496-497, 194 N.E. at 708.

clauses in Massachusetts, as conditions precedent. The *Warren* case is unique in that the decedent's affirmation of good health may have been incorporated into a valid condition precedent to constitute a "good health" clause. If this is true, then *Warren* may demonstrate a recognition by the court of appeals of a change in Massachusetts law applicable to "good health" clauses.

There are three main divisions of opinion in the law applicable to "good health" clauses. They are the "apparent good health" school, the "change of health" school, and the strict construction, "actual good health" school.[56] The "apparent good health" doctrine, followed in a minority of the states, requires only that the insured must be in apparent good health and be aware of nothing to indicate the contrary.[57] Its supporters rationalize its use on the basis that:

> Policies of insurance, as other contracts, should be construed according to the ordinary sense and meaning of the terms employed . . . . When one says that he is in good health he does not mean, and nobody understands him to mean, that he may not have a latent disease of which he is wholly unconscious. It is doubtless competent for a life insurance company, in its policies, to take the expression "good health" out of its common meaning and make it exclude every disease, whether latent and unknown or not (assuming that any person would ever accept a policy of that kind), but it must do so in distinct and unmistakable language.[58]

This doctrine gains support when applied to situations where a medical examination is given by the insurance company and the insured was given a clean bill of health by their physician.[59] An economic argument stressing the equity of possible losses is also advanced to support the "apparent good health" view:

> In a situation where the contracting parties expect differing results it may be reasonable to impose the loss on the party best able to anticipate the harm and make provision for it. An insurer is likely to be quite able to estimate these additional costs and spread them among its policy holders, lessening the risk to each individual insured of his unknown "defects." This allocation of risk to the insurer will prevent catastrophic harm to the individual insured or his beneficiaries, as contrasted with the relatively light impact on the insurer.[60]

A narrow majority of the courts have adopted the "change of

[56] Wick, The Good Health Clause — What It Says and What Some Courts Say It Says, 23 Ins. Counsel J. 311 (1956) (hereinafter cited as Wick).

[57] Id. at 317.

[58] Combs v. Equitable Life Ins. Co. of Iowa, 120 F.2d 432, 436 (4th Cir. 1941).

[59] Comment, Good Health Clauses, Conditional Receipts, and the Risk of the Insured's Unknown Ailments, 41 So. Cal. L. Rev. 182, 186 (1967-1968).

[60] Id. at 194-195.

health" doctrine.[61] Under this doctrine the "good health" clause applies only to changes in the condition of the insured's health between the date of the application and medical examination, and the date of issuance or delivery of the policy.[62]

Often the courts have been led to adopt the "change of health" doctrine by the language of the particular "good health" clause at issue.[63] Clauses calling for delivery in the "continuance of good health" are one type which would lead to the "change of health" interpretation. "An even clearer example is a clause providing that "insurance shall date from the date of approval of this application . . . provided that I shall then be in the same condition of insurability as shown by this application. . . ."[64] With this view, only a subjective change, that is one capable of being known by the insured, intervening between application and delivery should void the policy.[65] In most cases, however, this view is not based solely upon the wording of the policy, but rather on the idea of equity as expounded by the courts which adopt the "apparent good health" view. In addition, it is contended that having given a medical examination itself, the insurance company must be deemed to have waived any further obligations, with respect to disclosure, regarding the health of the insured prior to the time of the examination.[66]

The third major view, ascribed to by a minority of the states, including Massachusetts, is the "actual good health" doctrine, often referred to as the "Massachusetts rule."[67] Originally enunciated in *Gallant v. Metropolitan Life Insurance Co.*,[68] the basic feature of this theory is succinctly stated as:

> . . . The company made its own contract, a part of which was that no obligation was assumed by the company unless at the time when the policy was issued the insured was "alive and in sound health." If in fact the insured at that time was not in sound health, then the defendant is not liable on the policy. . . .[69]

This requirement of good health "in fact" has been demanded by courts following the "actual good health" doctrine even in situations where the applicant believed himself to be in good health at the time of his application and the company satisfied itself by medical examination that he was insurable, *and no subsequent change in his condition took place prior to the delivery of the policy.*[70]

61 Wick, 23 Ins. Counsel J. at 318.
62 Annot., 136 A.L.R. 1516 (1942).
63 Wick, 23 Ins. Counsel J. at 318.
64 Ibid.
65 Note, 42 Cornell L.Q. 576 (1956-1957).
66 Annot., 60 A.L.R.2d 1422, 1436-1437 (1958).
67 Wick, 23 Ins. Counsel J. 311; Comment, Good Health Clauses, Conditional Receipts, and the Risk of the Insured's Unknown Ailments, 41 So. Cal. L. Rev. 182, 186 (1967–1968).
68 167 Mass. 79, 44 N.E. 1073 (1896).
69 Id. at 80–81, 44 N.E. at 1074.

When the statement of "good health" is considered to be a condition precedent the Massachusetts rule places the burden of proof of good health on the insured, or the beneficiary.[71] The question arises whether there is a necessity of proving a causal relationship between the death of the insured and the preexisting ill health. In *Barker v. Metropolitan Life Insurance Co.*,[72] where the insured died of pneumonia but was suffering from kidney disease before he was insured, " . . . the court . . . passed over the question without comment, apparently regarding the absence of a causal link between death and ill health as immaterial."[73]

The rationale of the "actual good health" doctrine is that the parties, being free to contract as they pleased, have made actual good health a condition precedent to coverage and the court cannot remake the contract.[74] The principal complaint, with this objective test, on the other hand, is that the insurer, after examining the insured with its own doctor, should not be permitted to benefit unjustly from events which subsequently reveal that the applicant was not in fact in "good health," so long as the applicant's health has not further deteriorated prior to delivery of the policy.[75]

The court in *Warren* ruled that the clause in the application for the policy was sufficient to establish a condition precedent, which was the basis of its final determination.[76] The court compared the language of the clause to a similar clause in *Lee v. Prudential Life Insurance Co.*[77] In *Lee* the clause provided: ". . . the policy . . . shall not take effect until the same shall be issued . . . while my health is in the same condition as described in this application."[78] In *Warren* the clause provided: "[A]ny policy . . . will not take effect until the . . . policy has been delivered . . .while the facts concerning the insurability . . . are the same as described in this application . . . ."[79] While the differences are slight the question arises whether the condition precedent

70 Barker v. Metropolitan Life Ins. Co., 188 Mass. 542, 74 N.E. 945 (1905).

71 Paratore v. John Hancock Mutual Life Ins. Co., 335 Mass. 632, 141 N.E.2d 511 (1957); Connolly v. John Hancock Mutual Life Ins. Co., 322 Mass. 678, 79 N.E.2d 189 (1948); Ansin v. Mutual Life Ins. Co. of New York, 241 Mass. 107, 134 N.E. 350 (1922); Lee v. Prudential Life Ins. Co., 203 Mass. 299, 89 N.E. 529 (1909).

72 188 Mass. 542, 74 N.E. 945 (1905).

73 Wick, 23 Ins. Counsel J. at 316.

74 Id. at 313.

75 Note, 42 Cornell L.Q. 576, 581. A common definition of "good health" has been used by all three groups. "As employed in a life insurance policy the words 'sound health' refer in general to a state of normal health free from infirmity or disease having a direct tendency to shorten life." Connolly v. John Hancock Mutual Life Ins. Co., 322 Mass. 678, 682, 79 N.E.2d 189, 192 (1948).

76 This can be inferred from the opinion when it states, "Defendant contended that the policy never took effect or, alternatively, was voidable for a misrepresentation which increased the risk as a matter of law." 401 F.2d at 488. This result is possible only when a condition precedent has been violated.

77 203 Mass. 299, 89 N.E. 529 (1909).

78 Id. at 300-301, 89 N.E. at 530.

79 Warren v. Confederation Life Assn., 401 F.2d at 489.

in *Warren* applies only to the insured's freedom from "symptoms of disease" or also to his "good health."[80] As discussed previously, one's statement of "good health" in an application for insurance is considered to be an opinion, and not a fact. Therefore it is questionable whether the insured's actual good health could be made a condition by the clause in question which limited its applicability to the "facts" concerning insurability. The clause in *Lee* avoided this problem by expressly requiring the insured's health to be the same as described in the application. The court in that case found this specific standard of health sufficient to establish a "good health" condition precedent, making the application of the "actual good health" doctrine easier than in *Warren*, where no specific standard was given.

It may be that this possible ambiguity, the lack of a specific standard of "good health" in the *Warren* application, is what prompted the court to state that: "Even condition precedent language, however, should be construed against the company, at least to the extent of not permitting it to rely upon the literal wording to achieve a result not disclosed."[81] This undisclosed result, alluded to by the court, might also be the establishment of the insured's actual good health as a standard applicable to the condition in the application. The court attempts to deny this when it waiveringly states: "It may well be that the instant provision does not make the truthfulness of the statements in the original application a condition precedent; in other words, that the condition is limited to subsequent events."[82] This equivocal statement leads to two distinct interpretations. If it is read as just posing a possibility, but not declaring a position, then the court can be seen to be adhering to the old view that a condition precedent requires actual, objective fulfillment under all circumstances and under all terms provided in the policy as long as a "good health" clause has been established. If taken as a statement of fact, however, that is in this case the condition *is* limited to subsequent events, the court can be interpreted as altering the standard of "actual good health" to a form of the "change of health" standard similar to that derived in *Bronx Savings Bank v. Weigandt*.[83]

The clause in *Weigandt* provided that: " . . . the policy shall not take effect until the first premium is paid and the policy delivered while the person to be insured is in good health."[84] The court adopted a "change of health" view interpreting this clause as

80 Warren's answer in the application, which the insurance company argued was made a condition precedent by the clause in the policy application, stated that he was in "first-class health and free from all symptoms of disease." Id. at 489. Thus the court could consider the answer to be totally or partially a condition precedent.

81 Id. at 490. It can be argued, however, that this is not the court's meaning. If the "literal" wording were relied on, the limitation of the condition precedent clause to "facts" would operate to exclude this "opinion" of good health.

82 Ibid.

83 1 N.Y.2d 545, 136 N.E.2d 848, 60 A.L.R.2d 1422 (1956).

84 Id. at 550, 136 N.E.2d at 851.

> . . . sufficiently ambiguous . . . to find . . . in the absence of fraud, the policy would become effective upon . . . delivery . . . in the absence of an adverse intervening change of health where the applicant is given a medical examination and found to be in good health [at the time of the application].[85]

The court qualified the standard "change of health" doctrine by stating:

> An insurer may, "when not restricted by the Legislature, condition the valid inception of a contract of insurance upon the existence at the time of perfect and complete health, free even from temporary slight impairment; but such . . . condition should be phrased in clear and unequivocal terms."[86]

In this way the *Weigandt* court adopted an intermediate position between the traditional "actual good health" and "change of health" doctrines. That is, it held, that an insurer may condition an insurance contract on objective good health, if it is done by employing clear and precise terms denonstrating an intention to do so. If the policy is not so worded, it is to be construed to require a change in the insured's condition, such change to be measured by subjective standards.[87]

If the *Warren* court had considered the condition precedent in the application to embrace only the insured's affirmation to be free from "symptoms of disease" and not "first class health," then a subjective standard would be applicable also to the condition. This subjective standard would not be one of "good health" for by definition "symptoms" must be capable of discovery.

If the *Warren* opinion is read in the *Weigandt* interpretation of the law applicable to "good health" conditions precedent, then the court in *Warren* would be recognizing a change in the established "Massachusetts rule" in favor of a more subjective, insured's point of view standard.

The *Warren* opinion leads to a third possible, but not probable, interpretation. The court could have intended that an objective, actual good health criterion was to be used in the period between application and delivery. This would be a difficult standard to apply, however, as it would require the determination of the exact date of the inception of a latent disease, as, according to the court, only latent diseases developing *after* the date of application would violate the condition.[88] Because of this difficulty, the inability of determining the inception of a latent disease, the employment of a subjective stan-

[85] Ibid.

[86] Id. at 553, 136 N.E.2d at 852.

[87] See Note, 42 Cornell L.Q. 576.

[88] See Annot., 136 A.L.R. 1516 (1942), for an analysis of the treatment given by the "change of health" courts on the question of the effect of latent diseases. See also Annot., 100 A.L.R. 362 (1936).

dard by the court is presumed. The discussion by the court of "selection"[89] also leads to this conclusion. The court focused on prevention of "selection" by the insured as a major aim of conditions precedent. This implies that a conscious decision must occur in the mind of the insured. To have this happen, some basis for a decision must also have occurred. Some symptom must have been observed by or known to the insured.

If the court has used subjective standards to determine the effects of the insured's affirmation of "good health," the results of such an application are still distinguishable from mere representations in an insurance policy, in that questions of materiality and intent to deceive would be irrelevent if ill health at the time of application could be demonstrated as known to the insured.

Because of the uncertainty of the court's language, this *Weigandt* interpretation of the *Warren* opinion must be considered as merely a possibility. Even if this interpretation is the correct one, its broader applications would be doubtful. Two cogent reasons combine to support this conclusion. One, this is an extreme case where the wording of the condition clause almost compelled a conclusion that it was applicable only to the period between the date of application and delivery. Two, the court discusses, at length, post application selection by the insured. The court specifically stated:

> [I]nsurance departments of the states regularly permit companies to use condition precedent provisions with respect to the interval between the submission of the application and the applicant's tender of the premium, or the insurer's delivery of the policy.[90]

If read in this *Weigandt* or modified change of health manner, this case does represent a beginning of a possible weakening of the strict "actual good health doctrine" in Massachusetts. With the demand for strict construction in reading condition precedent language stated by the court, an opportunity is provided to use ambiguities in "good health" clauses to soften their often harsh effects, and judge the cases on the merits of their particular facts. A specific rule for avoiding ambiguities has not, as yet, been established. Therefore, an opportunity for further interpretation is available. A useful precedent may have been set by *Warren*, which provides greater equity in this area of insurance law where early doctrines have been outmoded by the facts of today's large, impersonal insurance market, in which the opportunity for equality in the negotiations of a policy is non-existent.

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[89] Warren v. Confederation Life Assn., 401 F.2d at 489–490. "Selection," as used by the court, is the conscious decision by the potential insured, the applicant, either to accept or reject the agreed upon coverage on the basis of a possible change in his physical condition or insurability that occurs after he was examined by the insurers' physician.

[90] Id. at 490.