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THE APPLICANT'S MISREPRESENTATION ANNOTATED*

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Controversies arising out of representations made by applicants for sickness, accident, or hospital insurance have been a fertile source of litigation in recent years. Because of the ever-increasing amount of such coverage being written, it has become essential that the practicing attorney have at least a general acquaintance with the problems which may be encountered. The purpose of this article is to point up certain phases of the problem which have been troublesome, with particular emphasis on recent case law.

A policy of sickness, accident or hospital insurance is essentially a written contract, the terms of which are agreed to between the insuring company and the applicant. Certain standard clauses for these insurance agreements are prescribed by insurance codes in most states. Every individual is not insurable, and as a matter of right, is not entitled to such insurance protection. To determine insurability and to arrive at the terms of the contract ordinarily involves the use of some type of an application. The various answers made by the applicant to questions in the application are considered representations. When these answers contain false or inaccurate information, they lose their character as representations and become misrepresentations, and as such, assume that characteristic when they become a part of the policy contract.

I. TRUTHFUL ANSWERS BUT INACCURATE RECORDING

A. Agent for the Company or the Insured?

One of the situations which frequently gives rise to litigation may occur where the agent of the insurer prepares the insurance application. It is common practice for an insurance application to be filled out by an agent of the insurer, who usually orally questions the applicant and records his answers. In certain instances the insured may allege that he correctly and fully answered the interrogatories but the agent recorded them incorrectly. Where the truth of such allegations can be established, and where the application contains no limitation upon the authority of the agent, it is generally held that the agent is representing the company and thereby the company has constructive

* See also Fraizer, Misrepresentations in the Inception of Life, Health and Insurance Contracts, 32 Neb. L. Rev. 248 (1953).

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notice of all answers and statements made by the applicant to the agent.[1] One company unsuccessfully contended in a 1950 Nebraska case that an agent who was the daughter of the applicant was acting as the representative of her mother and therefore the company was not on notice of false medical answers which the agent had inserted in the medical application.[2] The court rejected this reasoning, saying that the daughter was the agent of the company. When insurance is procured through a broker, whichever party the broker is representing will be the controlling factor in determining whether or not the company had notice.[3]

B. Duty of the Insured to Examine the Policy.

When the agent has inaccurately recorded truthful answers on the application, the insurance companies may present another argument. If the application is attached and made a part of the insurance contract, the insurance company may contend that the insured has a duty to inspect the policy and attached application and give notice of any false answers. The courts have been liberal toward the insured in this area because they recognize that a policy is seldom carefully examined when it is received. In a recent decision, a Georgia court held that when false answers were inserted by the agent, the applicant was excused from reading the application at the time it was executed and that the insured was under no duty to examine the application after the policy was issued. The company would have to show actual knowledge of the false answers after delivery of the policy in order to show such fraud on the part of the insured as would avoid the contract.[4]

II. REPRESENTATION AS TO HEALTH

A. Unknown Malady.

Another frequent source of controversy involves representations by the applicant concerning his past and present condition of health. An applicant for personal insurance may be unaware that in fact he has a disease or congenital condition which may affect his health within a short time.[5] The common law rule

1 Mutual Benefit Health & Accident Ass'n v. Milder, 152 Neb. 519, 41 N.W.2d 780 (1950).

2 Supra note 1.

3 Moone v. Commercial Casualty Ins. Co., 350 Ill. App. 328, 112 N.E.2d 626 (1953).

4 Barber v. All American Assurance Co., 80 Ga. App. 270, 179 S.E.2d 48 (1953).

5 Sterling Ins. Co. v. Dansey, 195 Va. 933, 81 S.E.2d 446 (1954).

that all answers are deemed warranties has been modified by statute in most states so they will be considered simply representations as a matter of substantive law. Insureds have been further protected from misstatements found in an application being used in defense of their claim by the use of required Standard Provision Number 2 or the new Uniform Provision Number 1[6] in the insurance contract. This section provides that no statement by the applicant not included in the policy shall avoid the policy or be used in any legal proceeding thereunder. A 1954 Virginia case involved a policy containing such a provision. The application required the insured to answer the questions to the best of his knowledge and belief. This was a more favorable provision than that required by the statute, and in defending a claim the company sought to rely upon the statute. In discussing this point, the Virginia court stated:

> It is, therefore, consistent with public policy to permit the insurer and insured to enter into an agreement, the validity of which is based on knowledge and belief in the statements made by the insured rather than on the literal truth thereof. Indeed ... the insurer here could and did make a more favorable agreement with the insured than the statute prescribed .... In this connection, we note that the legislature in 1952 enacted [certain sections] ... pertaining to accident and sickness insurance, all of which provide that if the insurer does not include the provisions therein contained then he may substitute therefore other provisions which are not less favorable in any respect to the insured or beneficiary.[7]

B. Latent Condition.

Another problem is when an illness is deemed to begin—before the policy was in force or after the policy was in force. If the insured had a latent condition which never caused medical trouble before the policy, and this condition becomes patent after the policy was issued, the courts hold that the condition arose after the issuance of the policy.[8]

C. When Is An Applicant Under a Doctor's Care?

Medical and health questions also offer the most fertile environs for litigation involving misrepresentations. For example, when a physician is periodically "consulted," is one under his care? In a recent Maryland case a chest x-ray had revealed a questionable spot and the applicant had been advised to return every six months for further examination. After graduation from college,

[6] Neb. Rev. Stat. § 44-742 (Reissue 1952).
[7] Sterling Ins. Co. v. Dansey, 195 Va. 933, 81 S.E.2d 446 (1954).
[8] Group Hospital Service Inc. v. Bass, 252 S.W.2d 507 (Tex. 1952).

the insured secured coverage under a professional engineer's group policy and some months later became disabled with tuberculosis. The application contained no information that the insured had experienced any "physical condition requiring a doctor's care." The court decided that periodic precautionary checkups every six months, at which time no medication was given, no treatment prescribed, and no advice given, save a precautionary admonition that it would be well to return in six months, contained no elements of care and were solely examinations.[9]

D. Failure to Reveal Past Medical History.

A similar problem arises where the insured completely fails to reveal his past history of medical treatment or consultations with a physician, although the application requires such information. Under such circumstances, if his claim for disability or indemnification for hospital expense is due to a cause entirely foreign to his earlier sicknesses, he may still recover under the policy.[10] This will hold true when the parties have agreed in the insurance contract that the falsity of the answers will bar a recovery only in the event they materially affect either the acceptance of the risk or the hazard assumed by the company.

E. Failure to Understand Medical Terms.

The use of correct medical terminology in describing a disease or physical ailment in an application may also become a matter of controversy. In a 1954 South Dakota case the insured admitted he had had acute arthritis in 1943. Regarding such disease as a form of rheumatism, the trial court found that he made a false representation in the application in declaring that he had never had rheumatism. The court declared that it could not say as a matter of law that acute arthritis could not be considered to have been included within the meaning and the scope of the question in the application regarding rheumatism, and affirmed judgment for the insurer.[11]

III. MISREPRESENTATION OF CORRECT NAME ON APPLICATION

The obvious purpose of the application is to elicit specific information concerning the potential insured so the insurance company may more accurately guage the risk involved. The insurer will always require the correct name of the applicant. This is desired not merely to provide an accurate recored, but also to

[9] Baker v. Continental Casualty Co., 94 A.2d 454 (Md. 1953).
[10] National Casualty Co. v. Johnson, 67 So.2d 865 (Miss. 1953).
[11] Norris v. World Ins. Co., 63 N.W.2d 804 (S.D. 1954).

identify the person so that an inquiry may be made about him. A recent Pennsylvania case demonstrates the reason for this requirement. A combination of life, health, and accident policy was issued in the name of Rinaldo Joseph DeBillis. Five months after the policy was issued, the insured was found under a railroad bridge in South Philadelphia, stabbed to death. The company denied liability, contending that the insured failed to disclose that he had an alias name, that he had been involved in a criminal action, and had served a prison sentence. In an action by his beneficiary, the evidence revealed he had been previously treated in a hospital following a shooting under the name of Joseph De Luca, convicted of a conspiracy to commit a felony, and was on parole from another violation at the time. The court found the utmost good faith is required of the insured because the company takes the risk largely on his representations. The court also decided that there may be misrepresentation by concealment, and the trial judge should have so declared as a matter of law.[12]

IV. PROBLEMS CURED BY UNIFORM ACCIDENT AND SICKNESS POLICY PROVISIONS.

The lawyer who has before him a policy of accident and health insurance for examination with particular reference to statements made by the insured in obtaining the policy, must distinguish between the old Standard Provisions and the new Uniform Accident and Sickness Policy Provisions contained therein. Most policies issued prior to 1951 will be found to have the old Standard Provisions which provide that "the policy includes the endorsements and attached papers, if any, and contains the entire contract of insurance; further, no statement made by the applicant for insurance not included therein shall avoid the policy or be used in any legal proceeding thereunder."

Many policies issued since 1951 will be found to have the Uniform Accident and Sickness Policy Provisions. They provide that "the policy, including the endorsements and attached papers, if any, constitute the entire contract of insurance; further, after three years from the date of issue of the policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to avoid the policy or to deny a claim for loss incurred for disability commencing after the expiration of such three year period." In a few states, this limitation has been set at two years.

[12] DeBellis v. United States Benefit Life Ins. Co., 373 Pa. 207, 93 A.2d 454 (1953).

The new policy provisions law has now been enacted, or will be in use in forty-four states and the District of Columbia. Many companies are currently issuing policies with these new clauses. Minnesota, Missouri, Oklahoma and West Virginia are the only states which do not have the new law or permit its use under administrative regulations.

Those who cooperated with the National Association of Insurance Commissioners in developing the new uniform provisions believe the provision establishing a period of limitation on certain defenses introduces a new principle in accident and sickness insurance. This provision, of course, does not exclude the defense of fraud where the misstatements or misrepresentations may be shown to have been made for the purpose of fraudulently inducing the company to issue the policy. And it is not as all inclusive as the incontestable clause which has been a common provision in life insurance policies for many years. In fact, in certain noncancellable accident and sickness insurance policies, the time limit provision may be found to carry the title of incontestable.

Attorneys for insureds and those representing companies writing accident and health insurance will, no doubt, find that these new provisions will save many misunderstandings between the insured and his company and will also help solve the problem originating where the agent who is alleged to have recorded incorrect answers.