

Life Insurance Denials Based on Material Misrepresentations: The Application Process, the Law, and Public Policy Collide

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The healthcare debate has been in the political spotlight since President Obama took office. One point that served as a rallying cry for its supporters is the particularly unsavory practice of insurers cancelling healthcare coverage due to pre-existing conditions—otherwise known as rescission. The new federal healthcare law, in fact, prohibits this practice, except in instances when the insured has committed fraud.

A similar practice persists in the field of life insurance. What happens is the insurance company, which has already approved the application and accepted premiums, waits until the insured has died before it investigates whether misrepresentations or omissions were made. If it finds any, it denies coverage. The term for this practice is “postclaim underwriting,” and it has been roundly criticized by policyholder advocates. When does it occur? The answer is when the insured dies within the “contestability period” for the policy, which in most states lasts for two years after the policy was issued. After the contestability period passes, there generally cannot be rescission for a material misrepresentation. However, in most states, rescission is permitted even when the misrepresentation has no connection with the cause of death. The end result of this practice is that beneficiaries discover only after the loss of loved one that there is no insurance coverage, leading them in many cases to suffer severe financial hardship. On an emotional level, denials only compound the tragedy of the loss of a loved one.

Along with her colleague Sandra Poindexter, *Los Angeles Times* reporter Lisa Girion, who exposed how health insurers rescinded coverage due to pre-existing conditions, turned her focus to the life insurance industry in a November 21, 2010, article entitled *Flaws Can Cancel Life Insurance—after Death*.¹ The article profiles three widows who each had life insurance claims rejected based on alleged material misrepresentations made in the application, none of which related to the cause of death. One of these widows, Jean Lin, was my client.

According to the article, more than 5,000 life insurance denials occurred in 2009 and approximately \$372 million was withheld from beneficiaries.² The number one reason for life insurance denials was material misrepresentations, accounting for two-thirds of all denials.³

This article will address the public policy concerns regarding life insurance denials in our society and the applicable law of different states. Although it will discuss Mrs. Lin’s case in particular, the broader focus will be on how the law allocates responsibility between consumers and insurance companies for omissions or misrepresentations in life insurance applications. Many of the observations made herein apply to other types of insurance, but nevertheless life insurance will serve as the main thread in the discussion.

Jean Lin’s husband, Bang Lin, died in 2006 at age 36 from stomach cancer that was diagnosed about one year after he obtained a \$1,000,000 life insurance policy from the Metropolitan Life

Insurance Company. At the time of his death, Jean Lin was 35-years-old and their two children were ages ten and nine. Mr. Lin had operated a computer business in Southern California where the family lived, and after his death Mrs. Lin had to close down the business. MetLife refused to pay her the death benefit, claiming that Mr. Lin failed to disclose a history of hepatitis B in the application. The hepatitis B was completely unrelated to Mr. Lin's stomach cancer and, over five years earlier, had been successfully treated with a short course of self-administered interferon treatment with no liver damage. At his deposition, Mr. Lin's doctor testified that when the treatment ended, he told Mr. Lin that he was "cured."

One might think that an insurance company about to issue a \$1 million life insurance policy would first request and review an applicant's medical records, but in this case MetLife did not. It only had the Lins fill out an application and a paramedic came to his business to take a blood and urine sample. This limited scope of inquiry is quite common in the life insurance industry.

The Lins had an explanation for why the hepatitis B was not disclosed. According to Mrs. Lin, the insurance agent, who filled out the application herself, did not ask any of the health questions, and she and her husband signed the application without reviewing it. The Lins and the agent communicated in Chinese. Because MetLife refused to pay, a lawsuit was filed in the Federal District Court, Southern District of New York, where MetLife has its headquarters. Ultimately, the court ruled in favor of MetLife at summary judgment.

The Ninth Circuit Court of Appeals has held that an omission or misrepresentation in an insurance application is material "if it affects insurability or the amount of premium paid."⁴ In other words, a misrepresentation, to be material, must cause the insurer to reject the application or charge a higher premium rate. It is generally unimportant if the misrepresentation was innocently or unintentionally made. Further, the law does not require there to be a connection between the misrepresentation and the cause of death. Nor is there a mechanism for the beneficiary, if the misrepresentation does not relate to the cause of death and would not have prevented insurance from being issued, to have deducted from the death benefit the difference between the aggregate premiums that were charged for the policy and the premiums that should have been charged.

In Mrs. Lin's lawsuit, MetLife conceded that it would have issued a policy to Mr. Lin if it had been aware of his hepatitis B history, but said it would have done so at a less desirable rate. More specifically, its medical director claimed that Mr. Lin was entitled to a "standard" rate at best. He was, however, issued a policy at the highest available rate of "select-preferred," with only "preferred" standing between the two ratings. On its face, this was all that was needed to justify a denial.

At first blush, it may seem like Mrs. Lin faced an uphill battle. But a significant argument made on her behalf was that Mr. Lin never deserved a "select-preferred" rate in the first place. MetLife had rated him incorrectly based on information known to it, giving him a better rate than he was entitled to. Specifically, MetLife deviated from its underwriting guidelines, which expressly prohibited a "select-preferred" rate for known blood elevations that Mr. Lin had with respect to his bilirubin and triglyceride results. Consequently, it was argued, MetLife could not strictly

apply its guidelines against the Lins during postclaim underwriting because to do so would be applying a double-standard in its favor and against the insured.

A second component to this argument was that the very fact that MetLife deviated from its guidelines was proof that its underwriting guidelines were discretionary—indeed, the underwriter acknowledged this at his deposition—and the materiality analysis in the case was not subject to exactitude. A California federal district court has held that where underwriting guidelines for the maximum amount of coverage that could be provided to an insured were parameters that could be exceeded in certain circumstances, it was a genuine issue of fact as to whether they could be exceeded in the case.⁵ Thus, the materiality analysis had to be flexibly performed. MetLife could have given a blurred range of ratings to the Lin policy based on hepatitis B that could have overlapped with the possible ratings for the elevated bilirubin and triglyceride levels.

A key approach to contesting material misrepresentation claims is to analyze if the insurer followed its guidelines and manuals in evaluating medical conditions that were known to it. If it failed to properly classify such conditions, it should not be permitted to strictly classify the undisclosed condition. In other words, the insurer should not be able to unilaterally determine when its written standards apply and when they will be ignored. Furthermore, if the insurer deviated from its guidelines when it issued the policy, the rating it assigned should not be used as a baseline to assess materiality. To use the *Lin* case as an example, materiality would not be based on whether the hepatitis B warranted a “select-preferred” rate. For these reasons, it is important to obtain the guidelines and other underwriting materials pertaining to any medical condition that the insurance company knew about when it issued the policy and analyze whether they were followed. This line of argument, if successful, can dramatically reduce the burden faced by a beneficiary to prove that even if there was a misrepresentation, it was not material.

In the *Lin* case, however, the court utilized a different standard. It interpreted California law to hold that materiality exists if the undisclosed fact “would have had a substantial effect on the insurer’s underwriting decision.”⁶ Expanding on this standard, the court held that materiality will exist if an undisclosed fact would trigger the insurance company to demand more information or make “substantially different inquiries” if it knew the true facts.⁷ The district court claimed this standard was satisfied because the hepatitis B history, had it been known, would have altered how the insurance company performed its underwriting for the policy, no matter that the premium rate would have remained unchanged.⁸

The district court’s standard is subjective and contrary to established California law, which contemplates an objective measurement of materiality—whether insurance coverage would have been denied or issued at a higher rate. The district court’s standard, as is evident, would allow insurance companies to prevail in nearly every case, so long as they are able to show that they would have taken some different or additional step when evaluating the application, a fairly easy hurdle to clear and difficult for an insured to disprove.

The district court’s ruling was affirmed in a 358-word summary opinion from the Second Circuit Court of Appeals.⁹ During the course of the litigation, Mrs. Lin had to sell the family home and move with her two children into a smaller apartment.

California law concerning materiality, as enunciated by the Ninth Circuit, is similar to many other states.¹⁰ An omission or misrepresentation in an insurance application does not need to relate to the cause of death in order for there to be rescission. This represents a stark departure from common law principles, such as in the field of torts where causation is required—the breach of a duty must be a proximate cause of the resulting harm—and in the area of contracts, where a breach of contract must result in actual damages to a party. In effect, a form of strict liability has been imposed against life insurance consumers. If you make a mistake in the application, there will be no coverage. There are exceptions to this rule, as will be discussed, but they are limited.

Some states have enacted variations on this material misrepresentation standard. While New Jersey generally adheres to this standard, it goes a step further by drawing a distinction between “subjective” and “objective” questions on the insurance application form.¹¹ The dividing line between these two categories can be difficult to discern. One court has characterized “objective” questions as those that inquire about information known to the applicant, such as whether she has been examined by a physician, while “subjective” questions, on the other hand, such as those that inquire about the applicant’s state of health or if she has had certain illnesses or diseases, are susceptible to varying answers and probe the applicant’s state of mind.¹² These two categories were developed in an effort to alleviate the harsh result that can occur from an innocent misrepresentation. Similarly, a California court has noted that there may be a difference between giving an incomplete answer to an open-ended question as opposed to a false answer to a closed question.¹³

As is evident, New Jersey law scrutinizes the type of questions contained in the application. Massachusetts law, on the other hand, focuses on the nature and extent of the underwriting performed by the insurance company. Specifically, it distinguishes between life insurance policies issued with and without a medical examination. While Massachusetts does impose a materiality analysis for misrepresentations made when obtaining an insurance contract, an exception has been carved out specifically for life insurance policies issued without a physician-conducted medical examination, in which case the insurer, in order to deny payment, must show that a misrepresentation was “willfully false, fraudulent or misleading.”¹⁴ This obviously is a tougher standard imposed on insurance companies—requiring them to prove the intent of the deceased insured—that provides an incentive for them to thoroughly examine applicants and underwrite applications. Part of the legislative history of this law includes an 1889 report from the Commissioner of Insurance which observed that:

It is the business of the company to ascertain whether lives presented for insurance are impaired; and, if it chooses to waive any pretence of an examination to test this vital question, the responsibility should be upon itself. Existing contrary practice leads to a wilderness of misunderstanding and misrepresentation, with hardships and losses to a class of people illy able to bear it.¹⁵

In his book about the insurance industry, *Delay, Deny, Defend: Why Insurance Companies Don't Pay Claims and What You Can Do About It*, Rutgers Law Professor Jay Feinman explains that in the Nineteenth century, life insurance applications would request voluminous disclosures about myriad conditions to set up a material misrepresentation argument. If any answers were found to

be incomplete or incorrect, the company would void the policy, sometimes many years after it was issued. In 1906, New York's Armstrong Commission investigated widespread abuse in the life insurance industry and proposed modern incontestability legislation.¹⁶ In 1946, model incontestability legislation was recommended by the National Association of Insurance Commissioners that was subsequently adopted in most states.¹⁷ Most states now have incontestability laws which provide that a life insurance policy cannot be voided after it has been in effect for two years because of an omission or misrepresentation in the application.

Insurance company attorneys argue that insurers are disadvantaged by incontestability laws. But this argument does not withstand scrutiny. The contestability period is similar to a statute of limitations that pertains to other causes of action—the purpose of both is to prevent stale claims. After two years have passed, an insurance company cannot disclaim coverage based on a material misrepresentation. Similarly, after three years have passed in most states, a tort claim cannot be pursued. In some states, like Tennessee, medical malpractice cases have only a one year statute of limitations. Historically, life insurance companies would deny coverage years after the policy was issued. Is it fair to make beneficiaries defend an application process that occurred years or decades earlier of which they perhaps had no first-hand knowledge? In fact, in all material misrepresentation cases, the insured is not available to testify, automatically putting beneficiaries at a disadvantage in litigation. And in these cases the stakes are often high—the financial well-being of surviving family members.

Another argument why contestability periods are similar to a statute of limitations is that most all misrepresentations concerning health or financial information are knowable to the insurer at or before when the policy is issued.¹⁸ With minimal effort, the insurer could request medical and financial records, and conduct an examination of the insured, prior to issuing coverage. The discovery rule that can toll a statute of limitations does not apply in this context.¹⁹ From a public policy perspective, incontestability legislation laudably encourages insurers to investigate applications prior to the issuance of coverage. But many insurers fail to do this in a comprehensive manner, supported by the material misrepresentation law which allows them to deny coverage based on any omission or misrepresentation in the application that would have changed the premium rate even minimally.

The burden of proving a misrepresentation rests on the insurer. Insurance companies cannot simply rest on their own self-serving testimony. They must present documentation concerning their underwriting practices, including underwriting guidelines, bulletins, and rules pertaining to the risk at issue.²⁰ As one California court stated: “[T]he trier of fact is not required to believe the ‘post mortem’ testimony of an insurer’s agents that insurance would have been refused had the true facts been disclosed.”²¹

In the discovery phase, an insured should, at least in theory, be able to obtain documents concerning how the insurer has evaluated similar risks. If, for example, the alleged misrepresentation was hepatitis B, as in the *Lin* case, the insured should be entitled to information about how other applicants with hepatitis B have been rated. However, there is not a developed case law on this particular subject. In *Matilla v. Farmers New World Life Insurance*, the insurance company denied coverage to the family of the insured who entered the country illegally and misrepresented his immigration status in his life insurance application. The

California federal district court stated that “[t]he relevant question...is whether any similarly situated person had been afforded identical insurance coverage, which would demonstrate that immigration status is immaterial.”²² This statement, made similarly by other courts, can be utilized as support for obtaining discovery of other policies that addressed similar risks.²³ After all, how an insurer underwrites in practice can differ from the dictates of its underwriting guidelines and manuals, as is demonstrated by the *Lin* case.

Generally, there are only limited circumstances under which a material misrepresentation in the application will be excused.²⁴ In New York, the fact that it was innocently or unintentionally made will not prevent rescission.²⁵ Once the insured signs the application, she is bound by the answers, regardless of whether she read it.²⁶ The inability to speak English will not excuse an insured from the application of this general rule.²⁷ New York courts have even held that rescission is proper if correct information was provided to the agent who made a mistake completing the application, if the agent failed to ask questions in the application, or if the agent told the insured it was unnecessary to read the application.²⁸ The burden clearly is placed on the applicant and not the agent to make sure that the application is understood by the former and accurately completed. As a matter of fact, the law even excuses agent negligence.

However, there are some mitigating factors that will prevent rescission. An insured will not be penalized if an agent incorrectly advised the applicant about the meaning of specific questions on the application.²⁹ A distinction can be made, therefore, between the agent being negligent and performing an affirmative misdeed. An insured will also not lose coverage on the grounds that a misrepresentation was made if she had no knowledge of a medical condition or, if she knew of it, did not comprehend its significance.³⁰ In a New York Appellate Division case, *Legawiec v. North American Company for Life and Health Insurance of New York*, the insured failed to disclose that his physician treated him for an enlarged lymph node in his neck.³¹ Because the evidence showed that he was not advised that the lymph node was possibly malignant or that it was a serious medical condition, it was held that the insurance company was not entitled to summary judgment.³²

California law, which is more favorable to insurance consumers than New York law, more broadly allows insureds to “offer a plausible explanation for the falsehoods appearing in the insurance application, an explanation which the insurer then may rebut in order to avoid liability on the policy.”³³ Once a plausible explanation for the misrepresentation is proffered, the burden returns to the insurer “to negate to the satisfaction of the trier of fact the various plausible explanations.”³⁴

Generally speaking, with three parties to a life insurance contract—the insurance company, the agent, and the insured—there is always potential for there to be inaccurate information in the application due to carelessness, a lack of understanding, or the confusing nature of many standard questions that lump together a string of medical conditions in small print preceded by language such as, “Have you ever, in the past 10 years, had....” In addition, some applicants may not recall conditions from many years ago that have since resolved. As noted in *Hailey v. California Physicians’ Service*, “[m]ost people are capable of forgetting facts at the time they apply for insurance, especially if those facts relate to a condition or event in the past which is no longer (and perhaps never was) deemed a problem by the applicant.”³⁵

The question arises: How is the potential for error addressed by the law? As has been shown, in many states it is the insured, not the insurance company or agent, who is presumed to be at fault. The insurance company only has to show that a misrepresentation was made—any misrepresentation, even if unrelated to the cause of death—and the beneficiary is in danger of losing coverage unless a sufficient excuse for it can be proffered. Insurance agent negligence will not always suffice.

From the perspective of a policyholder advocate, there is a disconnect between the law and the reality of life insurance sales practices. Some applicants for life insurance are dishonest, but there are also some insurance companies and agents that do not always act with probity or have the insured's best interests in mind. On balance, with its tough standard for insureds, the law seems to acknowledge the former, but not the latter. Yet, it is acknowledged that insurance agents have only a divided loyalty to their customers, at best. The New York Court of Appeals has recently held that an insurance agent has no fiduciary duty at common law to her customers in light of the fact that the agent has obligations running to both the insurance company and her customer.³⁶ With Massachusetts as a notable exception, when there is a lawsuit concerning an alleged material misrepresentation in an insurance application, the insurer's investigatory methods are not scrutinized. An insurance company does not have to prove that the insured acted dishonestly when completing the application in order to void the policy, but if the insurance agent committed wrongdoing or implemented sharp practices, it is the beneficiary who has the burden of proof on the matter.

Over the years, the life insurance industry and its sales practices have been subject to fines and penalties from federal and state regulators. David Evans of *Bloomberg News* has reported that MetLife and Prudential Financial, Inc., each paid \$19 million to settle claims by the New York Attorney General's Office in 2006 that they illegally paid brokers in order to obtain new corporate clients.³⁷ He also covered the story of how Prudential profited by distributing life insurance payouts due to family members of deceased military service members in the form of a "checkbook" from the company, rather than a lump-sum payment, allowing the money to stay in its corporate account and earn investment income.³⁸

In 2006, the Securities and Exchange Commission filed suit against American-Amicable Life Insurance Company and two of its affiliates for allegedly defrauding military service members with an investment product that it claimed would earn them millions.³⁹ According to the SEC, sales agents for the companies misled military personnel by promoting their product, known as "Horizon Life," to troops who already had access to low-cost government-sponsored insurance, while denigrating other investments such as mutual funds, bonds, and savings accounts.⁴⁰ The insurers agreed to pay \$10 million to the 57,000 military personnel who invested in the product and agreed to a five-year ban from sales on any military base.⁴¹ If these thousands of servicemen were misled into buying insurance, it is reasonable to believe that other citizens could either be misled or make mistakes during the application process.

The business of insurance is affected with a public interest.⁴² As Professor Feinman states in *Delay, Deny, Defend*, "insurance provides a social safety net for individuals and businesses, particularly for the middle class. Most Americans are only a car accident, a fire in the home, a lawsuit, or an injury away from having the wealth, the comfort, and the lifestyle accumulated

over a lifetime of work wiped out.”⁴³ As such, insurance companies are not supposed to deny coverage based on unduly restrictive policy interpretations or unfair standards imposed on insureds.⁴⁴

Postclaim underwriting, however, often involves exactly that, and it frays the social fabric that insurance is meant to protect. A California state appeals court has severely criticized the practice:

It is patently unfair for a claimant to obtain a policy, pay his premiums and operate under the assumption that he is insured against a specified risk, only to learn after he submits a claim that he is not insured, and, therefore, cannot obtain any other policy to cover the loss. The insurer controls when the underwriting occurs.... If the insured is not an acceptable risk, the application should be denied up front, not after a policy is issued. This allows the proposed insured to seek other coverage with another company since no company will insure an individual who has suffered serious illness or injury.⁴⁵

Insurance companies should investigate an applicant’s medical and financial history, rather than just accepting at face value the answers filled in on the application. They should realize the propensity for error in the application process and enact safeguards, especially since the incentive for agents is to sell as many policies as possible, not to make sure that each application is filled out carefully. The agent does not earn a commission when an applicant is denied coverage, and coverage is more likely to be declined if an applicant discloses a harmful medical condition. Moreover, the agent could lose the customer’s business if the customer is not given a preferential rate. The better an applicant’s medical history and state of health appear, the better the rate that will be given. The incentive is simply not there for agents to do a thorough job of leading applicants through the application process.

Not only have insurance companies failed to act, but the laws of many states are seemingly blind to this reality. They do not provide a disincentive for sloppy or deceptive sales practices. What they do instead is provide enhanced protection for insurance companies by imposing a form of strict liability on insurance consumers.

Insurers typically demand signed releases authorizing them to obtain applicants’ medical information. If they are able to request this information after a claim is made, there is no reason they cannot request it beforehand. The choice comes down to whether insurers are willing to better investigate applications at the outset, which, although more costly, will result in them insuring better risks, or if they will insist on maintaining cursory underwriting standards in order to increase sales and lower costs. The best way to change the status quo is to provide more incentives in the law for insurance companies to perform underwriting when initially evaluating the application, not after a claim is made. Massachusetts is on the right track with a more onerous standard for insurers who do not conduct medical examinations, as is Missouri which requires a link between the misrepresentation and the cause of death.⁴⁶ Time will tell if other states will follow suit.

¹ <http://articles.latimes.com/2010/nov/21/local/la-me-life-insure-20101121>.

² *Id.*

³ *Id.*

- ⁴ *Sec. Life Ins. Co. of Am. v. Meyling*, 146 F.3d 1184, 1192 (9th Cir. 1998), *reh'g denied*, No. 97-15595, 1998 U.S. App. LEXIS 22331 (9th Cir. Sept. 14, 1998).
- ⁵ *Xiong v. Lincoln Nat'l Life Ins. Co.*, No. 08-345, 2009 U.S. Dist. LEXIS 45280, at *24 (E.D. Ca. May. 28, 2009).
- ⁶ *Lin v. Metropolitan Life Ins. Co.*, No. 07-3218, 2010 U.S. Dist. LEXIS 17146, at *5, *aff'd*, No. 10-909, 2011 U.S. App. LEXIS 3483 (2d Cir. 2011).
- ⁷ *Id.* at *6.
- ⁸ *See id.* at *5-6.
- ⁹ *Lin*, No. 10-909, 2011 U.S. App. LEXIS 3483 (2d Cir. 2011).
- ¹⁰ *Meyling*, 146 F.3d at 1191-92; *The Mutual Benefit Life Insurance Company v. JMR Electronics Corp.*, 848 F.2d 30, 33 (2d Cir. 1988).
- ¹¹ N.J.S.A. 17B:24-3(d); *Mass. Mut. Life Ins. Co. v. Manzo*, 584 A.2d 190, 194-95 (N.J. 1991).
- ¹² *Formosa v. The Equitable Life Assurance Society of the U.S.*, 398 A.2d 1301, 1304-05 (N.J. App. 1979).
- ¹³ *Matilla v. Farmers New World Life Ins.*, 960 F. Supp. 223, 226 (N.D.Ca. 1997).
- ¹⁴ Mass. Gen. Laws ch. 175, §§ 124 and 186 (2010); *see also Torres v. Fidelity and Guaranty Life Ins. Co.*, 611 N.E.2d 733, 735 (Mass. App. Ct. 1993).
- ¹⁵ *Protective Life Ins. Co. v. Sullivan*, 682 N.E.2d 624, 631 (Mass. 1997) quoting Thirty-fourth Annual Report of the Insurance Commissioner, Pub. Doc. No. 9, at vii (1889).
- ¹⁶ Jay Feinman, *Delay, Deny, Defend: Why Insurance Companies Don't Pay Claims and What You Can Do About It*, p. 43 (Portfolio/Penguin 2010).
- ¹⁷ *Id.*
- ¹⁸ *Sullivan*, 682 N.E.2d at 633.
- ¹⁹ *Id.*
- ²⁰ *Curanovic v. New York Central Mut. Fire Ins. Co.*, 762 N.Y.S.2d 148, 151 (App. Div. 2003).
- ²¹ *Thompson v. Occidental Life Ins. Co.*, 513 P.2d 353, 360 (Cal. 1973) (citation omitted).
- ²² *Matilla*, 960 F. Supp. at 226, fn. 4.
- ²³ *Rafi v. Rutgers Casualty Ins. Co.*, 872 N.Y.S.2d 799, 800 (App. Div. 2009) (“[I]n order to prevail on its affirmative defense, the [insurer] was required to submit proof concerning its underwriting practices with respect to applicants with similar circumstances”) (citation and quotations omitted); *see also Legawiec*, 832 N.Y.S.2d at 725 (citation and quotation omitted).
- ²⁴ *Thompson*, 513 P.2d at 362.
- ²⁵ *Curanovic*, 762 N.Y.S.2d at 150.
- ²⁶ *See id.*
- ²⁷ *Id.*
- ²⁸ *Nationwide Ins. Co. v. Dorch*, No. 94-5842, 1996 U.S. Dist. LEXIS 22730, at *5-6 (S.D.N.Y. Mar. 25, 1996); *Zachary Trading, Inc. v. Northwestern Mut. Life Ins. Co.*, 668 F. Supp. 343, 346 (S.D.N.Y. 1987).
- ²⁹ *Xiong*, 2009 U.S. Dist. LEXIS 45280, at *18 (citation omitted).
- ³⁰ *Thompson*, 513 P.2d at 360 (citations omitted).
- ³¹ 832 N.Y.S.2d 723, 724 (App. Div. 2007).
- ³² *Id.*
- ³³ *Lettieri v. Equitable Life Assurance Soc.*, 627 F.2d 930, 932 (9th Cir. 1980), *citing Thompson*, 513 P.2d 353).
- ³⁴ *Thompson*, 513 P.2d at 363.
- ³⁵ *Hailey v. Cal. Physicians' Service*, 69 Cal. Rptr. 3d 789, 800 (Ct. App. 2007), *modified and reh'g denied*, No. G035579, 2008 Cal. App. LEXIS 112 (Ct. App. Jan. 22, 2008).
- ³⁶ *People v. Wells Fargo Ins. Services, Inc.*, 2011 N.Y. Slip Op. 01070, 2011 N.Y. LEXIS 153 (Ct. App. Feb. 17, 2011).
- ³⁷ David Evans, *Accidental Death Becomes Suicide When Insurer's Dodge Payouts*, Bloomberg Markets, Mar. 1, 2011, at <http://www.bloomberg.com/news/2011-03-01/accidental-death-becomes-suicide-when-insurers-dodge-paying-life-benefits.html>.
- ³⁸ David Evans, *Prudential Profits from Slain Soldiers with Help from Taxpayers*, Bloomberg Markets, Sept. 30, 2010, at <http://www.bloomberg.com/news/2010-09-30/prudential-profits-from-slain-soldiers-with-help-from-taxpayers.html>.
- ³⁹ U.S. Securities and Exchange Commission, Litigation Release No. 19791, Aug. 3, 2006, at <http://www.sec.gov/litigation/litreleases/2006/lr19791.htm>.
- ⁴⁰ *Id.*
- ⁴¹ *Id.*; Penni Crabtree, *Insurer to Pay \$10 Million to Troops*, The San Diego Union-Tribune, Aug. 4, 2006, at http://www.signonsandiego.com/uniontrib/20060804/news_1b4insure.html.

⁴² *Calfarm Ins. Co. v. Deukmejian*, 771 P.2d 1247, 1262 (Cal. 1989) (internal citation and quotation omitted).

⁴³ Feinman, p. 23.

⁴⁴ *Tilbury Constructors, Inc. v. State Comp. Ins. Fund*, 40 Cal. Rptr. 3d 392, 396 (Ct. App. 2006) (internal citation omitted).

⁴⁵ *Hailey*, 69 Cal. Rptr. 3d at 799.

⁴⁶ Mo. Rev. Stat. §376.580 (2002).