The postclaims underwriting 'gotcha'

When life insurers refuse to pay claims, alleging fraud or mistakes in policy applications, consumers have few options. But legal reform—and smart trial strategies—can provide them with needed protection.

ERIC DINNOCENZO

Purchasing life insurance is no fun. But worse is when the insurer refuses to pay the policy.

Most states specify that for two years after a life insurance policy is issued, an insurer can contest its validity on the ground that a material misrepresentation was made in the application.[1] Afterward, the insurer can no longer challenge the policy and must pay the beneficiary.

When an insured person dies within this two-year contestability period, insurers typically scour his or her medical history for a misrepresentation that can serve as grounds for the rescission of the policy. This process, known as postclaims underwriting, can result in hardship for those who rely on the life insurance.

The laws of most states facilitate postclaims underwriting. When consumers sue after being denied payment, for instance, states often impose a strict liability standard, requiring insurers to prove only that any misrepresentation, if it had been known, would have caused an increase in the premiums, no matter what the amount. And insurers need not show a causal connection between misrepresentation and cause of death.

Also, many laws fail to take into account that misrepresentations are frequently the result of the consumer's lack of sophistication as well as the insurer's sloppy and sometimes fraudulent practices. For instance, many life insurance companies do not adequately investigate potential customers before signing them up for a policy.

Reform is needed to make life insurance laws fair to consumers and controlled by the same legal framework that governs other consumer transactions. By requiring that insurers better evaluate the risk posed by consumers before taking them on as customers, prove intent to deceive, and provide a causal connection between any misrepresentation and cause of death, state laws would balance the interests of both consumers and insurers.

Companies would still be able to void a policy if they could establish the legal elements of fraud and would have more incentive to do their homework ahead of time, while consumers would be given much-needed protection from careless, and sometimes unscrupulous, insurers and their agents.

Contestability period

The contestability period is similar to a statute of repose, limiting the time in which an insurance company can disclaim coverage. Currently, 43 states have enacted contestability laws.[2] The purpose of these laws is to prevent insurance companies from asserting years after a policy is issued that it was invalid from its inception.

If contestability laws did not exist, courts would be flooded with cases involving polices issued many years before; in those cases, it would be difficult, if not impossible, for beneficiaries to prove the health history of the insured and the circumstances under which the application was completed. (Imagine, for instance, a 40-year-old beneficiary having to prove the facts surrounding an application submitted by a deceased parent when the beneficiary was only a teenager.) Contestability periods satisfy the need for security in the area of life insurance benefits.

Postclaims underwriting has been applied to other forms of insurance as well. In 2007, when a health insurance company rescinded health care coverage after the insured was involved in an accident that left him permanently disabled, a California appeals court in *Hailey v. California Physicians' Services* issued a stinging critique of the practice:

> It is patently unfair for a claimant to obtain a policy, pay his premiums, and operate un-

ERIC DINNOCENZO *is a senior associate with Trief & Olk in New York City.*

> der 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. . . . If the insured is not an acceptable risk, the application should [be] denied up front, not after a policy is issued.[3]

In California, health insurance policies are governed under a separate statutory framework, prohibiting postclaims underwriting except where there is a willful misrepresentation. This rule should apply also to life insurance policies, and not just in California but in all states. After all, with both types of insurance the consumer justifiably believes that coverage is in effect, the insurer could have (but did not) properly investigate the veracity of the insurance application at the outset, and the consumer may suffer serious hardship if the policy is rescinded.

So why don't life insurance companies better investigate the risk posed by applicants at the outset, when evaluating applications? The simple answer is that not doing so is better for the bottom line. After all, why would an insurer spend money on a physician-conducted medical examination and a medical records review, when it can issue a policy and immediately begin collecting premium payments?

No doubt, the nature of existing laws also encourages insurers to take a lax approach. Simply put, if the law does not disadvantage insurers when they do not adequately evaluate the risk posed by consumers, they will not do so.

Misrepresentation standard

Many states—including Arizona, Connecticut, Florida, Indiana, Louisiana, Michigan, New Jersey, New York, and Tennessee—allow for life insurance policies to be rescinded if the insurer can show that a material misrepresentation was made in the application.[4] This black-letter law, in fact, applies in many states to all forms of insurance.

Under this standard, an insurance company has to show only that an undisclosed medical or financial condition inquired about in the application, if it had been known, would have resulted in a higher premium. The insurer need not show that there would have been a refusal to issue the policy[5] or that there was an intent to deceive.

New York has taken an especially tough stance against consumers in life insurance cases. Not only does it apply the material misrepresentation standard, but its courts have held that an insurer can successfully void a policy even if correct information was provided to the agent who made a mistake completing the application, if the agent failed to ask questions contained in the application, or if the agent told the insured that it was unnecessary to read the application.[6] In short, the buck stops with the consumer once he or she signs the application.[7]

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New York allocates the risk of carelessness in completing the application to consumers rather than insurance companies. The law assumes that in cases where there is a misrepresentation, the consumer rather than the insurer or its agent is the wrongdoer.

According to the Second Circuit, if the law were otherwise it "would reward the practice of misrepresenting facts critical to the underwriter's task because the unscrupulous (or merely negligent) applicant would have everything to gain and nothing to lose from making material misrepresentations in his application for insurance."[8]

Of course, some applicants for life insurance do commit fraud, and this rightly is a real concern for insurance companies. The problem with the New York law, and other state laws like it, is that there are no safeguards to protect consumers who lack sophistication or fall prey to unscrupulous insurance companies and their agents.

Consumers may provide incorrect information when they do not understand a question in the application. Or they may not have a firm grasp of their medical histories. Or they may be careless in completing the application. Or the agent might not read all the questions to them or might incorrectly record their answers.

When any of this happens, the laws in many states say "tough luck" to consumers. And they fail to penalize life insurance companies that later seek to disavow policies they mistakenly or carelessly issued. Meanwhile, the policyholder and beneficiary have assumed that the life insurance is in effect.

What goes unrecognized is that life insurance agents have an inherent conflict of interest when selling policies because they generally earn commission-based salaries and receive promotions for generating new business. If they try to discover every potential customer's medical impairments, the company might deny the customer's application or offer a less attractive rate, causing the customer to go elsewhere.

Agents do not make money by spending time with applicants to make sure their applications are filled out correctly. Rather, they make money by securing policies for current customers and moving on to the next customers. After all, each minute spent with a policyholder already signed up is time that could be devoted to obtaining new business.

Agents typically read application questions aloud to applicants and record their answers. One treatise has noted that "39 out of 40 application blanks are filled out by the company agent who shoots his questions rapid fire and may or may not mark down the replies accurately."[9]

Some questions are worded in a manner that is apt to lead to misunderstand-

ing. For instance, two parts of a five-part question in a Mutual of Omaha application ask the following:

> During the past 10 years, have you, or any person proposed for insurance:
>
> (a) had any illness, injury, surgery, hospitalization, medical examination, or care not listed above?
>
> (b) had or received treatment for any unexplained fever, fatigue or chronic cough?[10]

As the California appeals court in *Hailey* observed, it is foreseeable that when sitting down to complete the application, some applicants might not recall each and every instance of a condition or impairment that occurred many years ago.[11] In fact, a Louisiana court has observed that nonspecific health questions that ask if an applicant has had an "impairment" or "illness" provide a "window of opportunity" for insurance companies to deny coverage after death, especially when a medical examination is not administered before the application is accepted.[12] The vagueness of the questions—what *is* an unexplained fever, fatigue, or chronic cough?—may lead reasonable people to interpret them differently.

No investigation

Although all life insurance applicants must answer a series of questions on an insurance form, uniformity in applications typically ends there. Sometimes, blood and urine tests are administered and analyzed by a lay underwriter. Physician examinations are probably the exception rather than the rule.

Underwriters then evaluate the information obtained and, if it passes muster, assign a rating to the policy. Although companies have underwriting guidelines that match health conditions with specific ratings, underwriters sometimes deviate from them based on their own independent judgment.

Some companies even offer online life insurance products that bypass most of this scrutiny. An applicant answers with the click of a mouse three or four compound health questions listing a variety of ailments, and the policy is approved or rejected instantaneously without the involvement of an underwriter—and without any type of medical examination or testing.

Some have justified this lack of a meaningful investigation into the applicant's medical condition by noting that it allows him or her to obtain a policy quickly.[13] But is speed the paramount concern? Certainly insurance companies, when evaluating claims for payment, do not put a premium on speed. What about the interest in properly assessing the risk posed by the applicant? If insurers did so, the consumer's coverage would be more secure, and the life insurance company could feel confident that it was issuing policies at the proper premiums and was protected from fraud.

Unfortunately, many states provide no incentive for such up-front scrutiny. Courts in Illinois, Missouri, and New York, for example, have held that insurers are entitled to rely on statements

Tips and tools for fighting postclaims underwriting

When countering a life insurance company's claim that the insured made a material misrepresentation in the policy application, keep in mind a few basics. For example, life insurers often apply less rigorous standards when initially evaluating applications than when conducting postclaims underwriting. Uncovering any inconsistencies between these two stages is key to defeating postclaims underwriting.

Contact the treating physician. When a claim is denied because the insured allegedly failed to disclose a medical condition, contact the insured's treating physician while you evaluate the case. If you file suit, the insurer will likely depose the physician, so it's better to talk to him or her sooner rather than later. Ask the physician if the condition would have had an impact on the insured's mortality. If not, it may be a case you want to take.

Obtain underwriting guidelines. Life insurance companies have vast, detailed underwriting guidelines that assign a rating to nearly every type of medical condition. During discovery, obtain the guidelines that cover the subject matter of the alleged material misrepresentation and, importantly, any other irregularities during the application process.

For example, if the policy was rescinded due to a failure to disclose a history of high blood pressure and the insured also had a known high cholesterol level, get the guidelines for both conditions. Check what rating the insured's high blood pressure would have received under the guidelines. Also match up the guidelines to the cholesterol test results to see if the insurer issued a proper rating. If not, the insurer will have a difficult time relying on a strict interpretation of its guidelines with respect to the undisclosed condition.

Depose the agent. If you think there were irregularities in the application process, depose the insurance agent (or, if it is an independent agent, consider hiring an investigator to take a statement). Ask whether all the application questions were read word-for-word to the insured. Press the agent on this point, since agents often omit or oversimplify questions when interviewing the customer. Also ask if the insured reviewed the application before signing it.

Although in some states, such as New York, courts have said that improper acts of agents are not legally significant—applicants are deemed to have approved the application by signing it—it can be helpful for a jury to hear that the agent may be the cause of the misrepresentation.

Assess mortality as a factor. Take the deposition of the underwriter for the policy and try to get a concession that mortality is the significant factor in underwriting. Ask: "Don't you agree that if a medical condition has no effect on a person's life expectancy, it should not affect the rate assigned to the policy?"

made in a life insurance application and have no obligation to perform an independent investigation to ascertain whether they are true.[14]

A decision from a New York federal district court (authored by Attorney General Michael Mukasey) denied the payment of a life insurance policy after the insured died in an automobile accident because he had not disclosed his driving history, which included a number of moving violations. According to the court, which noted that the widow-beneficiary had filed a bankruptcy petition and foreclosure actions had been commenced against her property, it did not matter that the insurer could have easily requested a copy of the driving record as part of the application process.[15]

Why should a life insurance company not be required to request this record—or obtain a signed authorization for it—if the company might later void a policy because of information contained in it?

In contrast, the law that applies to other types of fraudulent consumer transactions typically requires a party to act diligently to uncover the fraud before being able to recover damages. For instance, a New York appeals court ruled against a homebuyer who alleged that a seller falsely represented an adequate water supply and roof in good repair. The court said the buyer had failed to meet his responsibility to thoroughly inspect the property.[16]

Similarly, in a case of an alleged fraudulent sale of art, a New York federal district court noted that "if the [buyer] has the means of knowing, by the exercise of ordinary intelligence, the truth, . . . he must make use of those means, or he will not be heard to complain that he was induced to enter into the transaction by misrepresentations."[17]

Before issuing a life insurance policy, the insurer has the ability to fully inquire into the applicant's medical history—just as a homebuyer can inspect a property and a purchaser of art can appraise a painting. Yet New York law, and that of many other states, imposes no such requirement for insurers. Worse, life insurance companies that deny policies based on material misrepresentation do not have to show any intent on the part of consumers to deceive.

But there is no reason why insurers should not be held to the higher standards that consumers are held to. After all, the companies have various means at their disposal to discover the truth—and certainly do not lack knowledge and sophistication.

Better ways

The law of some states has evolved to become more favorable to life insurance consumers. For instance, although California has enacted by statute the material misrepresentation standard, its courts have allowed beneficiaries to explain "plausible reasons" for errors or omissions in an application, which, in turn, must be negated by the insurer.[18] California therefore allows the benefici-

If your retained medical expert, or better yet, the treating physician, will testify that the undisclosed medical condition had no effect on mortality, you should survive summary judgment. The underwriting guidelines are not the final word when it comes to assessing the risk posed by an applicant.

Find subjectivity. Most underwriters will readily admit that underwriting is subjective in nature and that the company underwriting guidelines do not always have to be followed. In fact, most underwriters have at some point deviated from the guidelines, even where the guidelines explicitly prohibit it.

A plaintiff can use this testimony to undercut the insurer's strict interpretation of its guidelines during postclaims underwriting.

Discover other policies. Life insurance cases should not be litigated in a vacuum. Most of the time, the insurer has previously evaluated applications involving the same medical condition at issue in your case. Ask for those applications and policies in discovery. Of course, some courts will allow more extensive discovery than others, but the objective is to uncover examples of how the insurer treated similar applicants.

Construct a waiver claim. Scour the policy application for inconsistent answers as well as answers that indicate the existence of the undisclosed condition. If the insurer was careless and disregarded information suggesting that the application was unreliable, or that the insured had the medical condition at issue, you may be able to successfully claim that the insurance company waived any right to deny coverage based on information the plaintiff did, or did not, provide.

For example, assume that the insurer cancelled a policy on the ground that the insured failed to disclose the existence of a tumor. But the insured revealed in the application that she had recently undergone a CT scan. The insurer never investigated, and the CT scan revealed the existence of the tumor. You can claim that the insurer should have investigated the CT scan and that it alone should bear the burden of its failure to do so.

Tap the Medical Information Bureau (MIB). This is an insurer-sponsored entity used by most insurance companies as a clearinghouse for medical information about people who are insured (www.mib.com). For instance, if John Smith has diabetes and applies for life insurance with company A, the company will enter a numerical code indicating that John Smith has diabetes and send the information to the MIB. If John Smith later applies for a policy with company B, that company can run a name search for him with the MIB that would reveal the code for the condition. Check to see whether the insurance company in your case received information from the MIB about the insured. ■

—Eric Dinnocenzo

ary to set forth as a defense that the agent was careless or negligent in filling out the application.[19] The state legislature, however, should enact a change to the law so that the standard that applies to postclaims underwriting for health insurance contracts also applies to those involving life insurance.

Louisiana requires that an insurer prove not only that a false statement had a material effect on its risk, but that the statement was also made with an intent to deceive.[20] Massachusetts has adopted a nuanced approach in which the material misrepresentation standard applies in cases where the insurance company has conducted a physician examination of the insured, but in all other cases the insurance company has a higher burden to prove that the misrepresentation was "willfully false, fraudulent, or misleading."[21]

Massachusetts enacted this two-tier law to encourage insurance companies to comprehensively investigate the risk posed by applicants before issuing policies. The goal was to prevent situations where there was a misunderstanding that later resulted in serious hardship to the beneficiary. As the state's high court noted:

> If . . . risks are taken without a medical examination, alleged misrepresentation by the applicant—who in a large number of these cases is made to understand next to nothing of the statement he is asked to sign—as to his physical condition, ought not to be permitted as a bar when a claim arises. Misrepresentation by the agent and misunderstanding by the assured now lead, under the methods thus pursued, to almost innumerable cases of hardship and injustice.[22]

It may not be a perfect legislative scheme for consumers, but Massachusetts has taken a thoughtful and considered approach. Its law acknowledges that both the insured and the insurer have an obligation to make the transaction as honest and accurate as possible.

Most states do not require a causal connection between alleged misrepresentation and cause of death for a life insurer to void a life insurance policy. The Michigan Supreme Court, for instance, denied a claim after the insured failed to disclose a health problem completely unrelated to his death.[23] The Tennessee Court of Appeals upheld a policy rescission for failure to disclose psychiatric treatment after the insured died in a car accident.[24]

Is speed in obtaining a policy the paramount concern? When evaluating claims for payment, insurers do not put a premium on speed. What about assessing risk at the outset?

But Missouri is a notable exception to this approach. Its law requires that any alleged misrepresentation must have "contributed to the contingency or event on which the policy is to become due and payable."[25]

Reforms and remedies

As plaintiff lawyers know, when bringing negligence claims, causation is a critical element of proof. And in any breach-of-contract action, the breach must have caused the damages that are claimed.

Life insurance laws should be no different. Insurance companies may claim an entitlement to a more favorable legal standard because they are subject to contestability periods. But no contestability period puts insurers on a different footing than parties in other types of litigation. Just ask medical negligence plaintiffs in Nevada and Tennessee, who must file a claim within one year of discovery of the alleged negligence and no later than three years after the act occurred.[26] These plaintiffs certainly do not have a lesser burden of proof with respect to their claims filed against doctors and hospitals.

Moreover, insurers are able from the outset to investigate applicants' backgrounds and detect any irregularities in their applications. Thus, the discovery rule that tolls the statute of limitations does not apply here. Put another way, if the insurer fails to discover that an applicant had a medical condition before it issues a policy, it alone should bear the risk unless there are special circumstances that would make such a result unjust.

To remedy the disparity between life insurance laws and those governing other consumer transactions, states should first jettison the material misrepresentation standard and replace it with the fraud standard. In that case, the insurer would have to prove both that the insured had an intent to deceive and that there is causal connection between the misrepresentation and the cause of death.

Alternatively, a less generous reform —which could be made for consumers in states where the material misrepresentation standard exists—would be to require insurance companies to show that the undisclosed medical condition, if it had been known, would have caused the insurer to deny coverage. Any difference between the premium rate originally assessed for the policy and the correct rate, taking into account the previously undisclosed condition, would be deducted from the full policy amount at the time of payment.

The bottom line is that states need to encourage insurance companies to better evaluate the risk posed by applicants, including having a licensed physician perform a medical examination. States also need to discourage postclaims underwriting. If an application contains answers that are inconsistent or can reasonably be recognized as false, the insurance company should be deemed to have waived its defenses in litigation if it did not properly investigate.

Also, state agencies should impose tough measures against insurance companies and their agents who engage in unscrupulous conduct. And insurers should better monitor their agents.

These reforms would constitute a

sea change in many states. But the result would be better protection for both insurance companies and their customers. Significantly, the confusion and carelessness that at times plague the application process could be prevented so that beneficiaries would receive the financial protection they need and expect. ■

Notes

1. *E.g.* N.J. Stat. Ann. §17B:25-4 (West 2006); N.Y. Ins. Law §3203(a)(3) (McKinney 2006); *see also Appleman on Insurance* §178.03 (2d ed. 1998).

2. *Appleman*, *supra* n. 1.

3. *Hailey v. Cal. Physicians' Servs.*, 69 Cal. Rptr. 3d 789, 799 (App. 2007), *modified on denial of reh'g*, (2008) (quoting *Lewis v. Equity Natl. Life Ins. Co.*, 637 So. 2d 183, 188-89 (Miss. 1994)); *see also* Rebecca Porter, *Lawsuits Challenge New Heath Insurer Tactics to Deny Claims and Benefits*, TRIAL 14 (June 2008).

4. Ariz. Rev. Stat. §20-1109 (2008); *Pinette v. Assurance Co.*, 52 F.3d 407, 411 (2d Cir. 1995) (Connecticut); *Fernandez v. Bankers Natl. Life Ins. Co.*, 906 F.2d 559, 565 (11th Cir. 1990) (Florida); *Bush v. Washington Natl. Ins. Co.*, 534 N.E.2d 1139, 1142 (Ind. App. 1989); *Lamark v. Lincoln Income Life Ins. Co*, 169 So. 2d 203, 206 (La. App. 1964); *Oade v. Jackson Natl. Life Ins. Co.*, 632 N.W.2d 126, 130 (Mich. 2001); *Mass. Mut. Life Ins. Co. v. Manzo*, 584 A.2d 190, 194, 196 (N.J. 1991); *Mut. Benefit Life Ins. Co. v. JMR Elec. Corp.*, 848 F.2d 30, 32-33 (2d Cir. 1988) (New York); *Montgomery v. Reserve Life Ins. Co.*, 585 S.W.2d 620 (Tenn. App. 1979).

5. *See Mut. Benefit Life Ins. Co.*, 848 F.2d at 34.

6. *Nationwide Ins. Co. v. Dorch*, 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).

7. *See Zachary Trading*, 668 F. Supp. at 346.

8. *Mut. Benefit Life Ins. Co*, 848 F.2d at 34 (quotations omitted).

9. *Appleman*, *supra* n. 1, at §4.34.

10. Mutual of Omaha Life Insurance Application, www.quotit.net/resources/Apps/LifeApps/United%20of%20Omaha/application.pdf.

11. 69 Cal. Rptr. 3d at 800.

12. *Lilley v. Protective Life Ins. Co.*, 1989 WL 8831 at *7 (E.D. La. Jan. 27, 1989), *rev'd*, 884 F. 2d 575 (5th Cir. 1989) (table).

13. *See e.g.* David T. McDowell & Jarrett Ganer, *In Defense of Contestability: If Post-Issuance Investigations Amount to Bad Faith, Then What's the Point of Contestability?* (Feb. 13, 2008), http://tinyurl.com/559p92.

14. *Brandt v. Time Ins. Co.*, 704 N.E.2d 843, 846 (Ill. App. 1998); *Smith v. AF & L Ins. Co.*, 147 S.W.3d 767, 777 (Mo. App. 2004); *John Hancock Life Ins. Co. v. Perchikov*, 553 F. Supp. 2d 229, 239 (E.D.N.Y. 2008).

15. *Saint Calle v. Prudential Ins. Co.*, 815 F. Supp. 679, 687 (S.D.N.Y. 1993).

16. *See Cohen v. Colistra*, 649 N.Y.S.2d 540, 542 (App. 1999).

17. *Levin v. Gallery 63 Antiques Corp.*, 2006 WL 2802006 at *8 (S.D.N.Y. 2006) (citation omitted).

18. *Lettieri v. Equitable Life Assurance Socy.*, 627 F.2d 930, 932 (9th Cir. 1980) (discussing *Thompson v. Occidental Life Ins. Co.*, 513 P.2d 353 (Cal. 1973)).

19. *Boggio v. California-Western States Life Ins. Co.*, 239 P.2d 144, 145-46 (Cal. App. 1951).

20. *Coleman v. Occidental Life Ins. Co.*, 418 So. 2d 645, 646 (La. 1982).

21. Mass. Gen. Laws ch. 175, §124 (1998); *Protective Life Ins. Co. v. Sullivan*, 682 N.E.2d 624 (Mass. 1997); *Robinson v. Prudential Ins. Co.*, 776 N.E.2d 458, 460 (Mass. App. 2002).

22. *Sullivan*, 682 N.E.2d at 630-31 (citation omitted).

23. *Wickersham v. John Hancock Mut. Life Ins. Co.*, 318 N.W.2d 456, 460 (Mich. 1982).

24. *Montgomery*, 585 S.W.2d at 620.

25. Mo. Rev. Stat. §376.580 (2002).

26. Nev. Rev. Stat. §41A.097 (2004); Tenn. Code Ann. §29-26-116 (Lexis 1980).