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The *WRNewswire* is created exclusively for AALU Members by insurance experts led by Steve Leimberg, Lawrence Brody and Linas Sudzius. *WRNewswire #15.01.26 was written by Steve Leimberg*, co-author with Howard Zaritsky of Tax Planning With Life Insurance, Publisher of Leimberg Information Services, Inc. (LISI) and CEO of Leimberg & LeClair, Inc.

TOPIC: *American General v. Underwood* Part One: Impact of Failure to Disclose Change in Medical Condition

CITE: *American General Life Insurance Company v. Brenda K. Underwood*; No. 3:10–CV–63 2015 WL 137529 (U.S. D. C., E.D. TN Knoxville Div.).

SUMMARY: American General sued to rescind a life insurance policy or have the court declare that the policy never became effective. Brenda Underwood, the defendant, asked the court to hold that insurance coverage was in existence at the time of the death of her husband, David Underwood. The court granted American General's motion for summary judgment. American General's only obligation was the return of the premiums paid plus interest to the date of entry of the court's opinion and order.

American General also filed a third-party suit against the insurance agents involved in this case. This very important complaint will be the topic of a soon-to-follow *WRNewswire*.

RELEVANCE: *WRNewswires #14.08.21 and 14.07.29* on *Ramsey* and *PWPG v Primerica* reminded readers—as does this court—that when a proposed insured does not disclose material medical information initially *or* upon attempted policy delivery, the "Good Health" clause is violated. That clause is assurance by the proposed insured that "present facts" *remain* true, i.e. if the insured's health changes between the application date and the delivery date, the insurer can refuse delivery or declare the contract void from inception because the policy's terms were not met. Remember that the applicant does not need to know the exact nature of the physical ailment from which he suffers or is treated. He has a duty to inform the insurer of changes regardless of a lack of specific knowledge of his medical condition. The insurer has the right to know all that the applicant knows about the state of health and medical history. If an insurer asks a specific question, that alone is enough to establish materiality.

Medical intervention *after* the date of the application makes the duty to disclose obvious. The proposed insured must stand behind answers in the application and any amendments, inform the insurer of changes, and be truthful.

Finally, the law presumes that persons who sign documents, having been given the opportunity to read them, are bound by their signatures. Ordinarily, a person who has the ability and opportunity to be informed of the contents of a writing before signing it will not be allowed to avoid it due to ignorance of its contents or failure to read it.

With respect to the law suit against the agents which we will be reporting on in more detail soon, at this point, AALU members should take away from this case a reminder of the obvious, i.e., if an agent knowingly submits an application that contains material misrepresentations or material omissions or is complicit in the delivery of a policy when the agent has knowledge of a material change in the proposed insured's circumstances, or that someone other than the proposed insured has signed in the insured's place, legal action by the insurer can be anticipated and the ensuing liability and potential loss can be significant.

FACTS: On September 8, 2008, David Underwood signed Part A of an application for a $300,000 20-year term life policy with American General. He signed Part B of the application on September 24, 2008. David's wife Brenda was the primary beneficiary. The policy had a two-year contestability period.

The application required David to attest (among other things) that (1) he read the statements contained in this application and any attachments (2) they were true and complete to the best of his knowledge and belief and (3) any misrepresentation contained in the application and relied on by the insurer could be used to reduce or deny a claim or void the policy *if* (1) such misrepresentation materially affected the acceptance of the risk; and (2) the policy was within its contestable period.

David also stated that he understood and agreed that—even if he paid a premium—no insurance would be in effect unless or until all three of the following conditions were met: (1) the policy was delivered and accepted; (2) the full first modal premium for the issued policy was paid; and (3) there was no change in his health that would change the answers to any questions in the application before items (1) and (2) in this paragraph had occurred. He agreed that if all three conditions above were not met (1) no insurance was in effect; and (2) the Company's liability was limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded. He also affirmed that no agent is authorized to accept risks or pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements.

On January 19, 2009, David saw Dr. Anthony Morton for complaints of posterior cervical discomfort, fever, and chills which he had for a week. Morton prescribed Septra, Bactroban, and Hibiclens and told David to return if not improved.

At delivery of the policy on January 24, 2009, David signed a Health Statement Policy Acceptance Acknowledgement which provides in relevant part:

> I represent, on behalf of myself and any dependent that may have been proposed for insurance, that to the best of my knowledge and belief:
>
> 1. There have been no changes since the date of the application in either health or in any other condition which would affect insurability; and

2. Neither I nor any other proposed insured has, since the date of the application:

A. Consulted a doctor or other practitioner or received medical or surgical advice or treatment.

B. Acquired any knowledge or belief that any statements made in the application are now inaccurate or incomplete.

I hereby represent that I have read, understand and verify the accuracy of the statements made above. I agree that this Acknowledgment will be made a part of the policy. I understand that if any statement above is not true, I should not sign this form. Instead, I should have the policy returned to the Company with full details for further underwriting consideration.

On January 26, 2009, David again saw Dr. Morton who found on examination bilateral axillary lymphadenopathy masses and noted, "*Findings are suspicious for development of lymphoma*." He requested a referral to surgery for a biopsy. The following day David went to the emergency room because of an altered mental status. A biopsy revealed he had a lymphoproliferative disorder.

On October 4, 2009, David died from lymphoma and hemolytic anemia.

On November 9, 2009, Brenda Underwood submitted a claim for benefits.

Because David had died within the two-year contestability period, American General conducted a contestability investigation. When it received the records from Dr. Morton showing that David had seen him on January 19, 2009, and January 26, 2009, the insurer denied benefits under the policy based on misrepresentation of pertinent information on the health statement. The letter also stated that American General was rescinding the policy, *"making coverage null and void from the inception date."* American General represented that it would make a full refund of the premiums paid plus interest.

Did Coverage *Ever* Exist?

American General contended that no insurance ever took effect because the *conditions precedent* for the creation of coverage were not met. The application provided that insurance would not exist unless there had been *no changes* in the proposed insured's health that would change the answers to any questions in the application before delivery and acceptance of the policy and payment of the first premium. American General argued that there *were* changes to David's health that would have changed the answers to the questions cited above in the application before delivery of the policy and payment of the premium. As a result, it argued, no insurance came into effect. Specifically, five days prior to delivery of the policy, David (1) consulted a physician, (2) had an illness, and was (3) prescribed medications. None of these facts were noted by the signer of Part B of the application.

Brenda Underwood countered that the change in David's health was not a material change because he thought he was suffering from a cold or flu, not a serious condition. However, the court noted that the health statement directly asked whether—since the date of the Application—the proposed insured had *"consulted a doctor or other*

practitioner or received medical or surgical advice or treatment." It did not limit or qualify the inquiry by asking whether the consultation was for a minor illness or whether the proposed insured thought he was suffering from the flu, a cold or other less serious condition when he saw a doctor. The request was a blanket inquiry and was obviously seeking information about *any* doctor visit or treatment, *regardless of the severity*.

Here, it is clear that the facts show a change in David's health occurred *prior* to delivery of the policy. David was experiencing symptoms that warranted seeing his physician who placed him on three medications. That would have changed answers to key questions in the application, all conditions precedent that had to be met before the policy of insurance could come into effect. Because they were not met, the court held that no contract of insurance was formed.

_If_ Coverage Existed, was American General _Still_ Entitled to Rescission?

American General also contended that even if coverage existed, misrepresentations on the health statement increased its risk of loss so it was entitled to rescission of the policy, relying on state (Tennessee) law. The insurer argued that there were misrepresentations in the health statement stemming from David's changed health condition. Tennessee law provides in pertinent part:

> No written or oral misrepresentation ... in the application for contract or policy of insurance, by the insured or in the insured's behalf, shall be deemed material or defeat or void the policy or prevent its attaching, *unless* the misrepresentation or warranty is made with actual intent to deceive, *or unless the matter represented increases the risk of loss*. (emphasis added).

The court noted that this state law provision "authorizes an insurance company to deny a claim for benefits in two circumstances—if (1) the insured made intentional misrepresentations on the application *or* (2) if the insured made misrepresentations that increased the insurer's risk of loss...."

Misrepresentations, *even if unintentional*, may void an insurance policy if they increase the risk of loss to the insurer under the policy. Courts will evaluate whether the misrepresentation is of such importance that it naturally and reasonably influences the insurer's judgment in making the contract. If the insurer can prove it was denied information requested in good faith, and deemed necessary to an honest appraisal of insurability, that showing will be sufficient to establish the grounds for an increased risk of loss. It is *not* necessary for the insurer to prove it would not have issued the policy had the truth been disclosed.

The insurer argued that four *mis*representations were made: (1) that David had not seen a doctor five days prior to delivery of the policy; (2) that David had not been experiencing symptoms of cervical discomfort, fever, and chills for more than a week; (3) that David had not received medical treatment since the date of application and had not been prescribed the medications; and (4) that David had not acquired knowledge that three of the statements made in the application were incomplete or inaccurate at the time of executing the health statement.

The court found that reasonable minds could not differ as to whether misrepresentations were made when the health statement updating the application was executed.

With regard to whether the misrepresentations increased the risk of loss, American General's Director of Underwriting Services testified that if it had known about David's visit to Dr. Morton on January 19, 2009, the underwriters would have demanded an attending physician statement (APS). She further testified, "…had we known that the answers in the Application were false as of January 24, 2009, the Policy would not have been issued as applied for until such time as a review of those answers was completed."

Note: Brenda admitted that she—and not David—signed the health statement. She argued that the policy should not be voided nor coverage denied because "if a policy is completed and signed without authority, misrepresentations will not void the policy." In fact Jack Barker, the agent who delivered the policy papers (and who has been named a defendant in the lawsuit by the insurer against the agents), testified that he told Brenda to "read this" and that she "said she could sign for it." Yet Brenda testified that she could not remember whether she read the health statement and that she thought she was just signing to accept the policy.

This did not change the court's analysis. She had an obligation to read what she was signing. She knew her husband had seen Dr. Morton and had been prescribed three medications when she signed the health statement. American General noted that, even if it allowed Brenda to sign the health statement, which it denied, her signing still bound David. At the time she signed David's name on the health statement, Brenda knew that he had seen a doctor recently and had been prescribed medication. She had information concerning her husband's health that was directly addressed in the health statement and relevant to the coverage. The health statement also provided, *"I understand that if any statement above is not true, I should not sign this form. Instead, I should have the policy returned to the Company with full details for further underwriting consideration."* Whether she read the health statement or not, she is charged with knowledge of its contents.

According to the court, the inquiry *"is whether the misrepresentations increased the risk of loss generally, such that an insurer having the benefit of truthful information would have charged a higher premium to protect itself against an increased risk of loss, or otherwise deemed the risk altogether unacceptable*." The court concluded that the misrepresentations in the health statement that were directly related and integral to the application were such that they were likely to influence the judgment of the insurer in forming the contract.

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