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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 #15.06.22 was written by Steve Leimberg, co-author with Howard Zaritsky of Tax Planning With Life Insurance, Publisher of Leimberg Information Services, Inc. (LISI) and Creator of NumberCruncher Software.*

TOPIC: FAILURE TO INFORM INSURER OF CHANGE IN HEALTH PRIOR TO POLICY DELIVERY

CITATION: *Ramsey v. Penn Mut. Life Ins.Co.*, No. 14-3869 (6th Cir. 2015); Ohio Revised Code Section 3911.06.

SUMMARY: Penn Mutual refused to pay death benefits to named beneficiary Barbara Ramsey upon the death of her husband, John. The district court concluded that John had failed to inform Penn Mutual of a change in the status of his health prior to the delivery of his life insurance policy and that this breach of a contractual representation allowed the insurer to deny payment. On that basis, the district court granted summary judgment to Penn Mutual.

The 6th Circuit Court of Appeals overturned that decision. It held that summary judgment was inappropriate because there is a genuine dispute as to whether Ramsey misrepresented the state of his health by failing to disclose his rectal bleeding and doctor visits in 2010, and because the policy would be only voidable on that basis, not void. It remanded the case back to the district court for reconsideration.

RELEVANCE: Regardless of the eventual outcome, this case emphasizes important points we've made before (See *WRNewswire 14.12.22*):

- A policy applicant does not need to know the exact nature of a physical ailment from which he suffers or for which he has been treated before he is *required* to inform the insurer of that information *prior* to acceptance of the policy.

- The applicant has a contractual obligation to inform the insurer and update the answers given in the application if there is a change of health between the time the policy was applied for and the date it is delivered.

Life insurance policies are traditionally contracts of uberrimae fidei, utmost good faith. A a failure by the insured to disclose material conditions affecting the risk makes the contract voidable at the insurer's option. The duty to inform the insurer becomes obvious when medical intervention is necessary in the interim between application and policy delivery. That duty cannot be avoided by claiming that the applicant "did not know the ultimate findings of the tests" before the policy was delivered.

The key question is,

"Would the insurer unquestionably have made further inquiry before delivering the policy had it known the new or undisclosed facts?"

Regardless of the ultimate outcome of this case which has now been sent back to the district court, policy applicants must:

(1) stand behind their answers in the insurance application,
(2) keep answers they give in the application truthful and
(3) inform the insurer of any changes, up to the delivery date of the policy.

FACTS: In February 2010, John Ramsey applied for life insurance with Penn Mutual. He stated that he had been hospitalized for colitis in 1984 but that he had made a "full recovery" and had last been seen for this condition in 2006 and that the exam yielded "normal findings." Ramsey signed the typical good health representation under which he agreed insurance would not be issued unless (a) the first premium was paid in full, (b) the policy was delivered, and (c) his "health, habits, occupation and other facts" are "the same as described" in the application, the medical examiner's report, and in any subsequent amendments or supplements.

Penn Mutual obtained various medical records. After reviewing those health records, it offered to insure Ramsey – but at a higher than usual (i.e. a *rated)* premium.

Ramsey, meanwhile, unknown to Penn Mutual, was seeing a Dr. Lavery for serious and continuing rectal bleeding and diarrhea. However, when asked to sign an amendment, Ramsey did not disclose that he had seen Dr. Lavery in April and May of 2010, despite having represented in the original application that he had not seen Dr. Lavery since 2006.

Soon after the policy was issued (June 24, 2010), during surgery to address five months of "rectal bleeding and diarrhea," Ramsey was discovered to have colon cancer. He died fifteen months later due to complications from that cancer.

Ramsey's wife, Barbara, filed an application for death benefits. But Penn Mutual rescinded the policies, returned the premiums, and denied payment of death benefits. The insurer argued that a *condition precedent* to formation of a valid contract of insurance was that Ramsey's health be the same at the time the insurance policy was delivered as it was at the time of the application. Ramsey's serious gastrointestinal problems, including frequent, bloody stools, prior to delivery of the policy showed his health was *not* the same as when he applied for the coverage.

Penn Mutual also asserted that any right to recover under these policies was precluded by Ramsey's knowingly false answer to the question in the application and the application amendment concerning

whether he had indications of intestinal bleeding. Ramsey "knew of his treatments between the time of the application and the delivery of the policies, and knew that they rendered untrue the statement in the application that he 'had no gastrointestinal problems since (2004).'" Since they were made without any knowledge by the insurer of their falsity, and induced the insurer to deliver insurance policies that—but for the false answers would *not* have been delivered—Ramsey violated state law which renders the policies void *ab initio*.

Barbara Ramsey countered that her husband's answers on both the application and the application amendment were not false nor willfully intended to defraud, and further that Penn Mutual had knowledge of the actual situation and still issued the policy and so cannot claim ignorance. She claimed John was simply experiencing "characteristic symptoms of colitis" in his abdominal pain and bloody stools and that Penn Mutual knew of those symptoms and these occurrences were neither unusual nor remarkable to Ramsey. Therefore, she contended, when he submitted his answers, there was no change in his health—at least in his mind and to his knowledge—and thus no willful falsity on his part.

As noted above, the district court found for Penn Mutual. First, it focused on the "good health" requirement. It noted that this "clause does not refer to a future act or event, but rather is an assurance that the present facts, which the parties all suppose to then be true, remain true." Therefore, technically, that provision is *not* a *condition precedent* but rather a *representation*—but, according to Penn Mutual, one that is in fact a *condition* of the policy. Therefore, if the applicant's health changes between the time of his application and the date the life insurance was to take effect, the insurer could refuse payment since the policy's terms had not been met. Here, Ramsey represented (in essence promised) as part of the insurance contract that his health—at policy delivery—would be the same as he represented it in the application and its amendment. In fact, his health was not the same and Ramsey neglected to so inform Penn Mutual. According to the district court, this was sufficient to permit Penn Mutual to deny payment.

Here is the reasoning of the higher court in *reversing* the district court's summary judgment: First, Ramsey had amended his original answer to the question which asked when he had "last seen" Dr. Lavery. He changed his answer in an amendment to the application to reflect that he had not had a *colonoscopy* since 2004. The June 1 amendment, which became a part of the representation contained in his application took the place of his original answer.

A court, before awarding summary judgment, must construe all reasonable inferences in the Plaintiff's favor. Ramsey visited the doctor regarding his colitis once every few years and during that time "consistently and regularly experienced" colitis symptoms, "rarely discussed the specifics of his symptoms," "was not a 'complainer,' and had an abnormally high tolerance for pain and discomfort." Therefore, the appeals court found that "it is fair to infer —and a jury could reasonably conclude - that Ramsey's "last seen in 2006" answer and subsequent doctor visits in 2010 connote nothing as to the ongoing severity or non-severity of his colitis symptoms. The appeals court further concluded that it is also fair to infer that Ramsey's June 1, 2010, statement that "he had suffered no gastrointestinal problems since his last colonoscopy in 2004" was not a misrepresentation as to the state of his health. The insurer knew Ramsey suffered from chronic ulcerative colitis which its own underwriting guidelines define as a disease "characterized by attacks of bloody diarrhea punctuated by periods of remission.

According to the appeals court, because Ramsey was forthright with Penn Mutual about this condition, there was at least a genuine issue of material fact as to whether his rectal bleeding in 2010 was simply a continuation of the problems Penn Mutual was already aware of or was "manifestly something new." The appeals court noted that there was no evidence in the record that either Ramsey or his doctors knew that he had cancer prior to the delivery of his policy. The symptoms of rectal cancer are exactly the same symptoms that colitis presents, a fact and a risk that Penn Mutual knew about—and accounted for. In fact, its underwriting guidelines noted that Ramsey's colon resection procedure "is now rarely performed as persistent or recurrent symptoms almost invariably occur, and there is a risk of cancer developing in the rectal stump." Penn Mutual knew of his chronic condition and all of its attendant symptoms and also was aware of a prior surgical procedure that increased his risk of cancer. It accordingly charged him a higher premium and rated him at one of the lowest ratings offered by the company. Taken in the light most favorable to the policy's beneficiary, the plaintiff, all of this evidence added up to a genuine dispute as to whether the state of Ramsey's health at the time of the delivery of his policy was the same as described in his application.

Perhaps more important is that fact that state (Ohio) law dictates that while a false representation regarding the state of the insured's health renders the policy voidable at the insurer's option, it "may not be used to avoid liability arising under the policy *after* such liability has been incurred." Penn Mutual incurred liability to pay death benefits under the policy when it issued the policy with the rating. According to the appeals court, once Penn Mutual accepted the risk under those conditions, it could not later rely on a change in health misrepresentation (if in fact it was) as a defense to liability.

Under Ohio law, "No answer to any interrogatory made by an applicant in his application for a policy shall bar the right to recover upon any policy issued thereon, or be used in evidence at any trial to recover upon such policy, unless it is clearly proved that such answer" is (1) willfully false, (2) fraudulently made, (3) material, (4) induced the company to issue the policy, that but for such answer the policy would not have been issued, and (5) the agent or company had no knowledge of the falsity or fraud of such answer.

The statute requires an insurer to show only "that the applicant knowingly provided a false answer," not necessarily fraudulent intent. However, this law is not appropriate as a defense where, as here, there is evidence that the insured may have merely made an honest mistake. The court stated that "a jury could reasonably conclude on this record that Ramsey honestly believed that he had fully disclosed his medical conditions."

Penn Mutual had also argued that the policy never came into force because the "same health as described" provision was a condition precedent to the formation of the contract. The appeals court, in addition to reiterating that there is a genuine issue of material fact as to whether Ramsey's health remained the same as described in the application, noted that that the policy's "same health as described" provision was a *not* a condition precedent. Absent an explicit intent to establish a condition precedent, courts will not interpret a contractual provision in that manner...." Ohio law defines a condition precedent as "one that is to be performed before the agreement becomes effective. It calls for the happening of some event or the performance of some act ... before the contract is binding on the parties. Stated another way, a condition precedent is an act or event (other than a lapse of time) which must exist or occur before a duty of immediate performance of a promise arises. Provisions that merely require that a "state of facts ... remain true" are *not* conditions precedent. Hence, a change in

Ramsey's health as described in the application prior to delivery of the policy would render his contract *voidable*, not void *ab initio*.

What of the duty of the parties to a life insurance contract to deal in good faith with each other? The appeals court did not take exception to that most important rule but noted that (1) there is a genuine dispute regarding whether Ramsey's health as described in the application actually changed prior to the policy's delivery and (2) even if Ramsey breached his duty of good faith by misrepresenting the status of his health, Ohio law does not allow Penn Mutual to void the policy on that basis *after* accepting and incurring liability under its own terms. So the appeals court here decided that summary judgment was inappropriate because there is a genuine dispute as to whether Ramsey misrepresented the state of his health by failing to disclose his rectal bleeding and doctor visits in 2010, and because the policy would be only *voidable* on that basis, not void.

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