Civil Practice Committee Article for *Bar Briefs*

Learning to Sweat the Small Stuff in Life Insurance Litigation

By Brian D. Wassom

Most general practitioners are bound to handle a life insurance dispute at some point, but many may not be familiar with some of intricacies. As luck would have it, several of the matters I've litigated at Detroit's Honigman Miller Schwartz and Cohn LLP have involved defending life insurance companies in suits by claimants who have been denied benefits. That fact alone will keep me from winning any popularity contests. But in every such case that I've had, it was the insured—whether through poor choices, oversight, or blatant dishonesty—that was ultimately responsible for leaving their chosen beneficiary empty-handed. While I'm no expert in the field, I offer the following issues that I've encountered in Michigan courts in the hope of helping honest applicants avoid coverage-threatening mistakes, and of aiding insurers' attorneys in plugging the financial drain of fraudulent claims.

Different Dates Mean Different Things. My first insurance case began with a very troubled Macomb County man I'll call Alex Harris [only the names herein have been changed]. In November 1997, he bought a life insurance policy. It included a typical clause prohibiting the payment of benefits if he committed suicide within the first two years. Unfortunately, Harris did kill himself—in late November 1999, slightly over two years after he first applied and paid for the policy. Trouble was, however, that the "suicide exclusion clause" ran from the policy's "date of issue," not the application date—and Harris's policy wasn't issued until mid-December 1997. Harris's beneficiary, therefore, was excluded from receiving the policy's death benefit.

Harris could've assumed that the two-year exclusion clause ran from the date he bought the policy, rather than the issue date. Does that, as the beneficiary argued, render the suicide clause ambiguous? The judge said "no." The clause clearly listed the "date of issue" as its starting point. The policy's "date of issue"—the day it was actually approved and mailed by the insurer—was unmistakably stamped in bold letters on the policy's cover, which the judge recognized as the standard industry practice. Even if Harris had confused the "date of issue" with the application date, or some other date, such confusion would not render the policy's plain meaning ambiguous. Michigan courts have made clear that policies may contain more than one date on which something significant happens. Confusing the significance of these different dates will not render the policy ambiguous.

Pay Attention to Application Amendments. One reason offered for why the issue date of Harris's policy was ambiguous was a dispute over when coverage actually began. On the day he applied for the policy, Harris received a "conditional receipt." Harris could have been covered under the receipt, before the policy itself was issued, if, among other things, he turned out to be eligible for the exact type of policy he applied for. He wasn't. Instead of being insured as a "Preferred Non-Smoker," he got a "Standard Non-Smoker" policy. The insurer issued Harris an application amendment to reflect the change. Harris's signature on the amendment sank the argument that his policy took effect anytime other than its "date of issue."

Another claim against my client was also undone by an application amendment. A man I'll call Buddy Summers was a northern Michigan business owner who got insurance on his life to secure a loan made to his company. As his untimely end from cancer drew near, however, Summers switched the beneficiary of the policy from his lender to his children. Both sets of beneficiaries made claims. Both were denied, in part because of a critical misrepresentation in Summers's application amendment.

When Summers applied for his policy in January 1999, he represented that he did not have cancer and had not visited a doctor in the past five years. Like Harris, however, Summers did not get a policy at the level of risk he applied for, and was asked to amend his application accordingly. Included on the one-page form, however, was preprinted language attesting that his prior representations regarding his health and doctor visits continued to be true as of that day. By that time, however, Summers had already seen several doctors about a lump that had been diagnosed as malignant. In essence, Summers lied about his health in order to get insurance he wouldn't have gotten otherwise. (Lest your ire be raised in Summers's defense, the representation was in plain language and normal typeset, and his agent testified to instructing Summers to read the statement.)

"Material Misrepresentations" Void Life Insurance Policies. MCL § 500.2218 renders an insurance policy void *ab initio*—as if it never existed—if the insured is found to have made material misrepresentations in the application. Many lawyers unfamiliar with insurance law miss this section because of its curiously misleading title. Although § 2218 is labeled "Disability insurance; false statement in application; effect," the statutory text itself and plenty of interpretive case law confirm that the provision applies equally to life insurance.

A "material misrepresentation" in connection with an insurance contract differs significantly from the six-part tort of "fraudulent misrepresentation." It is defined as any false statement of fact made before a policy is issued that, had the insurer been aware of the truth, it would not have issued the same policy. Several elements of this test favor insurers. First, the insurer need not show that it actually relied on the misrepresentation, only that it materially affected the risk assumed. If the fact misrepresented relates to the eventual cause of death, it is presumptively material. Second, the test is wholly subjective; an affidavit from an informed employee of the insurer that *this* insurer would not have issued the policy is sufficient, regardless of what another insurer or an "objectively reasonable" one would've done. Third, the fact that the insurer might've issued a different policy, even a highly similar one, is immaterial. If knowledge of the true facts would've prevented the issuance of the *exact same* policy actually received, the misrepresentation was material. Finally, whether or not the insured's intended to defraud is irrelevant.

Obviously, Summers's representation that he did not have cancer, when in fact he did, was material. But equally damning were his denials of having seen a doctor. This alone can be sufficient to void a policy, since knowledge of the doctor visits could have prompted the insurer to investigate them before issuing the policy. Indeed, under MCL § 500.2218(4), denying a doctor visit is legally equivalent to denying all ailments or impairments that were treated or discovered as a result of the visit.

Misrepresentations Can Void Even "Incontestable" Policies. Most are familiar with the statutorily mandated clauses that render a policy "incontestable" after two years. Nevertheless, these are still clauses *in the policy*. How can they be enforced if the policy is held void *ab initio*, never to have legally existed?

This question arose in the case of "Mama Giles." Mama Giles, a private yet socially active matriarch of a large Ann Arbor-area family, passed away after a brief bout with cancer that took most of her family by surprise. Inter-sibling rivalries led to some predictably hostile disputes over who the proper beneficiaries were. One of the disaffected Giles children produced compelling evidence that Mama Giles had actually been diagnosed with her fatal disease years before applying for the policy, but had managed to keep it secret after the disease went into remission. Nevertheless, because the policy had long since become incontestable, we initially assumed that we'd have to pay the death benefit.

That is, until a jogged memory and some quick research revealed the seldom-cited decision in *Dedic v Prudential Life Ins Co of Am*, 14 Mich. App. 274 (1968). The *Dedic* court squarely held that even an incontestable policy can be rendered void by material misrepresentations in the application. The rule makes good policy sense. As one professor's law review article observed, "the incontestable clause should not cloak deception with respectability so that fraud seems to be okay if you can simply make it past the two year period."

Curiously, *Dedic* has fallen into relative obscurity in Michigan courts. But as recently as 1999, a dissenting opinion by a Sixth Circuit judge noted the logic and apparent vitality of its holding. Somewhat dishearteningly, though, we were unable to secure a more authoritative precedent on that argument; after we moved to amend our interpleader complaint based on *Dedic*, the several opposing lawyers quickly agreed to a highly favorable settlement.

Incontestability Doesn't Bar Exclusion Clauses, Either. Similarly, the fact that a policy has become incontestable doesn't bar the operation of a "suicide exclusion" clause like Harris's.
At first glance, to deny benefits on the basis of an exclusion clause strikes the average listener as an awful lot like contesting the policy's validity. It isn't. Instead, exclusion clauses simply define the parameters of what risks are and are not covered by the policy. And just like with the incontestability clause, the policy needs to be in effect in order for the exclusion clause contained in it to be enforced. Even incontestability, therefore, would not have secured benefits for Harris's beneficiary.

Life insurance litigation stems from factual situations that are sometimes macabre and always unfortunate, and relies on law that is often riddled with technicalities and fine distinctions. The layperson and the lawyer are also likely to sharply disagree over the equities of the result, even if it is legally correct. Nevertheless, I've found that attention to detail and an ability to challenge assumptions can make this line of work socially beneficial and personally satisfying.