

## CHAPTER 17

### Insurance

J. ALBERT BURGOYNE *and* GEORGE E. DONOVAN

#### A. GENERAL INSURANCE — COURT DECISIONS

§17.1. **General liability insurance: Hold harmless agreement.** Under a contract with the Massachusetts Turnpike Authority for the construction of the Callahan Tunnel under Boston Harbor, the Perini Corporation was obligated to "indemnify and save harmless the authority and . . . its officers, . . . and employees against all suits, claims or liability of every name and nature, for or on account of any injuries to persons or damage to property arising out of or in consequence of the acts of . . . [Perini] in the performance of the work covered by the contract and/or failure to comply with . . . [its] terms . . . whether by himself or his employees or subcontractors. . . ." The Employers' Liability Assurance Corporation, Ltd., issued to Perini as insured a Comprehensive General Liability Policy naming both the Authority and the bank trustee under an indenture securing bonds issued by the Authority as additional insureds. Under this policy the standard insuring language was amended by endorsement and, as amended, obligated the insurer "[t]o pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages for: (a) physical injury to or destruction of tangible property, or (b) loss of use of such tangible property, provided the physical injury thereto was caused by accident." The policy was also amended to provide that, except as respects loss of use, the word "occurrence" was substituted for the word "accident."

Prior to commencement of construction the Authority acquired by eminent domain takings and made available to the contractor all property and rights deemed essential by the Authority for the prosecution of the work under the contract. During the performance of the contract certain property of landowners was physically injured or destroyed, and in some cases rights of access were impaired and these landowners initiated petitions for damages against the Authority.<sup>1</sup> The Authority

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§17.1. <sup>1</sup> Acts of 1958, c. 598, conferred upon the Massachusetts Turnpike Authority power to construct and operate the Callahan Tunnel and to refinance and operate the Sumner Tunnel. Section 15 of this act provides in part: "Any person

called upon the contractor and the insurer to defend these proceedings and save the Authority harmless against the claims. In *Massachusetts Turnpike Authority v. Perini Corporation*,<sup>2</sup> the Authority sought relief for their refusal to do so. The defense contended that Perini had no obligation to defend under General Laws, Chapter 79, any petition against the Authority or to indemnify it for any judgment obtained upon such a petition and that the insurer had no such obligation under its policy naming the Authority as an additional insured. The Authority, conceding that damages for takings by eminent domain were not Perini's responsibility, argued that Perini and the insurer were bound to indemnify it for damages caused to property in the course of the construction. The Supreme Judicial Court, relying on its earlier decision in *Bryne v. City of Gloucester*,<sup>3</sup> held that the contract of indemnity required Perini to indemnify the Authority only from claims for Perini's acts and omissions causing damage other than damage attributable to a taking or inevitable in carrying out the purposes of the taking. Thus Perini would be liable only if its acts or omissions were tortious by reason of negligence or strict liability, maintaining a nuisance, participating in wrongful conduct, taking unauthorized action, or otherwise.

Clearly, damages for tortious action may not be recovered in a proceeding under General Laws, Chapter 79.<sup>4</sup> It is also clear that since damages recoverable under Chapter 79 are either attributable to a taking or inevitable in carrying out the work, Perini would have no obligation to hold the Authority harmless against claims for such damages. In the view of the Court the parties did not intend to extend the scope of Perini's obligation to the Authority beyond the customary tort liability by a transfer to Perini of the liability for compensatory damages imposed upon the Authority by reason of its appropriation of property by eminent domain. If any doubt existed concerning the intentions of the parties, then the contract must be construed against the Authority which drafted it.

The policy of insurance furnished in compliance with the contract requirements is customarily written to protect against tort claims and the Court would require clear language to warrant interpreting it as covering the direct or indirect effects of a sovereign act of appropriation. The substitution of "occurrence" for "accident" did not evidence an intention to modify the policy to provide such coverage. Rather, this substitution was intended to bring within the coverage injuries gradually occurring as contrasted with an injury arising from a sudden event, as usually associated with an accident.<sup>5</sup> The Court went on to say

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damaged in his property by the exercise of any of the powers granted by this act may recover his damages from the Authority under chapter seventy-nine of the general laws."

<sup>2</sup> 1965 Mass. Adv. Sh. 1081, 208 N.E.2d 807.

<sup>3</sup> 297 Mass. 156, 8 N.E.2d 170 (1937).

<sup>4</sup> *Holbrook v. Massachusetts Turnpike Authority*, 338 Mass. 218, 154 N.E.2d 605 (1958).

<sup>5</sup> See Bean, *The Accident Versus the Occurrence Concept*, 1959 Ins. L.J. 550,

that the term "occurrence" may also be designed to expand the coverage so that it will be "more nearly as extensive as negligence and other forms of tort liability," observing in an interesting footnote that the necessity for this type of coverage expansion is probably greater in jurisdictions which have not taken as broad a view of the word "accident" as is reflected in Massachusetts decisions.<sup>6</sup>

The naming of additional insureds does not broaden the substantive coverage afforded by a policy; it merely extends to the additional insureds the protection given to the named insured.<sup>7</sup> Unless the claim, if proved, can be brought within the substantive coverage of the policy, the insurer has no obligation to defend.<sup>8</sup> Consequently, neither Perini nor the insurer has any obligation to defend the General Laws, Chapter 79, petitions brought against the Authority nor any liability to indemnify the Authority for any judgments obtained against it.

**§17.2. General liability insurance: Duty to defend.** In *Vappi & Co. v. Aetna Casualty & Surety Co.*<sup>1</sup> the plaintiff sought to recover counsel fees and the cost of engineering services incurred in the defense of a suit which the defendant insurer declined to defend on its behalf under a Comprehensive General Liability Policy issued to it by the defendant. This policy was apparently in the standard form and contained the "excavation" exclusion denying coverage for "injury to . . . any property arising out of . . . structural injury to any . . . structure due (a) to grading of land, excavation . . . filling . . . pile driving . . . caisson work, or (b) to moving, shoring . . . raising or demolition of any . . . structure or removal or rebuilding of any structural support thereof."

The suit in question was commenced as an equity action in which the bill alleged that Vappi, in the course of constructing a building for Boston University, wrongfully closed and excavated a sixteen-foot passageway which the complainant was entitled to use for access to her land, which abutted the construction site. This bill, asking an assessment of damages and injunctive relief, was dismissed when reached for trial on the ground that the complainant no longer sought relief under the original bill, but now sought damages for alleged specific acts by Vappi. The substituted action at law sought to recover for (a) withdrawal of water and soil from under her buildings and land causing them to settle, (b) some diversion of surface water onto her premises, and (c) damage to her land, buildings, and their foundations because of vibrations from Vappi's use of trucks and heavy equipment close to

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553; Leslie, *Automobile and General Liability Insurance*, A.B.A. Section of Insurance, Negligence, and Compensation Law, 1962 Proceedings 70, 84-85.

<sup>6</sup> Cases involving definition of "accident" are collected in *Vappi & Co. v. Aetna Casualty and Surety Co.*, 1965 Mass. Adv. Sh. 167, 204 N.E.2d 273, discussed in §17.2 *infra*.

<sup>7</sup> *Sonoco Products Co. v. Travelers Indemnity Co.*, 315 F.2d 126, 128 (10th Cir. 1963).

<sup>8</sup> *Magoun v. Liberty Mutual Insurance Co.*, 346 Mass. 677, 195 N.E.2d 514 (1964), noted in 1964 Ann. Surv. Mass. Law §17.9.

§17.2. <sup>1</sup> 1965 Mass. Adv. Sh. 167, 204 N.E.2d 273.

her land. Aetna at this point refused Vappi's request to assume the defense of this action and took no part in the proceedings, which ultimately resulted in a defendant's verdict.

So long as the plaintiff's suit merely asserted deprivation of access to her property, the contractor's insurer had no obligation to defend since any consequent liability of the contractor was clearly not within the coverage of the policy. However, when allegations of specific negligent acts are introduced into the proceedings, an obligation upon the insurer to defend arises if the allegations are reasonably susceptible of the interpretation that they assert injury to property caused by accident and of a type not within the excavation exclusion. The insurer's obligation is determined by the scope of the allegations and until it succeeds in narrowing claims to those not covered by the policy, it is not relieved of this obligation.<sup>2</sup>

The Court found that the allegations were not clearly limited to activities of a type within the excavation exclusion nor were they clearly limited to injuries of a type caused otherwise than by accident. Allegations of a failure to take precautions to prevent the diversion of surface water and harmful results from vibrations would permit proof of acts and omissions or injuries not within the exclusion. Moreover, these allegations are sufficiently general to permit proof of injuries which could be regarded as "caused by accident" under the Court's decisions holding that unintended or unforeseen consequences of reckless or negligent acts, and even of intentional acts, at least if not undertaken "with malice or intent to injure" the person or property hurt, may be within the definition of "accident."<sup>3</sup>

Further weakening of the concept of "accident" and the usefulness of this word in insurance policies seems inevitable. The Court in this case was at pains to remark that it would be slow to adopt any narrow construction of the term "accident" which will limit or defeat any coverage fairly intended to be given by a policy described by the insurer in any such broad terms as "Comprehensive General Liability Policy."

**§17.3. Liability insurance: Loan receipt agreement.** The plaintiff trustees in *Crocker v. New England Power Co.*<sup>1</sup> brought an action in tort against the defendant power company for negligent injury to the plaintiffs' property. This action was based upon an allegation that the defendant failed to inform the Armor Fence Company, which had been engaged by it to install a fence around a new substation, of the existence of a conduit carrying power cables to the plaintiffs' mill. In the digging of a post hole for the fence the conduit was broken, causing a power failure which in turn was the cause of the damage to the plaintiffs' property. Liberty Mutual Insurance Company, as insurer of the

<sup>2</sup> See *Magoun v. Liberty Mutual Insurance Co.*, 346 Mass. 677, 195 N.E.2d 514 (1946), noted in 1964 Ann. Surv. Mass. Law §17.9; *Fessenden School, Inc. v. American Mutual Liability Insurance Co.*, 289 Mass. 124, 193 N.E. 558 (1935).

<sup>3</sup> *J. D'Amico, Inc. v. City of Boston*, 345 Mass. 218, 186 N.E.2d 716 (1962), discussed in 1963 Ann. Surv. Mass. Law §16.1.

§17.3. <sup>1</sup> 1964 Mass. Adv. Sh. 1313, 202 N.E.2d 793, also noted in §5.8 *supra*.

fence company, had entered into an agreement with the plaintiffs under which it paid to the plaintiffs the amount of the loss "as a loan, without interest, repayable only out of any proceeds of any recovery upon any claims or causes of action" arising out of the accident. Liberty Mutual was by this agreement appointed attorney in fact for the plaintiffs, with sole and irrevocable power to conduct at its own expense all legal proceedings in connection with the accident.

The defendant contended that the plaintiffs should not have recovery because their claim had been satisfied in full and argued further that the loan receipt agreement was a device to evade the rule that there can be no contribution among tort-feasors. It has long been established that a loan receipt agreement between a plaintiff and his own insurer constitutes a valid loan which does not bar the plaintiff from prosecuting his cause of action.<sup>2</sup> The validity of such an agreement between the plaintiff and the insurer of a party possibly liable in tort to the plaintiff was a new question and one of first impression before the Massachusetts Court.

The Court pointed out that the validity of the loan receipt agreement in these circumstances has been upheld elsewhere but also noted the lack of discussion to support the reasoning of the cases. Believing the result desirable, the Court adopted the same view, likewise without discussion. Moreover, it had no difficulty disposing of the contribution argument, taking the position that there never was much logic behind the rule prohibiting contribution among tort-feasors.<sup>3</sup>

§17.4. **Motor vehicle insurance: Uninsured motorists coverage.** The plaintiff insurer in *Employers' Fire Insurance Co. v. Garney*<sup>1</sup> sought a declaratory judgment whether a claim for damages was within the uninsured motorists coverage of the Massachusetts Motor Vehicle Liability Policy issued by the plaintiff to the claimant's father. At the trial the judge had made findings of fact and concluded that any damages sustained by the claimant were covered by the policy. The claimant had sustained bodily injury while riding in his father's automobile which was struck by a hit-and-run automobile. Following the accident the claimant provided the insurance company with a detailed accident report on the company's accident report form, but at no time filed with the company the sworn statement required by the terms of the policy when the accident involves a hit-and-run automobile.<sup>2</sup> There was no

<sup>2</sup> August A. Busch & Co. of Massachusetts v. Liberty Mutual Ins. Co., 339 Mass. 239, 158 N.E.2d 351 (1959), noted in 1959 Ann. Surv. Mass. Law §16.1; National Shawmut Bank v. Johnson, 317 Mass. 485, 488, 58 N.E.2d 849, 851 (1945).

<sup>3</sup> G.L., c. 231B, added by Acts of 1962, c. 730, changed this rule in Massachusetts. See discussion in 1962 Ann. Surv. Mass. Law §16.11.

§17.4. 1 1965 Mass. Adv. Sh. 391, 205 N.E.2d 8.

<sup>2</sup> For the purposes of bringing injuries caused by hit-and-run automobiles within the coverage of Part II of the Massachusetts Motor Vehicle Liability Policy ("Damages for Bodily Injury Caused by Uninsured Automobiles") the policy includes the following definition: "'Hit-and-Run Automobile' means an automobile which causes bodily injury to an insured arising out of physical contact of such automobile with the insured or with an automobile which the insured is occupying

evidence that the company requested the defendant to furnish such a sworn statement.

The claimant contended that under the provisions of General Laws, Chapter 175, Sections 102 and 186B, the filing of the sworn statement is unnecessary inasmuch as he had given the insurance company seasonable notice of the accident.<sup>3</sup> The company took the position that these statutory provisions relieve an insured of the consequences of a failure to file the customary proof of claim or proof of loss and not of a failure to file a sworn statement that the insured has a cause of action against a person whose identity is unascertainable. The company's effort to distinguish between the proof of claim required under the "Proof of Claim" condition<sup>4</sup> of the policy and the sworn statement required of an insured claiming damages against an unidentified and unascertainable person was rejected by the Court.

The Court held that both the sworn statement called for by the hit-and-run definition and the written proof of claim, if sworn to, were sworn statements of loss as that term is used in Section 186B. Failure of the claimant to render either of these statements did not impair his claim since the company had received prompt and full notice of loss. If the company needed more information the burden was on it to make a request for such additional information.

The Court also addressed itself in this case to the question of the extent to which a claim under the Uninsured Motorists Coverage must be submitted to arbitration,<sup>5</sup> although it is unclear what precise matter

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at the time of the accident, provided: (1) there cannot be ascertained the identity of either the operator or the owner of such 'hit-and-run automobile'; (2) the insured or someone on his behalf shall have reported the accident within 24 hours to a police, peace or judicial officer or to the Commissioner of Motor Vehicles, and shall have filed with the company within 30 days thereafter *a statement under oath* that the insured or his legal representative has a cause or causes of action arising out of such accident for damages against a person or persons whose *identity is unascertainable*, and setting forth the facts in support thereof; and (3) at the company's request, the insured or his legal representative makes available for inspection the automobile which the insured was occupying at the time of the accident." [Emphasis supplied.]

<sup>3</sup> Section 102 protects the insured under a Massachusetts Standard Fire Policy against forfeiture of coverage for failure to render the proof of loss required under the policy, provided the insured gives notice of the loss, forthwith upon occurrence of the loss, to the company and complies with a written request of the company to furnish it with a sworn statement of loss.

Section 186B, enacted by Acts of 1959, c. 168, extends this protection to an insured who has failed to render a sworn statement of loss under any type of policy issued in the Commonwealth.

See 1959 Ann. Surv. Mass. Law §16.14.

<sup>4</sup> Condition 2 of the policy applicable to the Uninsured Motorists Coverage provided in part as follows: "As soon as practicable, the insured or other person making claim shall give to the company written proof of claim, under oath if required, including full particulars of the nature and the extent of injuries, treatment, and other details entering into the determination of the amount payable. . . ."

<sup>5</sup> The "Arbitration" Condition of the policy applicable to the Uninsured Motorists Coverage provided in part as follows: "If any person making claim

thought to be arbitrable was in dispute. This question was not reached in the only Massachusetts case<sup>6</sup> which has involved the arbitration clause because the parties were in agreement that coverage questions are not a subject for arbitration under the applicable statutory provisions.<sup>7</sup> In the leading case of *Rosenbaum v. American Surety Co. of New York*<sup>8</sup> the New York Court of Appeals in a four-to-three decision held that the policy agreement to arbitrate did not encompass a dispute between the insurer and the insured on the preliminary issue as to whether the automobile driven by the tort-feasor was uninsured.

Specifically adopting the view of the minority in the *Rosenbaum* case, the Supreme Judicial Court in the present case held that whether a particular situation of fact comes within the policy provisions, assuming their meaning has been determined, was a matter which may be submitted to arbitration. Examples offered were whether the other motorist was or could be identified, whether he was insured, whether his acts or omissions caused the accident, whether he was negligent, and whether the insured was guilty of contributory negligence. It would appear that the Court was persuaded that the arbitration provision should be read as applying not only to questions of "liability" and "damages," as was intended by the language, but also to some questions of coverage. It does not appear that the question raised by the plaintiff's petition regarding the insured's compliance with the conditions of the policy necessary to recovery was an arbitrable question.

**§17.5. Motor vehicle insurance: Loading and unloading.** In *Improved Machinery, Inc. v. Merchants Mutual Insurance Co.*<sup>1</sup> the plaintiff insured and its general liability insurer sought a declaratory judgment that the plaintiff insured's automobile liability insurer was obligated to defend suit brought against the plaintiff insured. The automobile liability policy issued by the defendant insurer covered the ownership, maintenance, or use of automobiles owned by the insured and contained the standard provisions defining "use" to include loading and unloading of the automobile, and defining "insured" to include any person using the automobile with the permission of the insured.

The insured, having sold a piece of heavy manufacturing machinery which failed to operate satisfactorily, decided to replace a portion of

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hereunder and the company do not agree that such person is legally entitled to recover damages from the owner or operator of an uninsured automobile because of bodily injury to the insured, or do not agree as to the amount of payment which may be owing under this coverage, then, upon written demand of either, the matter or matters upon which such person and the company do not agree shall be settled by arbitration in accordance with the rules of the American Arbitration Association. . . ."

<sup>6</sup> *Fazio v. Employers' Liability Assurance Corp.*, 347 Mass. 254, 197 N.E.2d 598 (1964), discussed in 1964 Ann. Surv. Mass. Law §17.4.

<sup>7</sup> G.L., c. 175, §111D, added by Acts of 1959, c. 438, §2, discussed in 1959 Ann. Surv. Mass. Law §16.8.

<sup>8</sup> 11 N.Y.2d 310, 183 N.E.2d 667, 229 N.Y.S.2d 375 (1962).

§17.5. <sup>1</sup> 1965 Mass. Adv. Sh. 1095, 208 N.E.2d 796.

the machinery which had been installed in the buyer's plant. The buyer leased a forklift with an operator to unload from the insured's truck the new piece of equipment and to load the defective equipment onto its truck. While the forklift operator was using the forklift to load the defective machinery onto the insured's truck the weight of the machinery caused the forklift to tip over, striking and killing an employee of the buyer. The Court held on these facts that the automobile liability insurer was obligated to assume the defense of the suit, not a surprising result in the light of the broad sweep given by it to the unloading operation in the earlier *Busch* case.<sup>2</sup>

The defendant apparently also sought to avoid liability on the ground that the forklift operator was not an insured under the policy, relying on *Nichols & Co. v. Travelers Insurance Co.*<sup>3</sup> The Court rejected this argument, pointing out that the policy in the *Nichols* case contained a narrower definition of "insured" than that contained in the present policy.

**§17.6. Agents and brokers: Liability.** The plaintiff, in *Schooner Dartmouth, Inc. v. Piper*,<sup>1</sup> sought to recover from the defendant, an insurance broker, damages sustained as a consequence of the plaintiff's reliance upon the broker's representation of the coverage afforded by a marine Protection and Indemnity Policy. The schooner *Dartmouth* was involved in a collision at sea with another vessel at a time when the *Dartmouth* was covered by \$22,500 of hull insurance, an amount equal to 50 per cent of its appraised value. The broker had been unable to obtain hull insurance to the full value of the vessel, despite diligent efforts to do so. Under the standard hull policy, coverage for damage to others is in the amount of the value of the insured vessel, or if the policy is written for a lesser amount than such value, then for the proportion of the loss that the amount of insurance bears to the appraised value of the vessel.

In these circumstances the plaintiff instructed the broker to procure a renewal of its Protection and Indemnity Policy in the amount of \$100,000. The broker had advised "that if the vessel was in collision and caused damage to others, the P & I insurance would pick up the liability where the hull insurance left off," and the plaintiff had understood this to mean that in case of collision at sea causing damage to another vessel the *Dartmouth* would be fully covered by insurance. In fact, the P & I coverage attached only to that portion of a loss which exceeded the value of the insured vessel, so that a loss up to that amount would be borne by the hull insurers. As a consequence the hull insurer paid one half the \$15,000 judgment obtained against the *Dartmouth* and the

<sup>2</sup> August A. Busch & Co. of Massachusetts v. Liberty Mutual Insurance Co., 339 Mass. 239, 158 N.E.2d 351 (1959), discussed in 1959 Ann. Surv. Mass. Law §16.1. For a review of the cases, see Annotations, 95 A.L.R.2d 1122 (1964), supplementing 160 A.L.R. 1259 (1946).

<sup>3</sup> 343 Mass. 494, 179 N.E.2d 593 (1962), discussed in 1962 Ann. Surv. Mass. Law §16.6.

§17.6. <sup>1</sup> 1965 Mass. Adv. Sh. 943, 208 N.E.2d 214.



P & I insurer had no liability with respect to the balance, which was paid by the plaintiff.

The plaintiff, in seeking to recover from the broker for its uninsured loss, relied squarely and solely upon the contention that the broker's statement was made in the course of the sale of an insurance policy, as agent of the seller, and was an express warranty as to the nature of the coverage afforded by the P & I policy. The plaintiff did not seek to recover on the theory of an innocent misstatement of an existing fact susceptible of knowledge,<sup>2</sup> although the broker's statement could reasonably be construed as a representation of the prevailing view of insurance underwriters with regard to the coverage of the P & I policy. Neither did the plaintiff seek to rely on any negligence of the broker as agent of the plaintiff compensated to obtain the necessary insurance.<sup>3</sup>

The broker could have made an express warranty concerning the coverage of the policy in question but, in the opinion of the Court, there was here no such undertaking in express words and no facts upon which to imply one. Moreover, the broker's statement formed no part of a sale, nor was it made to induce a sale or to obtain a commission. His duty to the plaintiff in respect to this statement arose from his position as agent of the plaintiff providing professional insurance advice and procuring insurance policies at the plaintiff's direction. On the issue as tried, the plaintiff cannot have recovery.

**§17.7. Payroll robbery insurance: Robbery defined.** *Austin L. Burgess, Inc. v. Lumbermens Mutual Casualty Co.*<sup>1</sup> involved a policy issued by the defendant insurer obligating it, among other losses, to "pay for . . . direct loss of or damage to payroll . . . caused by robbery . . . from a custodian performing any of his regular duties with such payroll." "Robbery," in pertinent part, is defined by the policy to mean "the felonious taking of insured property (1) by violence inflicted upon a custodian; (2) by putting him in fear of violence; (3) by any other overt felonious act committed in his presence and of which he is actually cognizant. . . ." The plaintiff suffered the loss of a payroll when its custodian, carrying the payroll in a paper bag from the bank to his automobile, discovered he had a flat tire on the right rear wheel (afterward determined to have been deliberately caused), placed the bag containing the payroll under his hat in the open trunk of the automobile, and proceeded to remove the flat tire and replace it with the

<sup>2</sup> The Court suggested that recovery may have been had upon the theory of *Chatham Furnace Co. v. Moffatt*, 147 Mass. 403, 18 N.E. 168 (1888), citing *Prosser, Torts* §102 at 724-725 (3d ed. 1964); *Williston, Sales* §197 (rev. ed. 1948); *Bohlen, Misrepresentation as Deceit, Negligence, or Warranty*, 42 Harv. L. Rev. 733, 746-747 (1929); *Carpenter, Responsibility for Intentional, Negligent and Innocent Misrepresentation*, 24 Ill. L. Rev. 749, 771 (1930); *Williston, Liability for Honest Misrepresentation*, 24 Harv. L. Rev. 415, 420-422, 435 (1911). 1965 Mass. Adv. Sh. 943, 946, 208 N.E.2d 214, 216.

<sup>3</sup> *Rapp v. Lester L. Burdick, Inc.*, 336 Mass. 438, 146 N.E.2d 368 (1957), and *Rayden Engineering Corp. v. Church*, 337 Mass. 652, 151 N.E.2d 57 (1958), discussed in 1958 Ann. Surv. Mass. Law §18.1.

§17.7. <sup>1</sup> 1965 Mass. Adv. Sh. 379, 205 N.E.2d 1.

spare. In the course of this operation the automobile jack slipped and the custodian was obliged to go to the front of the automobile to chock the right front wheel. There was testimony that the custodian noticed a "suspicious looking person" when he emerged from the bank and that he saw no one in sight when he looked to see if anyone was around when he left the rear of the automobile. Upon completion of the tire-changing, the custodian picked up his hat only to discover that the bag of money was gone.

The defendant insurer appealed a denial of its motion for a directed verdict. The plaintiff's case rested upon the policy provision defining robbery to include any other overt felonious act committed in the custodian's presence and of which he is actually cognizant. While there may have been sufficient evidence to support a finding that a robbery was committed in the custodian's presence, there was no basis for finding that the custodian had actual knowledge of a felonious act during its commission. Without such actual knowledge, the loss cannot be brought within the clear intent of the coverage.

§17.8. **Surety bonds: Scope of undertaking.** *Treasurer and Receiver General v. Massachusetts Bonding and Insurance Co.*<sup>1</sup> involved an individual, one Gerald Carpenter, obligated to satisfy two statutory bonding requirements, one as the operator of a collection agency<sup>2</sup> and the other as a deputy tax collector.<sup>3</sup> The defendant was surety on Carpenter's bond as operator of a collection agency and subsequently became surety on his deputy tax collector's bond, which continued in force from April 24, 1958, the date of Carpenter's appointment, until December 31, 1958. Thereafter, Peerless Insurance Company became surety on the deputy tax collector's bond until Carpenter was removed from the deputy collector's office on May 8, 1959. During the period that Carpenter was deputy collector he collected and neglected to pay over to town officials taxes substantially in excess of the sum of the penalties of the two deputy collector's bonds issued by the defendant and by Peerless. In this action the town sought to recover the excess loss from the defendant as surety on Carpenter's collection agency bond. The Court found that a collection agency bond does not cover the performance of a tax collector's duty to account for collected funds. Two different statutory requirements were involved, one dealing with the regulation of trade, the other with the bonding of public officials charged with the duty of collecting taxes. The former requires bonding as a condition of licensing to carry on a business, which cannot be conducted without license. The latter requires bonding to guarantee performance of a public trust. That the principal in these bonds collected both taxes and private debts is purely a coincidence; it cannot enlarge the obligation of the surety on the collection agency bond.

A second case decided during the 1965 SURVEY year involving a surety

§17.8. 1 1965 Mass. Adv. Sh. 845, 207 N.E.2d 684.

2 G.L., c. 93, §§24-28.

3 Id., c. 60, §92.

bond was *Sands, Taylor & Wood Co. v. American Insurance Co.*<sup>4</sup> The bond was given to vacate a default judgment against the principal, one Richard D. Bowman.<sup>5</sup> Bowman's Bakery, Inc., was also a defendant in the action, but the default judgment against it was not vacated. On a subsequent trial on the merits, Bowman prevailed. The plaintiff thereafter sought to hold the surety liable for the original default judgment against Bowman's Bakery, Inc. Judgment of the trial court for the defendant surety was affirmed on the double ground that (1) the statute requires the bond to be conditioned upon satisfaction of a judgment against only the petitioner to vacate, and (2) if judgment is vacated, the condition is that the petitioner shall satisfy the execution on any judgment thereafter rendered in the action. If, as in this case, the petitioner prevails and the judgment is vacated, the condition of the bond<sup>6</sup> is satisfied and the obligation of the surety is terminated. The language of the bond condition cannot be construed as referring to a judgment previously recovered against another defendant who is a stranger to the proceedings to vacate judgment for which the bond was given.

## B. GENERAL INSURANCE — LEGISLATION

**§17.9. Stock companies: Securities regulation.** In 1964 the Congress of the United States amended<sup>1</sup> the Securities Exchange Act of 1934 to extend to certain over-the-counter securities the same registration and periodic reporting requirements as apply to those securities which are listed on a national securities exchange. The 1964 amendments were enacted to carry out the legislative recommendations made by a special study committee of the Securities Exchange Commission following a lengthy study of the adequacy, for the protection of investors, of the rules of the stock exchanges. The legislative bill, as introduced, would by its terms include securities issued by stock insurance companies.

During the legislative hearings, the National Association of Insurance Commissioners opposed the application of the new requirements to stock insurance company securities because to do so would (a) subject such securities to dual regulation, and (b) constitute a departure from the doctrine of the McCarran Act<sup>2</sup> which reserves to the several states the regulation of the business of insurance. The NAIC, not ob-

<sup>4</sup> 1965 Mass. Adv. Sh. 1111, 209 N.E.2d 189, also noted in §3.6 *supra*.

<sup>5</sup> G.L., c. 250, §17, prescribes the form of the bond to be given to the adverse party by the petitioner before a judgment is vacated and execution is stayed.

<sup>6</sup> The bond executed by the surety on behalf of Richard D. Bowman contained the following: "Now, Therefore, if the said Richard D. Bowman shall within thirty (30) days after final judgment in aforesaid action pay to Sands, Taylor & Wood, Inc. the amount if any which they shall recover plus costs (not to exceed the penal amount of this bond), then this obligation shall be void, otherwise to remain in full force."

§17.9. <sup>1</sup> Pub. L. 88-467, approved August 20, 1964, 78 Stat. 565, amending 15 U.S.C. §§77d, 78c, 781-78o-3, 78p, 78t, 78w, 78ff (1964 Supp.).

<sup>2</sup> Pub. L. No. 15, 79th Cong., 1st Sess., c. 20, approved March 9, 1945, 59 Stat. 34, 15 U.S.C. §§1011-1015 (1964).

jecting to the concept of security regulation but to the jurisdiction of the federal agency, sought and obtained a two-year moratorium period within which to enact necessary regulatory legislation in the states.

The bill as enacted exempts securities issued by stock insurance companies if (1) the company files with its home state an annual statement in the form prescribed by the NAIC; (2) the company is, with regard to proxies, consents, or authorizations in respect of its securities, subject to regulation by its home state and such regulations conform to those prescribed by the NAIC; and (3) after July 1, 1966, the purchase and sale of the company's securities by beneficial owners, directors, and officers are subject to regulation by the company's home state substantially in the manner provided in Section 16 of the Securities Exchange Act.<sup>3</sup> To meet the requirement of substantially equivalent regulation the NAIC is seeking the enactment by the states of a "model insider trading statute" which affords Section 16 protection.

Acts of 1965, Chapter 354,<sup>4</sup> enacted this legislation in Massachusetts and made it applicable to securities of a domestic stock insurance company unless (a) its securities are registered or required to be registered under Section 12 of the Securities Exchange Act,<sup>5</sup> or (b) its securities are not held of record by 100 or more persons as of the last business day of the next preceding year. It requires reporting of changes in stockholdings by any person who is a director, officer, or beneficial owner of more than 10 per cent of a security issue of the company and makes short term profits subject to recapture by the company within two years following the date such profit is realized. It further requires that solicitations of proxies be in accordance with rules and regulations to be prescribed by the Commissioner of Insurance and be accompanied by such information, including financial statements, as are specified by regulation. In the event no such proxy solicitation is made, the company is obliged, nevertheless, prior to its annual meeting, to file with the Commissioner and transmit to the holders of record the security information which would be required to accompany a proxy solicitation. The usual periodic reporting requirement will be satisfied by the statement required to be filed each year by all insurance companies with the Commissioner of Insurance.<sup>6</sup>

**§17.10. Agents and brokers: Licensing.** Acts of 1965, Chapter 125, eliminated the statutory restriction<sup>1</sup> upon the number of officers and directors who can be authorized to act under the license of a corporate

<sup>3</sup> Pub. L. 88-467, §3(c), amending 15 U.S.C. §§781, 78p (1964 Supp.).

<sup>4</sup> Adding Section 193I to G.L., c. 175.

<sup>5</sup> 15 U.S.C. §781 (1964 Supp.).

<sup>6</sup> The National Association of Insurance Commissioners has adopted a uniform reporting form, known as the convention blank, which has been adopted for use by every state. A special committee of the NAIC has developed a "stockholders' information supplement," which is to become a part of this basic annual report as submitted by stock companies for the 1964 and subsequent report years. All of the states have agreed to adopt this standard supplement.

§17.10. 1 G.L., c. 175, §174.

agent or broker and leaves the determination of the number of individuals who may act under such a license to the discretion of the Commissioner of Insurance.

**§17.11. Motor vehicle insurance: Minors' policies.** Heretofore minors who have attained the age of fifteen have been deemed competent by the statute to contract for life or endowment insurance. Acts of 1965, Chapter 403,<sup>1</sup> was enacted, following several years of efforts to obtain such legislation, to make minors who have attained the age of sixteen (the minimum age for licensing to operate motor vehicles) competent to contract for motor vehicle insurance. For reasons difficult to comprehend, the policies which the minor may no longer disaffirm are those affording compulsory insurance only<sup>2</sup> or those issued under the provisions of the Motor Vehicle Assigned Risk Plan<sup>3</sup> which, at the option of the insured, may afford, in addition to the compulsory insurance, extraterritorial, guest, and property damage liability coverages. Not within the protection of the new law are policies voluntarily written by insurers to afford more coverage than is required under the compulsory insurance law. This could increase the number of insureds using the facilities of the Assigned Risk Plan either as a consequence of the underwriting reluctance of the companies to assume such minor risks or of the minors' determination to obtain coverage broader than the compulsory requirement. In any case, the limitation of the statute seems to make little sense, even recognizing the rather sympathetic attitude of the legislature toward young drivers.

**§17.12. Motor vehicle insurance: Policy approval.** Acts of 1965, Chapter 383,<sup>1</sup> requires all motor vehicle liability and physical damage policies to be filed for approval by the Commissioner of Insurance. No such policy may be used for a period of thirty days following such filing unless it is sooner approved in writing by the Commissioner. Unless the policy form is, within the thirty-day period, disapproved in writing by the Commissioner, with a specification of his reasons for disapproving, the form will be deemed to be approved.

**§17.13. Liability insurance: Medical examination.** Acts of 1965, Chapter 369, added to the insurance law a new section<sup>1</sup> which requires a liability insurer to furnish, upon request, to the injured party or his attorney copies of the reports of medical examinations of the injured party made by the insurer, provided the injured party, upon request of insurer, furnished to the insurer copies of reports of all medical examinations and treatment made by his attending physician.

§17.11. <sup>1</sup> Adding to G.L., c. 175, a new §113K.

<sup>2</sup> G.L., c. 90, §34A, defines the insurance coverage required as a condition for the registration of a motor vehicle.

<sup>3</sup> Id., c. 175, §113H, prescribes certain provisions to be incorporated in a motor vehicle assigned risk plan and requires its approval by the Commissioner of Insurance.

§17.12. <sup>1</sup> Amending G.L., c. 175, §22A.

§17.13. <sup>1</sup> G.L., c. 175, §111F.

§17.14. **Accident and health insurance: Dependent's benefits.** Acts of 1965, Chapter 112, amended the individual accident and sickness policy provisions law<sup>1</sup> to bring within the definition of eligible dependent children the children of adopting parents during the pendency of adoption procedures.

§17.15. **Group disability insurance: Eligible groups.** Acts of 1965, Chapter 309, amended the definition of group disability insurance<sup>1</sup> to permit the issuance of a group disability policy insuring against loss of time to a bank, association, financial or other institution, or to the trustees designated by two or more of such institutions and covering debtors, guarantors, or purchasers for amounts not in excess of the indebtedness or unpaid balance of the purchase price.

### C. LIFE INSURANCE — COURT DECISIONS

§17.16. **Accidental death coverage.** *Gilmour v. Security Mutual Casualty Co.*,<sup>1</sup> decided during the 1965 SURVEY year, was an action by beneficiaries upon a policy insuring against loss of life resulting "directly and independently of all other causes from accidental bodily injury." The insured collapsed and died after running a mile on a track while participating in a high school athletic program. A death certificate stated the cause of death to be "presumably cardiac exhaustion." The Supreme Judicial Court in its rescript opinion affirming an order for judgment for the defendant stated that the evidence, as recited above, was not proof that death resulted from accidental injury.

In support of its decision the Court cited three cases,<sup>2</sup> each involving policy provisions insuring against death by external, violent, and accidental means. But a distinction may be drawn between such provisions and those insuring merely against accidental death, without mention of the external means or cause of death. Under the accidental means kind of provision "[i]t is not sufficient that the death . . . may have been an accidental result of the external cause, but that cause itself must have been . . . accidental."<sup>3</sup> For example, it has been held that under such a provision there can be no recovery for death unintentionally resulting from inhalation of a nasal douche, where the act of inhalation was exactly what the insured intended.<sup>4</sup> If the word "accident" in its common signification "means an unexpected happening without intention or design"<sup>5</sup> it is clear that the fatal result of the in-

§17.14. <sup>1</sup> G.L., c. 175, §108, specifically par. (a) of subd. 2.

§17.15. <sup>1</sup> G.L., c. 175, §110.

§17.16. <sup>1</sup> 1965 Mass. Adv. Sh. 251, 204 N.E.2d 502.

<sup>2</sup> *Cooper v. Prudential Insurance Co.*, 329 Mass. 301, 107 N.E.2d 805 (1952); *Henderson v. Travelers Insurance Co.*, 262 Mass. 522, 160 N.E. 415 (1928); *Smith v. Travelers Insurance Co.*, 219 Mass. 147, 106 N.E. 607 (1914).

<sup>3</sup> *Id.* at 149, 106 N.E. at 608.

<sup>4</sup> *Ibid.*

<sup>5</sup> *Henderson v. Travelers Insurance Co.*, 262 Mass. 522, 525, 160 N.E. 415, 416 (1928).

halation was accidental. But it is equally clear that, where the means producing the result are precisely what the insured intended, those means are not accidental. And where accidental means is the test, there can be no recovery for a mere accidental result. In *Reeves v. John Hancock Mutual Life Insurance Co.*<sup>6</sup> it was held that there could be no recovery under "death by accidental means" provisions where the insured died from a strangulated hernia occasioned by his lifting of mortar tubs. The evidence did not warrant a finding that this lifting was unintentional or at the time was accompanied by any unexpected occurrence. The Court said:<sup>7</sup> "Here the lifting itself was not attended by accident although the consequences to the insured were unforeseen. The case is illustrative of the distinction to be observed between accidental result and accidental cause."<sup>8</sup>

In the *Gilmour* case the provision did not expressly require that death result from accidental means, and the cases cited in support of the decision are technically inapposite. Nevertheless the result reached is correct. Even if the death were the unintended and therefore accidental result of running, there was nothing to indicate it so resulted "independently of all other causes." Neither the death certificate as recited by the Court nor any other medical evidence negated the active co-operation of disease or some other cause in producing cardiac exhaustion. Since the lack of any such contributing cause could not be inferred from the evidence, the plaintiffs failed to show that the death was within the coverage.

§17.17. **Taxation of policy proceeds.** In *DeVincent v. Commissioner of Corporations and Taxation*<sup>1</sup> the Supreme Judicial Court held that the proceeds of policies on the life of a decedent, who while in the hospital two months before his death set up a trust for the benefit of his family and named the trustees beneficiaries of the policies, were not taxable under General Laws, Chapter 65, Section 1, as a gift made in contemplation of death.

The Court relied upon its earlier decisions in *Tyler v. Treasurer and Receiver General*<sup>2</sup> and *Welch v. Commissioner of Corporations and Taxation*,<sup>3</sup> stating:

[Their] reasoning . . . was broad, and substantially proceeds on the principle that the payment of insurance proceeds at the death of the insured has not been subjected to succession tax by the Legislature. Although the facts of these cases directly raised only the question whether insurance proceeds could be taxed . . . as gifts to take effect in possession at or after the insured's death, most

<sup>6</sup> 333 Mass. 314, 130 N.E.2d 541 (1955), noted in 1956 Ann. Surv. Mass. Law §17.7.

<sup>7</sup> Id. at 316, 130 N.E.2d at 542.

<sup>8</sup> Contrast *Lee v. New York Life Insurance Co.*, 310 Mass. 370, 38 N.E.2d 333 (1941), applying foreign law.

§17.17. <sup>1</sup> 1965 Mass. Adv. Sh. 547, 206 N.E.2d 81.

<sup>2</sup> 226 Mass. 306, 115 N.E. 300 (1917).

<sup>3</sup> 309 Mass. 293, 34 N.E.2d 611 (1941).

of what was said . . . seems appropriate to exclude a tax upon such insurance proceeds as a "gift . . . made in contemplation of the death of the . . . donor."<sup>4</sup>

The Court noted that the application of the federal estate tax to the proceeds of life insurance policies is almost entirely a development which has taken place since the decision of the *Tyler* case, and said that the fact that there had been a change in concepts of transfers within both state and federal taxation statutes was insufficient reason to change by judicial decision the long-standing interpretation of General Laws, Chapter 65, Section 1. In *Tyler* the Court, in determining that the policy proceeds were not subject to succession tax, stated that taxing statutes are to be strictly construed, and gave weight to the practical construction put on the law by those charged with its enforcement through many years. That decision has been relied upon for almost fifty years. If any change is now to be made, concluded the Court in the *DeVincent* case, it should be done by the legislature.

**§17.18. Insurer's defense of misrepresentation in application: Hodgkin's disease; alteration of application.** In two cases decided during the 1965 SURVEY year, the Supreme Judicial Court has held that, as a matter of law, misrepresentation in an application for a life insurance policy of medical history concerning a condition diagnosed as Hodgkin's disease entitles the insurer to avoid the policy. The first of the cases was *Pahigian v. Manufacturers' Life Insurance Co.*<sup>1</sup> The insured in his application, dated December 28, 1960, denied he had had disturbances of the glandular system such as enlarged glands, tumor, cancer, X-rays, weight change in past year, illness, injury, operation, or medical examination not already mentioned, and denied that at the time of the application he had any disease or symptoms of disease. The application form called for "full particulars, condition, dates, duration, results, full names and addresses of doctors, hospitals and clinics." The only response to this was, "Usual childhood diseases good recovery." The words "good recovery" were inserted after the application had been completed.

There was evidence in behalf of the company that from April, 1959, until the time of his death the insured underwent treatment for a swelling on his neck. From April 12 to April 15, 1959, he was hospitalized at a medical center whose records showed a discharge diagnosis of "Hodgkin's Disease, adenopathy, left neck; surgery performed: excision of glands, left neck." Thereafter he was hospitalized at a Veterans Administration hospital on eight occasions, the first being from April 24 to May 28, 1959, and another from August 9 to September 7, 1960. The hospital records showed a diagnosis of Hodgkin's disease. The defendant's medical expert testified on the basis of the hospital records that the insured had Hodgkin's disease which had reached its most

<sup>4</sup> 1965 Mass. Adv. Sh. 547, 549-550, 206 N.E.2d 81, 83.

§17.18. <sup>1</sup> 1965 Mass. Adv. Sh. 645, 206 N.E.2d 660, also noted in §10.4 *supra*.



serious stage by September, 1960, at which time the insured had only a 10 per cent chance of surviving five years. He testified that X-ray treatment should be given to combat the disease and that the insured received such treatment.

The plaintiff, widow of the insured, was called by the defendant and testified that besides his 1959 and 1960 hospitalizations the insured had been attending a Veterans Administration clinic up until December 27, 1960, the day before his application. The insured died of Hodgkin's disease, but it was unknown if he ever knew what his ailment was.

The Supreme Judicial Court held there was error in the trial court's refusal to direct a verdict for the insurer. The Court stated the usual rules that misrepresentations in an application which are made with actual intent to deceive or which increase the risk of loss will enable the company to avoid the policy,<sup>2</sup> but that the burden is on the company to show the misrepresentations and such actual intent or such increase of the risk. It noted that although the issue of increase of risk is usually a question of fact, misrepresentations as to certain diseases, such as cancer,<sup>3</sup> require, as a matter of law, the conclusion that the risk is increased. The Court adverted to the plentiful and uncontradicted evidence in the present case of the seriousness of Hodgkin's disease, including that it is fatal in at least 75 per cent of the cases in a period of months or a few or many years and concluded that it falls clearly into the class of illnesses which, as a matter of law, increase the risk of loss.

The holding that Hodgkin's disease increases the risk as a matter of law is hardly surprising, since the disease is considered to be a form of cancer. What is more significant is the Court's ruling that, even though it was not conclusively established that the insured had the disease at the time of his application, nevertheless the company was entitled as a matter of law to avoid the policy.

In *McDonough v. Metropolitan Life Insurance Co.*<sup>4</sup> it was held to be a jury question whether the insured had cancer at the time the policy was issued because, despite uncontradicted medical evidence to that effect, it did not appear that the matter was undisputed. So in the *Pahigian* case the Court assumed that it need not be believed that the insured had Hodgkin's disease at the time of his application. Nonetheless, said the Court, the plaintiff was bound by her testimony admitting that the insured was hospitalized in April, 1959, and in August and September of 1960. The binding admission of the plaintiff, coupled with the insured's failure to disclose this medical history as required by the application form, established as a matter of law misrepresentations as to the existence of that history.

The . . . misrepresentations themselves increased the risk of loss. . . .  
[They] deprived the insurer of the opportunity to undertake

<sup>2</sup> G.L., c. 175, §186.

<sup>3</sup> *Lennon v. John Hancock Mutual Life Insurance Co.*, 339 Mass. 37, 157 N.E.2d 518 (1959), noted in 1959 Ann. Surv. Mass. Law §16.3; *McDonough v. Metropolitan Life Insurance Co.*, 228 Mass. 450, 117 N.E. 836 (1917).

<sup>4</sup> 228 Mass. 450, 117 N.E. 836 (1917).

further investigation which, in all likelihood, would have revealed the diagnosis of Hodgkin's disease. . . . Such misrepresentations were as prejudicial as would have been misrepresentations by the insured that he did not have Hodgkin's disease. In either case the insurer would have failed to receive the candid answers necessary for it to evaluate the risk involved. . . . In these circumstances the insurer is entitled to avoid the policy.<sup>5</sup>

The *Pahigian* decision thus holds that the risk of loss to the insurer is increased by an applicant's concealment of information, such as a medical diagnosis, strongly evidencing the existence of a deadly disease. Although earlier cases had required the establishment of the actual existence of the disease, the present decision is correct. The chance that an insurer will pay benefits because of an early death are greater in the case of a person whose record contains such information than in the case of one similarly situated but without such a history. Even if it may later be found that the record information is wrong, this can be of no aid to the insurer at the time when it must make its decision whether to issue the policy applied for. It is as of that time that the materiality of the misrepresentations must be judged, for that is the time when, if at all, they induce the insurer to enter the contract. Since the misrepresentations in the *Pahigian* case were such as to forestall any investigation leading to the discovery of the adverse records, they thereby made it more likely that the company would issue the policy and underwrite a greater risk than the application disclosed. The misrepresentations themselves, as the Court said, increased the risk of loss.<sup>6</sup>

In arriving at the question of increase of the risk, the Court ruled on problems raised by the alteration of the insured's application. The trial judge had ruled that the addition by the defendant's branch office manager, out of the insured's presence and after he had signed the application, of the words "good recovery" after the statement "Usual childhood diseases" constituted an alteration of the application requiring exclusion of the application from evidence under General Laws, Chapter 175, Section 131,<sup>7</sup> and therefore the exclusion of the medical evidence contradicting the statements in the application. The Supreme Judicial Court said that the fact that the policy was issued at the company's head office outside the Commonwealth did not render the statute

<sup>5</sup> 1965 Mass. Adv. Sh. 645, 652, 206 N.E.2d 660, 666.

<sup>6</sup> Compare *Lennon v. John Hancock Mutual Life Insurance Co.*, 339 Mass. 37, 157 N.E.2d 518 (1959), 1959 Ann. Surv. Mass. Law §16.3, where the misrepresentation consisted of failure to disclose a serious operation. It was held that since the operation was for cancer (although the insured did not know what his ailment was), it increased the risk as a matter of law. However, in that case it was undisputed by the plaintiff beneficiary that the insured in fact had cancer.

<sup>7</sup> G.L., c. 175, §131: "Unless a correct copy of the application is endorsed upon or attached to a policy of life or endowment insurance, when issued, the application shall not be considered a part of the policy or received in evidence for any purpose. Every such policy which contains a reference to the application, either as a part of the policy or as having any bearing thereon, shall have endorsed thereon or attached thereto, when issued, a correct copy of the application."

inapplicable to the policy, since everything except formal issuance occurred here. The Court ruled, however, that the addition of "good recovery" was not such an alteration as to require exclusion of the application. Slight or immaterial changes from an application as it exists at the time of signing do not result in making Section 131 operative. If the alteration here added anything to the meaning of "Usual childhood diseases" the addition was minimal.

The 1965 SURVEY year case of *Flanagan v. John Hancock Mutual Life Insurance Co.*<sup>8</sup> also involved denials in the application of significant medical history and evidence at the trial of extensive treatment prior to the application for Hodgkin's disease. The evidence was that the treatment included deep X-ray therapy on numerous occasions. The trial judge charged the jury that the plaintiff beneficiary was bound by her testimony that the insured had received X-ray treatments, and charged further that the insured's denial in his application that he had ever had X-rays was false as a matter of law. The plaintiff argued that she was entitled to the benefit of any other evidence in the case which was more favorable to her on this issue and that the very denial by the insured in the application that he had X-rays was such evidence. The Supreme Judicial Court said that there was no suggestion in the record that the application, necessarily admissible as part of the insurance contract,<sup>9</sup> was offered or received under General Laws, Chapter 233, Section 65, as a declaration of a deceased person evidencing the truth of the matters stated in it.<sup>10</sup> Indeed the judge's charge pointed quite to the contrary. The misrepresentation as to X-ray treatments was therefore established as a matter of law. Although the trial judge had let the case go to the jury on the question of increase of the risk, and the jury found for the insurer, the Supreme Judicial Court treated the false denial of X-rays like the false denial of hospitalizations in the *Pahigian* case, and held that by depriving the insurer of the opportunity by investigation to discover the diagnosis of Hodgkin's disease it increased the risk as a matter of law.

**§17.19. Nonlapsation for failure to pay premiums during strike of collection agents.** General Laws, Chapter 175, Section 187F, inserted by Acts of 1963, Chapter 796, was declared invalid by the Supreme Judicial Court in *John Hancock Mutual Life Insurance Co. v. Commissioner of Insurance*.<sup>1</sup>

The statute provided that no life insurance policy, noncancellable disability insurance contract, hospital expense or hospital and surgical expense contract now or hereafter in force in the Commonwealth, premiums for which are "normally collected" by insurance agents em-

<sup>8</sup> 1965 Mass. Adv. Sh. 1023, 208 N.E.2d 497.

<sup>9</sup> Under G.L., c. 175, §131, quoted in note 7 *supra*. See also G.L., c. 175, §132, subsec. 3.

<sup>10</sup> *Shurdut v. John Hancock Mutual Life Insurance Co.*, 320 Mass. 728, 730-731, 71 N.E.2d 391, 392 (1947).

**§17.19.** <sup>1</sup> 1965 Mass. Adv. Sh. 1007, 208 N.E.2d 516, also noted in §§11.3, 15.11 *supra*.

ployed by the insurer, should terminate or lapse by reason of default in payment of any premium, installment, or interest on any policy loan payable to the insurer during a period its agents are on strike. It allowed the premium payer a grace period of thirty-one days following the "authorized" termination of the strike in which to pay the premium, installment, or loan interest, during which time the policy or contract was to continue in full force and effect. Provision was made, in the event a claim should arise during a strike or grace period, for the overdue premium or installment and interest thereon, and the amount of any policy loan and interest, to be "deducted" from the amount payable under the policy.

An insurance company, doing extensive business both within and without the Commonwealth in the kinds of policies which the statute apparently was designed to embrace, proposed to issue an endorsement as to each such policy theretofore or thereafter issued by it. The endorsement provided, as the sole effect of a strike upon policy obligations, a reinstatement privilege more favorable to policyholders than the policies had provided. The endorsement, however, was less favorable than the provisions of Section 187F to holders of policies the premiums for which are normally collected by the company's insurance agents. For this reason the Commissioner of Insurance disapproved the use of the endorsement when its form was submitted to him pursuant to statute.<sup>2</sup>

The company petitioned for review of the Commissioner's action, contending that Section 187F, the only statute which the form did not comply with, was invalid, and therefore was no bar to use of the endorsement. Other interested insurers, the Life Insurance Association of America, and the Insurance Workers International Union, AFL-CIO (which had pressed for enactment of the statute), submitted briefs as *amici curiae*. The Supreme Judicial Court held that the statute was invalid because in conflict with the federal labor relations policy fostering collective bargaining free from coercion by state laws. It did not pass upon several other arguments of the company which included contentions that the statute violated constitutional protections against deprivation of property without due process of law and against impairment of contracts.

The Court held that on the facts presented the company's labor relations with its collecting or debit agents (with whom the company had a collective bargaining agreement) were subject to the National Labor Relations Act, as amended.<sup>3</sup> By virtue of the Supremacy Clause<sup>4</sup> of the United States Constitution, any state enactment conflicting with federal law is invalid. Section 187F was not within any of the express grants by

<sup>2</sup> G.L., c. 175, §§22A, 108 cl. 2(a), 132, 192.

<sup>3</sup> 49 Stat. 449, 61 Stat. 136, as amended, 29 U.S.C. §§151-168 (1964). See 59 Stat. 33-34, 15 U.S.C. §§1011-1015 (1964), the McCarran-Ferguson Act, allowing the states to regulate interstate insurance business but specifically leaving unaffected the application to such business of the National Labor Relations Act, as amended.

<sup>4</sup> U.S. Const., art. VI, par. 2.

Congress to the states of power over certain aspects of interstate labor relations, nor did it operate in a field which prior case law had shown to be clearly within state or clearly within federal control. Therefore its validity, said the Court, was to be determined by the extent to which its operational effects were in conflict with the purposes and policy of the federal labor laws. On this question it was irrelevant that the statute was presumably enacted for purposes not related to labor relations. For, regardless of its purpose, it plainly had profound effect upon collective bargaining between the company and its debit agents.

The facts of the case showed that the company's policies by their express terms require, and in issuing them the company relied upon, payment of premiums in advance of the period for which insurance benefits are provided, and that except as otherwise allowed by the usual grace period and nonforfeiture clauses, coverage ceases at the end of the period for which the most recent premium has been paid. The requirement of advance payment makes the premiums available for payment of expenses and claims, loans and nonforfeiture benefits, and also for investment.

The Court held that the effect of Section 187F was to enhance the power of the strike weapon in the hands of the company's agents, for a strike would not merely deprive the company of the agents' services. It would deprive it of its right to enforce policy provisions requiring prepayment of premiums as a condition precedent to insurance coverage under policies on which premiums are "normally collected" by the company's agents. This deprivation would occur not only throughout the strike but for thirty-one days after the "authorized termination" of the strike. The effect on the company would be severe. The company, deprived of current income, might be forced to liquidate investments in order to pay current claims, loans, and nonforfeiture benefits. It would also be in doubt as to who among those insured at the beginning of the strike remain insured. The Court said that it did not appear that the company could enforce the collection of premium arrearages after the strike from those who should then claim they had intended to let their policies lapse.

Presumably those terminating their insurance by nonpayment of arrearages would only be those who had neither suffered losses nor became increased risks during the strike, resulting in a process of self-selection, predicated upon the insurant's self-interest (see *New York Life Ins. Co. v. Statham*, 93 U.S. 24, 32), which would be adverse to the petitioner's contractual rights, and in contravention of sound actuarial principles upon which the insurance business is required by law to be conducted.<sup>5</sup>

<sup>5</sup> 1965 Mass. Adv. Sh. 1007, 1017-1018, 208 N.E.2d 516, 524. The *Statham* case is also reported at 23 L. Ed. 789 (1876). The United States Supreme Court, 93 U.S. at 30, 23 L. Ed. at 791, recognized: "All the calculations of the insurance company are based on the hypothesis of prompt payments. They not only calculate on the receipt of the premiums when due, but on compounding interest upon them." That Court went on to note that the business is based upon the law of averages

Even if provision could be made for a right to collect arrearages, collection costs which might be substantial would be involved, whereas under the system of prepayment of premiums basic to the insurance business these costs are not incurred.

The Court held that these prospective losses to the petitioner are inescapably contrary to the actuarial basis upon which the business of insurance is operated because they cannot be definitely provided for through adjusted premiums even in policies permitting change of premiums. The incidence of strikes is not predictable. The timing of a strike is exclusively, and its duration is largely, within the control of the bargaining unit of the company's agents. The statute in question thus gave the agents' union the power to inflict serious economic loss on the company and in doing so provided additional coercive strength to the agents' representatives at the bargaining table. The Court felt that these effects conflicted with Congressional intent that parties to collective bargaining should have wide latitude in their negotiations, unrestricted by any governmental power to regulate the substantive solution of their differences.<sup>6</sup> Although Section 187F did not regulate any substantive term of a labor-management agreement, it gave the union a potent weapon which could not fail unilaterally to restrict the desired bilateral freedom of collective bargaining which Congress left free for operation of economic forces. "For the State to intrude into such an area designed to be kept free is as much a violation of the Federal policy as it is for a State to attempt to regulate rights or duties specifically protected by the Federal acts."<sup>7</sup> The Court said that Section 187F tended to compel submission by the company in any labor dispute with its agents, a compulsion that is repugnant to the national policy favoring agreements arrived at in free collective bargaining. It compared Section 187F with General Laws, Chapter 150, Section 3. The latter statute required the State Board of Conciliation and Arbitration to ascertain and publish which party to a labor dispute was mainly responsible or blameworthy for its existence or continuance. The United States Court of Appeals for the First Circuit held that provision to be contrary to the national policy not to compel agreement but only to encourage voluntary agreements.<sup>8</sup>

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with the risks spread out over a large number of people (so that premiums of those who turn out to be healthy or long-lived make up the deficit of benefits paid out over premiums paid in for those who are not so fortunate) and said, 93 U.S. at 32, 23 L. Ed. at 792: "If every policy lapsed by reason of the war should be revived, and all the back premiums should be paid, the companies would have the benefit of this average amount of risk. But the good risks are never heard from; only the bad are sought to be revived, where the person insured is either dead or dying. Those in health can get new policies cheaper than to pay arrearages on the old. To enforce a revival of the bad cases, whilst the company necessarily lose the cases which are desirable, would be manifestly unjust."

<sup>6</sup> *NLRB v. Insurance Agents' Int. Union, AFL-CIO*, 361 U.S. 477, 488, 80 Sup. Ct. 419, 426, 4 L. Ed. 2d 454, 463 (1960).

<sup>7</sup> 1965 Mass. Adv. Sh. 1007, 1019, 208 N.E.2d 516, 525.

<sup>8</sup> *General Electric Co. v. Callahan*, 294 F.2d 60 (1st Cir. 1961), *cert. denied sub nom. Callahan v. General Electric Co.*, 369 U.S. 832 (1961).

The Supreme Judicial Court went on to hold that in addition to the general interference with free collective bargaining, Section 187F interfered with rights, specifically protected under the National Labor Relations Act as amended,<sup>9</sup> of employees not to strike and of employers guilty of no act proscribed by the N.L.R.A. to continue their business by hiring replacements for strikers. By suspending the obligation of policyholders to pay premiums, Section 187F had the effect of sharply curtailing or eliminating premium collection work available for non-striking workers or replacements, rendering these rights nugatory.

The Court concluded that the statute was invalid, and even if there had been a showing of a significant state concern which prompted its enactment this still could not have saved it in view of its inherent incompatibility with federal labor laws.

#### D. LIFE INSURANCE — LEGISLATION

**§17.20. Insurance companies: Variable annuities and pension contract funding agreements.** Acts of 1965, Chapter 260, authorized variable annuity insurance companies<sup>1</sup> to grant their variable annuity contract holders such voting rights as the companies deem necessary to qualify under the Federal Investment Company Act of 1940, as amended.<sup>2</sup> The United States Supreme Court had held in *Securities & Exchange Commission v. Variable Annuity Life Insurance Co.*<sup>3</sup> that such companies were within the purview of that act, that their variable annuity contracts were within the coverage of the Federal Securities Act of 1933,<sup>4</sup> and that neither was within the “insurance,” “insurance company,” “insurance contract,” or “annuity contract” exceptions written into those Acts<sup>5</sup> or in Section 2(b) of the McCarran-Ferguson Act.<sup>6</sup> And the United States Court of Appeals for the Third Circuit in *Prudential Insurance Co. of America v. Securities & Exchange Commission*<sup>7</sup> had affirmed a holding of the S.E.C. that, while a large insurance company not primarily engaged in the securities business was exempt from the Investment Company Act, its separate variable annuity investment fund constituted an “investment company” within the meaning of, and subject to, the act.

By Acts of 1960, Chapter 562, inserting General Laws, Chapter 175, Section 132F, the legislature permitted life insurance companies to enter “funding agreements” with holders of “pension contracts” so as to provide not only for the payment of guaranteed annuities, the funds

<sup>9</sup> 61 Stat. 140, 141, 29 U.S.C. §§157, 158(a)(1), 158(b)(1)(A) (1964).

§17.20. <sup>1</sup> See 1964 Ann. Surv. Mass. Law §17.19.

<sup>2</sup> 54 Stat. 789, 15 U.S.C. §§80a-1 to 80a-52.

<sup>3</sup> 359 U.S. 65, 79 Sup. Ct. 618, 3 L. Ed. 2d 640 (1959).

<sup>4</sup> 48 Stat. 74, 15 U.S.C. §§77a-77bbbb (1964).

<sup>5</sup> Investment Company Act, §§3(c)(3), 2(a)(17), 54 Stat. 789, 797, 15 U.S.C. §§80a-3(c)(3), 80a-2(a)(17) (1964); Securities Act, §3(a)(8), 48 Stat. 75, as amended, 15 U.S.C. §77c(a)(8) (1964).

<sup>6</sup> 59 Stat. 34, 15 U.S.C. §1012(b) (1964).

<sup>7</sup> 326 F.2d 383 (3d Cir. 1964), *cert. denied*, 377 U.S. 953 (1964).

and reserves for which must meet the companies' conservative general investment requirements, but also in the same contracts for nonguaranteed annuities, the funds for which may be more liberally invested through a separate investment account.<sup>8</sup> Such contracts are a compromise between standard annuity contracts and variable annuity contracts. Acts of 1965, Chapter 296, revised Section 132F. The 1965 statute principally provided that a life insurance company (1) may maintain more than one such separate account; (2) may, with the permission of the Commissioner of Insurance, transfer investments between a separate account and the company's general investment account when such transfers would not be inequitable; and (3) may accept in payment of amounts due it under a funding agreement a transfer of assets held under a qualified pension, profit-sharing, or retirement plan.

**§17.21. Insurance companies: Investments.** Acts of 1965, Chapters 269 and 300, changed the requirements concerning securities in which domestic insurance companies may invest their capital and reserves. Chapter 269 amended paragraphs 14A and 14C of Section 63, Chapter 175 of the General Laws, so as to make possible somewhat freer investment of a portion of a company's capital or reserve in bonds, notes, and certain other securities of American and Canadian firms, particularly when such firms are banks or are engaged in the finance or factoring business. Chapter 300 adds a new paragraph 14F to Section 63, allowing investment in equipment or chattels, or obligations secured thereby, acquired for sale or lease to qualified governmental units or business firms. It follows the theme of Chapter 269 of the Acts of 1965 by setting less stringent earnings history requirements in order for banks and finance and factoring companies to constitute qualified firms.

**§17.22. Insurance companies: Retirement from the field.** Acts of 1965, Chapter 499, amended General Laws, Chapter 175, Section 44, by adding a provision enabling an insurance company to cease issuing policies but to continue in existence as a corporation subject to the business corporation laws. This change will require the permission of the Commissioner of Insurance, the dropping of the word "insurance" or "assurance" from the company name, the filing of articles of amendment with the State Secretary, and the making of adequate provision for assumption by qualified solvent companies of all outstanding risks and claims. A retiring insurance company will continue to be liable on all its obligations, and the Commissioner may require that it deposit in trust a contingency fund out of which such obligations may be satisfied. The company, however, will be freed of asset restrictions applicable to insurance companies.

**§17.23. Life insurance: Dividends on industrial and debit policies.** Acts of 1965, Chapter 567, amended General Laws, Chapter 175, Section 140, so as to provide that the annual surplus distribution on participating industrial and debit life insurance policies, which must begin not later than the end of the fifth policy year, shall annually, at the op-

<sup>8</sup> See 1960 Ann. Surv. Mass. Law §16.15; 1964 Ann. Surv. Mass. Law §17.19.



tion of the owner, be (a) payable in cash, or (b) applied in reduction of premiums, or (c) left on deposit with the company to accumulate at interest, or (d) used to purchase paid up additions to the policy. This enactment gives options to the policyholders concerning methods of distribution of dividends apportioned to industrial policies, whereas in recent years the manner of distribution of industrial policy dividends had been left to the discretion of the company with the approval of the Commissioner of Insurance. It also categorizes all future "debit" life insurance policies with industrial policies, for dividend purposes, and thus makes inapplicable to them the somewhat different dividend option treatment heretofore specified in Section 140 for all nonindustrial participating life policies.<sup>1</sup> It thereby changes, from the end of the third to the end of the fifth policy year, the time by which annual surplus distribution will be required to begin on "debit" life policies. There is no definition of "debit" policies in the statute, but companies will probably insert provisions consonant with the new statute in forms for life policies as to which it is intended that premiums regularly be paid directly to agents who visit personally to collect them.

§17.23. <sup>1</sup> See 1963 Ann. Surv. Mass. Law §16.17.