2001 WL 35725469 (Mont.Dist.) (Trial Motion, Memorandum and Affidavit)
District Court of Montana,
Thirteenth Judicial District Court.
Yellowstone County

Barbara WILLIAMS, Plaintiff,
v.
UNION FIDELITY LIFE INSURANCE COMPANY, Defendant.

Cause No. DV 99-501.
December 20, 2001.

Plaintiff's Response to Defendant's Motion for Summary Judgment and Brief in Support of Plaintiff's Cross Motion for Partial Summary Judgment

Judge: Russell C. Fagg.

PROCEDURAL BACKGROUND

Plaintiff's complaint seeks compensatory and punitive damages from Union Fidelity for its denial of benefits and subsequent rescission of the credit life insurance policy it sold to Clarence and Barbara Williams. As an affirmative defense, Union Fidelity claims that its rescission was lawful because Clarence Williams misrepresented facts material to the risk assumed when the insurance was issued. Now, Union Fidelity has filed a motion for summary judgment grounded upon the affirmative defense of material misrepresentation. Williams not only opposes Union Fidelity's motion, but has filed a cross-motion seeking partial summary judgment upon her breach of contract claim and further establishing that Union Fidelity violated Montana law by engaging in the unfair claim settlement practice known as post claim underwriting.

FACTS

On December 7,1996, Clarence Williams and Barbara Williams purchased a new pickup from Archie Cochrane Motors in Billings. As was his long-standing custom, Clarence said, "yes," when he was offered credit life insurance as part of the deal. "He was a firm believer in it." (Williams depo. p. 28). The "Application" for this credit life coverage was incorporated in the Certificate of Insurance issued on the spot by Archie Cochrane, acting as agent for Union Fidelity. *See* Plaintiff's Complaint, Exhibit 1. The application is duplicated here, in its entirety:

TABLE

According to Union Fidelity Senior Vice President Laurie Rowe, two *opinions* regarding the applicant's condition of health are required at the time the certificate of insurance is issued, (1) the car dealer's sales agent, and (2) the applicant. No one else is involved. (Rowe depo., pp. 66-67, 69). As explained in Union Fidelity's "Underwriting Manual,"

> "... *the sales person who* had the personal contact with the proposed insured, *selects those to be proposed for insurance,* selects a plan, benefits and amounts to be applied for, quotes a premium price and completes the application."

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(Exh. 34, Sec. 1, Introduction, page 1-4; VonHagel depo., p. 28).

No forms, no fact-specific health questions, no medical examinations, no medical tests, no medical screening and no authorizations for release medical information are requested or required by Union Fidelity as a part of the application process. (Thomas depo. p. 34; VonHagel depo. pp. 20, 24; Rowe depo. pp. 79, 81-84). Once the Certificate/Application is signed by the applicant, credit life insurance coverage is issued. One signature does it all.

Union Fidelity has and uses credit life insurance Certificate/Application forms which contain fact-specific health questions, including forms which inquire particularly with respect to past treatment for cancer. (Exh.46). For example, its Credit Insurance Manual includes this example:

TABLE

(Exh. 31, p. 7.5; Rowe depo. p. 83). In Michigan and Oklahoma, the Union Fidelity application includes fact-specific health questions relating to medical history. For applicants in the State of Michigan, the questions explore the preceding five years:

TABLE

(Exh. 46; Rowe depo. p. 94). In Oklahoma, the medical history which Union Fidelity deems "material" is limited to the past twelve months.

TABLE

(Exh. 47; Rowe depo. p. 94-95).

Although Union Fidelity considers fact-specific health questions important in some states, it claims that, in Montana, an applicant's medical history is irrelevant, at least at the time coverage is issued. As expressed by Senior Vice President and corporate representative Laurie Rowe, "if past medical history were a part of insuring this risk, we would have asked." (Rowe depo., p. 101).

Union Fidelity's Application form designed for use in Montana also fails to define the words, "good health." This is not to suggest that Union Fidelity does not acknowledge the need to define the term -- Defendant's Credit Insurance Manual offers the following observation about, and interpretation of, the phrase:
Quite often, the question, what is good health, is asked of the home office. Although opinions vary slightly, it is generally agreed that a person in good from health is free from serious disease that could be expected to cause health problems in the *foreseeable future,* he's able to perform the usual activities of like age and build and is capable of working at least 30 hours per week...."

(Exhibit 31, page 4.3, UF450); Laurie Rowe depo., p. 70).

When asked to give meaning to the words, "foreseeable future," as used in the company's definition of "good health," Rule 30(b)(6) deponent Laurie Rowe testified that she considers them to mean, "the period of time for which the insurance will run." (Rowe depo., pp. 74,75).

Union Fidelity understands not only that opinions regarding good health vary, but also that opinions are different from facts. (Rowe depo., p. 53). Union Fidelity admits that the signature upon its Certificate/Application certifies nothing more than the applicant's *opinion* about his health. (Rowe depo., p. 102).

Insurance certificates and premiums obtained by the auto dealership are forwarded to Union Fidelity's Premium Processing Department. Upon receipt by Union Fidelity, each Certificate is checked to confirm that it has been signed and to assure that it was properly completed. (Paga depo., p. 17). No traditional insurance "underwriting" of any sort is performed by or for Union Fidelity, even though this insurer knows full well *when* underwriting is supposed to take place and *what* it is intended to accomplish. Indeed, Union Fidelity's Underwriting Manual defines the "life underwriter" as that person who,

> "reviews the application and decides whether an insurance contract will be issued. If that decision is affirmative, the life underwriter decides what plan benefits and amount will be issued with or without restrictions at a price that falls within the system of risk classification used by the insurance company. The process the life underwriter performs is, therefore, risk classification rather than risk selection. It ... has been traditionally called underwriting."

(VonHagel depo., pp.28-29; Exh. 34, page 1-4).

In December, 1997, Union Fidelity's sole "underwriter" was De'Laina VonHagel. (VonHagel depo., p. 8). Ms. Vonhagel admits she has never done any real underwriting. Union Fidelity's version of underwriting was always done only *after* a claim had been submitted. (VonHagel depo. p. 29; Paga depo., p. 17). It was her duty to review claim files "to determine if a misrepresentation of the application statement was made and whether the condition misrepresented was material." (VonHagel depo., p. 7).

Although Union Fidelity swears that past medical history is irrelevant when promises of coverage are made, it is equally clear that things change after a claim for benefits has been submitted. In the company Claims Department, past medical history is considered important to the risk undertaken by the insurer. (Thomas depo. p. 31). Indeed, a medical history which includes *any* prior treatment for cancer or tumor is so important that, *each and every time a claims analyst turns it up,* the claim is flagged and the certificate is to be submitted to "Underwriting" for possible rescission. (VonHagel depo., pp. 65, 66).

The purpose of Union Fidelity's post claim underwriting "system" was explained by Senior Vice President and Rule 30(b)(6) corporate representative, Laurie Rowe:
A: The process of underwriting eliminates poor risks.

Q: How?

A: If they have -- I think I don't understand your question because.

Q: The question is how?

A: How what?

Q: ...does the process of underwriting eliminate poor risks?

A: Because we expect a person to read and sign a health statement. And if they read that health statement and it -- they cannot honestly sign that as a true statement, then they say, I can't sign this, and therefore, they're not insured.

Q: And if they sign the -- the Montana form, and assuming that the term and premium are correct, then they are insured and the certificate is issued, right?

A: The certificate is field issued at the dealership based upon their cert --

Q: Signature.

A: Their certification of good health, yes."

(Rowe depo., pp. 23-24).

Union Fidelity's post claim underwriting "system" of eliminating poor risks, kicked in after Clarence Williams passed away on September 20, 1997. Following his death, the claim form and request for payment of credit life insurance benefits was submitted and received in the Union Fidelity Dallas, Texas claims office on October 14, 1997. (Mike Lively depo., p. 40; Exhibit 13). There, the claim was assigned to Claims Analyst Mike Lively for initial handling. His first act was to pull up a preprinted form known as a "New Claims Template." (Lively depo., pp. 42,44; Exh. 14). After first recording certain basic identifying information on this "template," Mr. Lively set out to determine whether this claim for Credit Life Insurance proceeds was "deniable." That is, whether it was within the 2 year period of "contestibility." (Lively depo., p. 53; Exh. 14). After concluding that Barbara Williams claim was indeed "deniable," Mr. Lively then moved on to Question 3A on the New Claims Template. This preprinted question asked the Claim Analyst to focus exclusively upon past medical history. Question 3A inquires:

Is it reasonably possible that condition *existed prior to* the effective date?

Union Fidelity insists that the applicant's Death Certificate be enclosed when a claim is submitted. Since Clarence Williams' death certificate identified renal cell carcinoma which had existed "for years" as an underlying cause of death, Claims Analyst Lively answered Question 3A affirmatively. (Lively depo., pp. 54, 55). At that point, Mike Lively was required to telephone Barbara Williams using the preprinted form titled, "Initial Telephone Contact," to guide his interrogation. Senior V.P. Rowe admits that this form serves as, "a directive to dig out information about past medical history." (Rowe depo., pp. 107; Lively depo., pp. 56-57, 60; Exh. 15). In fact, the template focused the conversation so neatly that Mr. Lively could not recall asking Barbara Williams about *anything other than* her late husband's past health history, including her confirmation that "there was no discussion of past medical history or treatment at the time of enrollment." (Mike Lively depo., pp. 60, 64). Finally, Mike Lively got around to asking why Mr. Williams signed the insurance application under the printed wording about "good health," and dutifully recorded Mrs. Williams' response on yet another pre-printed form titled, "Phone Call Regarding Application Misstatements." (Exh. 16). As Barbara explained it, her husband signed the form because, "He was in good health." (Lively depo., pp. 73, 73).

The next step in the claims handling process, was to request Mr. William's past medical records. (Lively depo., p. 80). When the medical records arrived, Union Fidelity set about "to determine whether or not he qualified for the insurance when he applied for it." (Thomas depo., p. 46). Without the assistance of underwriting manuals or underwriting consultations, Claims Analyst Jim Thomas decided that Clarence Williams was not qualified to obtain the insurance at the time it was issued to him by Archie Cochrane Motors on December 7, 1996.

Jim Thomas reported his recommendation to his "Claims Team Coordinator," Heidi Paga. Ms. Paga was free to form her own opinion regarding Clarence Williams condition of health on December 7, 1996, which might differ from that of Mr. Thomas (Paga depo., p. 28). As it turned out, she approved Thomas' recommendation, and then referred the matter for review by her supervisor, Patricia Miles. Ms. Miles, of course, was also free to form her own opinion about an applicant's condition of health, leading to the admitted, "... potential right here, within your own little unit for at least three different opinions on health, the claims analyst, the unit manager and the supervisor ...." (Paga depo., pp. 28-30). [1] In this instance, Ms. Miles placed her approval on the rescission recommendation, at which point Clarence Williams insurance Certificate was ready to be "underwritten" by Union Fidelity, for the very first time. All this opinion-forming, of course, was done without further investigation; Barbara Williams was never contacted again prior to rescission and none of her husband's treating physicians were ever contacted at all.

The testimony of Union Fidelity's post claim underwriter establishes that the sole ground for rescission was Mr. Williams' past medical treatment for cancer. (VonHagel Affid. ¶12; VonHagel depo., pp. 49-50).[2] This undisputed fact is driven home unequivocally in Ms. VonHagel's sworn testimony:

"Q: In paragraph 12 of your affidavit, if you have it there, it says -- would you read it for us?
A: "If Mr. Williams had disclosed the fact that he had been treated for advanced stage renal cell carcinoma in Spring of 1996, Union Fidelity would not have issued a life insurance policy for Mr. Williams in December 1996".

Q: That's the paragraph in which you're telling the Court the -- the reason why Union Fidelity rescinded, right?

A: Yes.

Q: And as we have already established, it was your intent to be accurate and complete in setting forth this affidavit testimony for the Court to consider, true?

A: True."

(VonHagel depo., pp. 62-63).

Upon completion of its post claim underwriting, Union Fidelity wrote to Barbara Williams on December 16, 1997, claiming that her late husband was guilty of misrepresenting his health, denying her claim for benefits and rescinding the policy. (Exh. 29). Team Leader Heidi Paga agreed with Claims Analyst Jim Thomas that this was, "the letter that was intended to inform Mrs. Williams of the basis in the policy and in the facts" for Union Fidelity's actions. (Paga depo., pp. 40, 41; Thomas depo., pp. 70, 71). Unfortunately, the letter provides no specifics at all. (Thomas depo., pp. 71, 72). It does not even attempt to explain that failure to "disclose" past treatment for cancer is what was considered a material misrepresentation, let alone how such a conclusion could possibly be reconciled with Senior V.P. Rowe's sworn testimony that, "if past medical history were a part of insuring this risk, we would have asked." (Rowe depo., p. 101).

Although it is true that Clarence Williams was treated for cancer in the Spring of 1996, the record provides a reasonable basis for Clarence Williams' belief that he had "beaten" this disease not once, but twice. In 1986, a cancerous tumor had been removed from his kidney, after which he returned to work and lived a normal life for the next 10 years. When, in March, 1996, he was diagnosed with recurrent renal cell carcinoma, histologically identical to the original renal cell carcinoma which had been treated ten years earlier, he confidently predicted, "Hon, I did it before; we'll do it again." (Barbara Williams depo. p. 40).

Throughout the spring of 1996, Clarence underwent a course of radiation therapy intended to shrink and neutralize his tumor. Barbara William's testimony is that her husband understood that, as a result of the radiation therapy, his radiation oncologist, Dr. John Terry of the Northern Rockies Cancer Center, was hoping Clarence "would be free of cancer." (Barbara Williams depo. p. 35.) Clarence completed his radiation therapy on May 10, 1996, (Dr. Terry depo. p. 14), and, on that day, Dr. Terry tried to give Clarence an understanding of what the future held:
"Q: You talked about symptom control and inhibiting further growth of the tumor in answer to Mr. Forsythe's questions. And as I recall, I tried to make a note, that one of the things you took pains to explain to them is that there could be a recurrence in another location of another tumor, is that correct?

A: Correct.

Q: Do you customarily give examples of the time frame within which this could occur.

A: General time frames. Months, years. I usually do not qualify three months, six months, one year, two years.

Q: Do you talk even in terms of five or ten years?

A: In this disease process, yes.

Q: Do you believe that would be the type of conversation that you had with Clarence Williams?

A: To the best of my recollection, yes."

(Dr. Terry depo. pp. 22, 23). (Emphasis added).

Clarence Williams' oncologist, Dr. Brock Whittenberger, concluded his treatment of Mr. Williams on November 18,1996. At the conclusion of therapy, it is his practice is to lay out "the full range of possibilities," including "an extensive period of normal living." (Dr. Whittenberger depo., p. 47; pp. 51, 52). It is also unequivocally established through Dr. Whittenberger's testimony that,
"Q: The level of problem that Clarence Williams was showing, and particularly after you treated it, was not going to kill him absent some later recurrence?

A: That's correct, although he had some complications from the treatment.

Q: Right, which had run their course?

A: Yeah.

(Dr. Whittenberger depo., p. 62).

Of course, Union Fidelity did not take this vital information into account in deciding to rescind, because it chose not to contact any of Clarence Williams' treating doctors, or even ask Barbara Williams what her husband's doctors had told them, during its "investigation." Nor did Union Fidelity have evidence that Clarence Williams did not, in good faith, believe himself to be in good health on December 7, 1996. His treating oncologist, Dr. Whittenberger, would have explained the situation this way if the insurer had bothered to ask:
"Q: With respect to Mr. Williams or Mrs. Williams, did you ever tell them anything about his disease that would lead them to conclude based on what you said that he was going to be okay?

A: Well, it is complicated, but when we discussed the results of that last CAT scan that he had and that, you know, his symptoms were from radiation pneumonia, *he may have interpreted that as saying, you know, the cancer is doing okay.*

(Dr. Whittenberger depo. pp. 39, 40). (Emphasis added).

Union Fidelity has proven that, on December 7, 1996, Clarence Williams had completed his cancer treatment, he had a *history* of cancer treatment and a non-terminal tumor, which had not only been stopped in its tracks, but actually reduced in size through radiation therapy. Defendant has also proved that Clarence was *at risk* for recurrence of his cancer at some unknown and unknowable location in his body, at some unknown and unknowable later time, which could be five or ten years down the road. In short, Union Fidelity has established that Clarence Williams had reason to count himself among that large, happy and optimistic group which refers to itself as, "cancer survivors," just as he had since 1986.

Based upon these facts, Barbara Williams respectfully submits not only that Union Fidelity's motion for summary judgment must be denied, but also that her cross motion for summary judgment should be granted.

ARGUMENT

1. Union Fidelity's misrepresentation defense fails as a matter of law.

Union Fidelity affirmatively contends that claim denial and policy rescission were appropriate, placing reliance upon Montana's "material misrepresentation" statute, Section 33-15-403, M.C.A. In asserting this defense, of course, Union Fidelity accepted the burden of proving a misrepresentation of fact, material to the risk. See e.g., *Watters v. Guaranty National Insurance Company,* 2000 MT 150, 300 Mont. 91, 3 P.3d 626, 639 (2000). *See also Jackson National Life Insurance Company v. Sneed* 499 S.E.2d 173 (Ga.App. 1998).

Montana decisions involving similar attempts at rescission clearly establish that Union Fidelity's attempt to avoid Barbara Williams' claim for credit life insurance benefits must fail. More than a quarter century ago, the Montana Supreme Court made clear that an insurance applicant's signature upon a form like this one constitutes a statement of opinion, not a representation of fact. In *Lentz v. Prudential Insurance Company of America,* 164 Mont. 197, 520 P.2d 769, 772 (1974), the decedent had signed an insurance application declaring, "that to the best of my knowledge and belief, I am now in good health." As the insurer later discovered, Lentz had been hospitalized just weeks before buying his insurance due to high blood pressure, back pain, abdominal aneurysm, and because "his kidneys weren't doing their full work." It also learned that Lentz' doctor knew he was in terrible shape, but reassured Lentz that his health was improving in order to avoid frightening him to death. Refusing to find misrepresentation, the Montana Supreme Court quoted and relied upon the general rule expressed in *Couch On Insurance,* 2d, Section 35:150.

> ... [W]here the applicant for life insurance certifies that his health is good according *to the best of his knowledge and belief,* a recovery may be had, on the death of insured, if it appears that *he had reason to believe and did believe, that at the time he was in good health,* although it subsequently develops that this was not in fact his condition, for *his statement was not unqualified, but only to the extent of his knowledge and belief.*

Lentz, supra, 520 P.2d at 772 (emphasis added).

While the rule of *Lentz,* standing alone, is more than sufficient to defeat Union Fidelity's attempt at rescission, the law of Montana governing material misrepresentation did not cease evolution in 1974. It changed even more dramatically in 1991, when the Supreme Court handed down *Schneider v. Minnesota Mutual Life Insurance Company,* 247 Mont. 334, 806 P.2d 1032. There, plaintiff's husband had purchased credit life insurance in connection with a bank loan. The Vice President of the bank assisted him in answering the following fact-specific health questions on the application:

1. During the last three years, have you been hospitalized or have you consulted a physician or physicians for any reason?

2. Have you ever been treated for or advised that you have had any of the following: heart, lung, nervous or kidney disorder, high blood pressure, cancer or tumor, diabetes?

Jock Schneider answered "No," to both questions. Not long after, he died of a self-inflicted gunshot wound to the head. Since Mr. Schneider's death occurred within the period of contestibility under the credit life insurance policy, Minnesota Mutual (like Union Fidelity here) embarked upon a "routine" investigation of his medical history. In so doing, it discovered that Mr. Schneider had actually been seen by his physician on several occasions between December 2, 1981 and January 21, 1982. Throughout this time, the physician was diagnosing Mr. Schneider as suffering from alcoholism and depression. Upon discovering these facts, Minnesota Mutual wrote to Mr. Schneider's widow, advising that:

> After careful consideration, we have determined that if this additional information [the visits to Dr. Shaub] had been available to our underwriters at the time they were considering your husband's application for this insurance, they would have declined to insure him.

Schneider, 806 P.2d at 1034.

In *Schneider,* as in the present case, the issue was whether the insurer had proven a *material* misrepresentation of fact within the meaning of Section 33-15-403(2), M.C.A.. With reasoning directly applicable to this action, the Supreme Court held that there was no material misrepresentation because the health questions on the insurance application *"failed to ask any specific questions about either alcoholism or alcohol use."* The Court gave fair warning that Montana law demands specificity in health questions on life insurance application forms.
... the prudent insurer would have specifically requested information about all critical underwriting factors. Thus, if alcoholism was indeed material to Minnesota Mutual's acceptance of the risk, it would have expressly asked questions about alcohol use, just as it specifically requested information about heart, lung, nervous or kidney disorders, high blood pressure, cancer and diabetes. Other courts have reached a similar conclusion. *Botway v. American Int'l Assurance Co. of New York,* 151 A.D.2d 288, 543 N.Y.S.2d 651, 652 (1989); *Kampfe v. Minnesota Mut. Life Ins. Co.,* C.V. 82-21-BLG, slip op. at 11-12 (E.D.Mont. 1983).

Schneider 806 P.2d at 1036 (emphasis added).

Schneider is not merely good law, it remains the seminal decision governing the affirmative defense of rescission based upon alleged material misrepresentation of fact. The *Schneider* approach was applied in *Steinback v. Bankers Life and Casualty Co.,* 2000 MT 316, 15 P.3d 872 (2001), where plaintiff's claim for benefits under a nursing home policy was refused and policy rescission was allowed. There, the Court majority was impressed by the selling agent's testimony that he had specifically asked the Steinbacks seven specific health questions, including whether Mr. Steinback had seen a doctor or received treatment or advice for "memory loss, Alzheimer's Disease, or any other organic brain disorder" within the year preceding the application. *Steinback,* 15 P.3d at 873. The opinion observes that, "the 'memory loss' question was not buried in the policy, but was one of only seven 'qualifying' questions on the front sheet of the application form." *Steinback,* 15 P.3d at 876. Accordingly, it held that the incorrect answer to this fact-specific health question recorded on the Steinback's application justified rescission.

The clear rule of *Schneider* was expressly applied most recently in *Schlemmer v. North Central Life Insurance Company,* 2001 MT 256, 2001 WL 1572714 (December 11, 2001)(copy attached). There, an insurer's rescission of a credit disability policy was affirmed in the face of an incorrect answer to the following fact-specific health question:

> 1. During the last two years, have you been medically treated for or been diagnosed by a physician as have any of the following: Cancer, High Blood Pressure (taking 2 or more medications), Heart Disease, Prior Heart Surgery, Stroke, Lung Disease, Seizure Disorder, Multiple Sclerosis, Muscular Dystrophy, Diabetes (insulin dependent), Disease or Disorder of the Liver or Kidney, Alcoholism or Drug Addiction, or Immune Disorder?

Granting summary judgment for the insurer, the District Court wrote:

> Under the analysis from *Schneider ... if an insurer considers a health condition to be material the insurer should specifically inquire about that condition.* Here the application specifically asked about lung disease. [Schlemmer's] misrepresentation is therefore material, and coverage may be denied.

Schlemmer. ¶¶7 & 13 (emphasis added). On appeal, the Supreme Court held, “the misrepresentation met the *Schneider* standard for materiality cited by the District Court, in that the North Central application included a specific question regarding lung disease.” *Schlemmer,* ¶17.

Section 33-15-403, M.C.A., permits rescission of an insurance contract only where a *material* misrepresentation of fact is proven by the insurer. As our Supreme Court held in *Schneider,* and confirmed in both *Steinback* and *Schlemmer, materiality* is determined at the time the policy is issued, not when a claim is submitted. It is measured by the scope of the fact-specific health questions which the insurer sees fit to ask the applicant. The “good health” ruse employed by Union Fidelity in order to facilitate its post claim underwriting scheme simply does not measure up in Montana, and it has not passed muster for years.

Union Fidelity cannot avoid the legal implications of its admission that it performs absolutely no underwriting functions except to see that the application form bears a signature. An insurance company which performs *zero* underwriting, cannot, as a matter of Montana law, argue that any alleged “misrepresentations” were *material.* A company which refrains from asking fact-specific health questions simply cannot claim that an incorrect answer “initially influenced the insurer to assume the risk of coverage ....” *Schneider, supra,* 806 P.2d at 1035. Union Fidelity's affirmative defense of material misrepresentation fails as a matter of law.

2. Union Fidelity's misrepresentation defense fails as a matter of fact.

While the Certificate/Application form Union Fidelity chose to use in Montana is adequate to sell credit life insurance, it is legally insufficient to support rescission for alleged “material misrepresentation.” But even if the Montana Supreme Court had not decided *Schneider* in 1991, Union Fidelity had no grounds for rescission. The record establishes that Clarence Williams had ample reason to believe he had beaten cancer again. Nothing more has ever been required by Montana law. *See Lentz v. Prudential Insurance Co., supra.*

Union Fidelity entrusted Archie Cochrane Motors' selling agent, Tate Nation, to select qualified applicants for this insurance. Tate Nation makes clear that he has never sold credit insurance to any applicant he knew to be, or who even appeared to be, in less than “good health.” Although Mr. Nation has no recollection of either Clarence or Barbara Williams, the fact that he offered them this Union Fidelity insurance policy means he believed Clarence to be in good health and had no objective reason to think otherwise. (Nation depo. p. 25).

According to Union Fidelity's Senior V.P. Laurie Rowe, the only other *opinion* which figured in the equation at Archie Cochrane on December 7, 1996, was that of Clarence Williams, who was advised in the fine print on the back of the form to sign the form, “to the best of his knowledge arid belief.” When contacted by Union Fidelity Claims Analyst Mike Lively, his widow explained that her husband signed the Application below the language referring to good health because, “He was in good health.” Claims Team Coordinator Heidi Paga testifies that nothing in the claim file indicates that Clarence or Barbara did not absolutely believe precisely this.

The medical records obtained by Union Fidelity were more than sufficient to show that Clarence Williams had reason to think he had beaten his cancer for the “foreseeable future,” once again. They establish that his radiation treatment was over, and had been since May, 1996 and that Clarence had concluded his visits to his oncologist, Dr. Whittenberger. The records also prove that, as Clarence understood it, his final CT scan in November proved that his isolated tumor had shrunk to the size of a peanut. At a minimum, Dr. Terry and Dr. Whittenberger told Clarence that his tumor was an isolated growth, that radiation treatment had shrunk its size, and that it was not going to kill him. He had been recertified as a school bus driver following physical examination in August of that year. And, he had been told that he could perhaps look forward to as many of another ten years without further problems with his cancer. Clarence Williams had plenty of reason to believe he had beaten the disease again, just like he had done in 1986.

3. Contrary to Defendant's assertion, it is Williams who is entitled to partial summary judgment upon her tort claim that Union Fidelity violated Montana law by engaging in unfair claim settlement practices.

For the reasons detailed above, Union Fidelity's affirmative defense of material misrepresentation fails, both as a matter of law and upon the undisputed facts. Plaintiff is entitled to prevail upon her contract benefits claim, including entitlement to prejudgment interest. Since Union Fidelity's motion seeking dismissal of plaintiff's tort claims is premised almost entirely upon Defendant's insupportable assertion that rescission was proper, little room remains for the insurer's argument that plaintiff's claims for fraud, bad faith and violation of Montana's Unfair Trade Practices Act should be dismissed. Indeed, much to the contrary, Williams submits that partial summary judgment establishing that Union Fidelity violated Montana statute by engaging in unfair claim settlement practices is inescapable.

A. Post claim underwriting is an unfair claim settlement practice, condemned within the insurance industry and expressly prohibited by statute in Montana.

Standard insurance industry practice is for the insurance company to conduct a comprehensive underwriting investigation *before* agreeing to insure a person. *White v. Continental General Insurance Company,* 831 F.Supp. 1545 at 1556 (D.Wyo. 1993). Union Fidelity's practice of reversing the usual order of things is known as post claim underwriting. In his dissenting opinion in *Steinback v. Bankers Life, supra,* Justice Regnier illuminated his concerns over such tactics, stating:

> Given the history of this case, ... it appears that the procedure followed by Bankers Life is to do a mass solicitation targeting the **elderly**, issue insurance policies without investigating medical histories, accept premiums, and ask questions later. It further appears that Bankers Life is only concerned about a prospective applicant's medical status when a claim is filed. Then the investigation begins in an effort to deny the claim.

Steinback, 15 P.3d at 877 (Regnier, dissenting, joined by Trieweiler and Hunt).

In *Steinback,* Justice Regnier described post claim underwriting, without actually using the phrase. He easily could have, because post claim underwriting is known to be so manifestly wrong that our Legislature has seen fit to outlaw the practice entirely. Section 33-18-215, M.C.A., states in pertinent part:

> Post-claim underwriting prohibited -- condition. An insurer ... may not ... rescind coverage provided by a ... certificate ... after a certificate ... has been issued unless the insured has made a material misrepresentation or fraudulent misstatement on the application ....

This case presents a classic example of post claim underwriting, as expressly prohibited by Section 33-18-215. As a matter of law, Union Fidelity has long been charged with the knowledge that only false responses to fact-specific health questions can give rise to a material misrepresentation. *See Schneider, supra.* The harmful consequences of any less forceful rule, which are obviously well-understood by the Montana Legislature, are ably expressed in *Lewis v. Equity National Life Insurance Company,* 637 So.2d 183, 188-89 (1994):

> It is patently unfair for a claimant to obtain a policy, pay his premiums and operate under the assumption that he is insured against a specified risk, only to learn after he submits a claim that he is not insured, and, therefore, cannot obtain any other policy to cover the loss. The insurer controls when the underwriting occurs. It therefore should be estopped from determining whether to accept an insured six months or more after a policy is issued. If the insured is not an acceptable risk, the application should be denied up front, not after a policy is issued. This allows the proposed insured to seek other coverage with another company since no company will insure an individual who has suffered illness or injury. While it may be appropriate to rely upon health questions to "screen out" applicants who present unacceptable risks, it certainly is not

> acceptable to engage in post-claim underwriting and policy rescissions based upon health questions, or answers to health questions, which are vague or ambiguous.

Here, of course, Union Fidelity admits that it does not bother even to ask its applicants to answer health questions which were vague and ambiguous; it asks no questions at all. It sells credit life insurance with the confessed intention to conduct an underwriting investigation, not for the purpose of evaluating the risk in advance, but solely for the purpose of denying the claim of the grieving spouse. In this manner, it cuts its underwriting cost to zero and increases its revenues by taking on new policy holders, secure in the knowledge that will be able, in the words of Senior V.P. and Rule 30(b)(6) corporate deponent, Laurie Rowe, to "eliminate poor risks," by rescinding the insured's policy after a claim is submitted. This is the essence of the prohibited practice of post claim underwriting. Section 33-18-215, M.C.A.; *White supra* and *Lewis, supra. See also Andrew Jackson Life Insurance Co. v. Williams,* 566 So.2d 1172, 1193 (Miss. 1990) and *St. Joseph's Hospital & Medical Center v. Reserve Life Insurance Company,* 154 Ariz. 307, 742 P.2d 808, 815 (1987).

B. Unequivocal admissions establish Union Fidelity's fraud, bad faith and unfair claim settlement practices.

Count Two of plaintiff's Complaint states a claim for relief for fraud, based upon the specific facts alleged therein. Clearer and more convincing evidence of intentional withholding of pertinent information from an insurance applicant is rarely found. The sales pitch presented by Tate Nation at Archie Cochrane Motors promised "peace of mind" in the form of security for "an unprotected payment." (Nation depo. p. 17). Speaking on behalf of his principal, selling agent Tate Nation proudly assured Mr. and Mrs. Williams that the promised peace of mind was theirs in return for their signature (and premiums of $2,359.79). A frank representation of insurance coverage was made by issuance of this Certificate at the dealership. By calculated design, however, Union Fidelity saw to it that its selling agent did not discuss Clarence Williams condition of health, [3] let alone the carefully planned program geared toward rescission following a one-sided investigation and post claim underwriting. Certainly, neither Clarence Williams, nor his wife Barbara, knew that by relying upon the promise of coverage, which they surely had the right to do, they were inviting the harm which Barbara later sustained. This is fraud. *See Batten v. Watts Cycle & Marine,* 240 Mont. 113, 117, 783 P.2d 378, 380-381 (1989). Count Two of plaintiff's Complaint is well pleaded and well supported in the record.

Count Three of Williams' Complaint plainly states a claim for relief of the type recognized by *Thomas v. Northwestern National Insurance Co.,* 292 Mont. 357, 973 P.2d 804 (1998). In *Thomas,* the Supreme Court reversed the determination that Section 33-18-242(3), M.C.A., precluded plaintiff's common law tort claims for breach of fiduciary duty and negligence, explaining its reasoning in the following terms:

> ... the [Unfair Trade Practices] Act addresses the relationship between an insured and an insurance company once a claim has been filed. * * * The appellants' causes of action focus on Northwestern's conduct during the renewal of the policy, not on the improper handling of the claim ... *All of appellants' tort claims pertain to event that occurred prior to the handling of the claim.*"

Thomas, 973 P.2d at 809 (emphasis added).

The unlawful conduct of Union Fidelity *after* Williams' claim was presented are actionable as permitted by Section 33-18-242(3), M.C.A. (by action for breach of contract, fraud and under 33-18-242). Consistent with the holding in *Thomas,* however, Count Three of Williams' Complaint states a claim for common law bad faith "in connection with the application process and underwriting of the credit life insurance policy sold to Clarence Williams." Its focus is upon the "front end planning" which makes Union Fidelity's post claim underwriting scheme possible, supported by admissions of Union Fidelity's Rule 30(b)(6) corporate representatives that Defendant ignored its own definitions of "life underwriting" and intentionally refrained from asking questions about past medical history during the application phase, knowing all along that its decision to rescind will

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be grounded upon nothing else. Substantial evidence supports plaintiff's well plead claim for relief set forth in Count Three of her Complaint.

Count Four of Plaintiff's Complaint states the independent cause of action for violation of the Unfair Claims Settlement Practices Act, expressly authorized by Section 33-18-242, M.C.A. As is true for Counts One, Two and Three, Count Four is also well supported in the record. Union Fidelity flatly misrepresented pertinent facts and the language of its Certificate in a most cruel manner when it wrote to Barbara Williams claiming that her husband was guilty of a material misrepresentation simply because he chose to buy their product. It is, after all, impossible to buy this insurance without signing the form, one of 15 or 20 to be signed when buying a new car at Archie Cochrane Motors. (Nation depo. p. 22). No attention is drawn to the printed language on the form; Tate Nation simply tells the applicant "sign here." (Nation depo. p. 20). The words, "good health" are not explained or defined, either orally or in writing; no attention is drawn to the subject at all. (Nation depo. p. 21).

Of course, once Clarence and Barbara Williams had signed the form, the snare was set. One of two things relevant to the "risk" was certain to occur: Either the contract would run its course, or it would not. If death were the reason it did not, then Union Fidelity would use that opportunity to ask itself, for the first time, "Gee, I wonder if we ought to insure this guy?" In short, Union Fidelity's scheme is dependent upon patent violation of Section 33-18-215 which lead inexorably to equally patent violation of Sections 33-18-201(1), (4) and (6), M.C.A. [4]

C. Union Fidelity had no reasonable basis in law or in fact for its conduct.

In view of the foregoing, Union Fidelity's claim that it had "a reasonable basis in law or in fact" for its conduct is exposed as patently ridiculous. Under no stretch of the imagination does the Montana Insurance Commissioner's approval of this Certificate provide "a reasonable basis in law or in fact" for Union Fidelity's unlawful post claim underwriting scheme, or its rescission of the Williams' policy. In the first place, the Commissioner of Insurance lacks the authority to approve that which is prohibited by statute. *See Sullivan v. Doe,* 159 Mont. 50, 495 P2d 193, 199 (1972). Second, the Commissioner authorized Union Fidelity to sell credit life insurance, not take it away through flagrant violation of the Unfair Trade Practices Act. The Commissioner's action "does not imply that the manner in which a form is subsequently interpreted or used by an insurer has been approved." *See* Affidavit of Louise Ford and *Attorney General v. Diamond Mortgage Company,* 327 N.W.2d 805, 811 (Mich. 1982)(approval of real estate brokers license does not authorize conduct in violation of Michigan Consumer Protection Act).

D. Punitive damages are expressly allowed by statute and by common law in insurance bad faith cases and are clearly evident in this case.

Union Fidelity is surely correct that it should not be punished for doing "what the law plainly allows." (Union Fidelity Brief in Support of Motion for Summary Judgment, p. 23, line 5). No insurer should ever be punished for "engaging in lawful activity." But while Union Fidelity is correct on the moral issue, it is wrong on the law. Union Fidelity is a proud purveyor of the harm which consistently results from post claim underwriting, an unfair claim practice which just happens to be patently in violation of Section 33-18-215, M.C.A.

Very few cases demonstrate such a clearly proven plan to subvert applicable law and conceal the nature of the intended fraud, combined with such callous disregard of the certainty of injury, as was implicit in the post claim underwriting scheme deployed against Barbara Williams. It has long been recognized that violation of statute is malice sufficient to call for an award of punitive damages. *See First Security Bank of Bozeman v. Goddard* 181 Mont. 407, 593 P.2d 1040,1047 (1979). And, as if defendant's violation of statute were not alone sufficient to show actual malice, Claims Team Leader Heidi Paga has testified that Union Fidelity teaches its people not to concern themselves with the **financial** and emotional impact of their deliberate actions, thus amply fulfilling the proof requirements of Section 27-1-221(2), M.C.A.

Punitive damages are allowed in cases of fraud and malice against insurance companies for good reason. Real people like Barbara Williams seldom have the emotional strength to fight a pitched battle against a professional litigator like Union Fidelity. While the death of Clarence Williams spawned nothing more than another routine claim for Union Fidelity, it dramatically and permanently changed Barbara's life. And while it may serve the corporate interest to shift the burden and expense of life underwriting and claims investigation to new widows, it is the law of Montana that such tactics are so socially and legally reprehensible that punitive damages are entirely appropriate. *See Dees v. American National Fire Insurance Company,* 260 Mont. 431, 861 P.2d 141 (1993)(insurer's failure to "consult knowledgeable sources" constitutes clear and convincing evidence of actual malice). Montana law rightly empowers those who pursue such claims to exact damages for the purpose of punishing the guilty insurer and making an example of its wrongs.

CONCLUSION

For all the foregoing reasons, Union Fidelity's motion for summary judgment should be denied and Williams cross motion for partial summary judgment should be granted declaring that plaintiff is entitled to the benefits due her under the insurance Certificate sold to her husband, together with prejudgment interest, and further declaring that Union Fidelity is liable in tort, as a matter of law, for both compensatory and punitive damages for its purposeful and unlawful engagement in the prohibited practice of post claim underwriting.

Footnotes

1 When the opinion of the Risk Department "underwriter" is included in the mix, along with the those of the applicants, Union Fidelity admits that it can find itself juggling as many as five or six differing opinions on the condition of health of a single applicant. (Paga depo. p. 29).

2 Ms. VonHagel did not base rescission upon information regarding Mr. Williams surgical resection of a kidney ten years earlier, radiation pneumonia, coronary artery disease, alleged (but non-existent) myocardial infarction in 1994, single vessel atrial fibrillation or high blood pressure. (VonHagel depo., p. 50).

3 Agents who do, sometimes get sued by Union Fidelity. (Rowe depo. pp. 69, 70)

4 Deposition testimony establishes that Union Fidelity employed unfair claim practices to deny Williams' claim very quickly. Accordingly, plaintiff no longer contends that defendant violated subparagraph (5) of Section 33-18-201 (failure to promptly affirm or deny coverage)

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