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## Disability Insurance in California

The health insurance industry has received a considerable amount of attention in the last few years due to a number of factors. Perhaps the major factor behind this public attention is the realization that the American family is not adequately protected from the financial burdens of catastrophic illness. Total incapacity due to cancer, kidney disease, or some other debilitation can cripple a family, both emotionally and financially. The health insurance industry has not been able to solve this dilemma. Even though some charitable hospitals and "health maintenance organizations" such as Kaiser-Permanente have helped alleviate many of these problems, their impact is limited.

Medical spending in this country has increased from 3.6% of the G.N.P. in 1929 to 7.5% of the G.N.P. today, with the prospect of a 10% share in less than twenty-five years.<sup>1</sup> The disability segment of the insurance industry collected premiums in 1973 which were in the billions of dollars.<sup>2</sup> However, the public's reliance on health insurance has proved to be unworthy. The industry's prime objective is to make as large a profit as possible. One way to accomplish this task is to limit the payment of claims. The health insurance companies can create such a windfall by (1) selling policies with exclusions that make them nearly worthless and (2) repeatedly resisting claims that appear legitimate.<sup>3</sup> However, it has only been recently in California that the insurance industry has been subject to severe financial penalties for refusing to pay legitimate claims. The insured can now recover punitive damages,<sup>4</sup> which have amounted to hundreds of thousands of dollars per case, and the insured now has a cause of action for bad faith against the insurance company.<sup>5</sup> But even with these remedies, the insured may have to wait years to recover, and the difficulty of proving

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1. Los Angeles Times, February 17, 1974, § IX (Opinion), at 5, col. —.

2. Wall Street Journal, January 28, 1974, at 1, col. 8.

3. *Id.*

4. *Wetherbee v. United Ins. Co.*, 265 Cal. App. 2d 921, 71 Cal. Rptr. 764 (1968).

5. *Gruenberg v. Aetna Ins. Co.*, 9 Cal. 3d 566, 510 P.2d 1032, 108 Cal. Rptr. 480 (1973).

bad faith and the uncertainty of punitive damages may still leave the insured unsatisfied.

Wilbur Cohen, Secretary of Health, Education, and Welfare under President Johnson, said that the time for national health insurance had come "... [T]he question no longer is whether every American should be protected by comprehensive coverage, but how and when."<sup>6</sup> Significant discussion is now underway in Congress concerning changes in health care coverage. Two major proposals, one by President Nixon and the other by Senator Kennedy, provide for a national health insurance plan. However, both the Nixon plan<sup>7</sup> and Senator Kennedy's present plan<sup>8</sup> allow participation by private health insurance companies. With the present national health insurance plans providing for participation by private insurance companies, it must be determined whether these companies can provide adequate service to the public. To assist in this national evaluation, this comment will examine California law concerning disability insurance as it relates to pre-existing conditions and the cancellation or termination of health insurance policies.

As defined in this state by the California Insurance Code § 106,

Disability insurance includes insurance appertaining to injury, disablement or death resulting to the insured from accidents, and appertaining to disablements resulting to the insured from sickness.

Additionally, in the code Commission Notes it is stated that " 'Sickness and either accident or health' changed to 'disability' throughout code. Definition and scope remain in substance".

#### PRE-EXISTING CONDITIONS

##### A. *The California Cases*

In 1967 a new regulation affecting pre-existing conditions was issued by the California Insurance Commissioner:

(C) A policy, certificate of credit insurance or notice of proposed insurance shall not contain provisions which would encourage misrepresentation or which are unjust, unfair, inequitable, misleading, deceptive, or contrary to law or to the public policy of this State  
....

(2) A credit disability insurance policy violates this subsection if it: ...

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6. Los Angeles Times, February 17, 1974, § IX (Opinion), at 5.

7. *Id.*

8. Los Angeles Times, April 3, 1974, at 14, col. 2. Senator Kennedy's original proposal did not provide for participation by private health insurance companies—see Los Angeles Times, February 17, 1974, § IX (Opinion), at 5. However, the new plan seems to provide for some participation.

- (F) excludes coverages for pre-existing conditions other than those for which medical advice, consultation or treatment was required or recommended within . . . the six months following effective date of the insurance coverage.<sup>9</sup>

This provision was long in coming and will greatly aid the insured if it is followed by the insurance companies and enforced by the Insurance Commissioner. If neither party upholds this provision, the courts may need to intervene to determine its application. The problem with this administrative regulation, barring a court decision to the contrary, is that the section is not retroactive. It does not apply to disability insurance contracts entered into prior to August, 1967. To determine the law in California as it affected pre-existing conditions prior to this administrative regulation, one must analyze the case law on the subject.

There are only four California cases dealing directly with pre-existing conditions. The oldest of the four is *Fohl v. Metropolitan Life Insurance Co.*<sup>10</sup> In December, 1921, Mr. Fohl and Metropolitan entered into a contract of insurance. The contract provided that the company would pay benefits to plaintiff if he became totally and permanently disabled as the result of injury or disease occurring and originating *after* the issuance of the policy.

In February, 1920, prior to the issuance of this insurance policy, Mr. Fohl was placed in a hospital in Stockton. Upon examination he was found to have a strongly positive syphilitic reaction. On March 28 he was released from the hospital and returned to work. The evidence showed a general decline in the plaintiff's condition over the next several years. In December, 1921, upon contracting with defendant for insurance, Mr. Fohl did not disclose this prior condition nor the treatment he received. Finally, in December, 1928, plaintiff experienced a seizure and was placed in a sanitarium until June, 1929 when he was released and returned to work. In October, 1930 he experienced two additional epileptic seizures and, after December 23, 1930, was unable to work again. Plaintiff maintained that he was totally and permanently disabled after December 23, 1930. The defendant insurance company refused payment, relying on the defense of an undisclosed pre-existing condition.

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9. CAL. ADMIN. CODE, Title 10, § 2248.9(c)(2)(F) (1967).

10. 54 Cal. App. 2d 368, 129 P.2d 24 (1942).

The court described Mr. Fohl's illness as a latent condition which failed to manifest itself for some eight years after the issuance of the policy. The court maintained that it was epilepsy, not syphilis, which was the disabling disease:

. . . [E]ven though the medical cause of the disease which resulted in the incompetent's disability may have antedated the issuance of the policy, where, as here, the disease did not manifest itself for years after such issuance, the plaintiff is entitled to the disability benefits under the policy.<sup>11</sup>

The next such case ruled upon by the California courts was *Skroopka v. Royal Indemnity Co.*<sup>12</sup> In this case, the plaintiff and defendant entered into an insurance contract in September, 1952.

The contract insured plaintiff against loss resulting from accidental bodily injury and sickness. The policy, provided, however, that benefits would be paid *only* for sickness or injury contracted thirty days after the policy came into effect. Since the age of twenty, Mrs. Skroopka, age forth-seven, had consistently experienced pain in her breasts prior to menstruation. She had consulted physicians in the past concerning her problem but received no suggestions. In May, 1952, plaintiff again consulted a physician concerning this pain, but no medical treatment was prescribed. The doctor suggested that she watch the condition, since he had just operated on her sister for breast cancer. Finally, in December, 1952, the doctor conducted an exploratory operation. The growth was benign, and Mrs. Skroopka subsequently filed a claim with the insurance company to receive payment for the operation. The defendant denied the claim, basing its refusal on the defense of a pre-existing condition. The insurance company maintained that since Mrs. Skroopka had had this condition since she was twenty years old, it constituted a pre-existing condition.

The court relied on the *Fohl* decision and found for the defendant insurance company. The opinion stated that the presence of nodules or lumps in the breast was the *manifestation* of the sickness. Since these lumps had existed from age twenty, the sickness was a pre-existing condition.

It seems unescapable . . . that the "sickness"—if such it may be called—which occasioned the hospitalization and surgery—was a condition of the breasts . . . that existed prior to the effective date of the policy without regard to whether or not surgery ultimately disclosed a benign or malignant condition.<sup>13</sup>

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11. 54 Cal. App. 2d at 379, 129 P.2d at 29.

12. 132 Cal. App. 2d 910, 283 P.2d 111 (1955).

13. 132 Cal. App. 2d at 913, 283 P.2d at 113.

In 1960 the third California appellate decision concerning pre-existing conditions was decided. This decision, entitled *Cimino v. Reserve Life Insurance Co.*,<sup>14</sup> concerned an insurance contract which limited coverage to hospital confinement resulting from sickness which originated more than fifteen days after the effective date of the policy. The policy in question took effect in March, 1958. On May 17, 1958, the insured's son experienced a high fever and a sharp pain in his right hip and was unable to straighten his right leg. He had experienced a similar pain in that area for about two years, but had not consulted a physician with regard to the condition until May 20, 1958. Prior to May 17, he had been in excellent health, attending school regularly and playing on the school football team. He was finally hospitalized between May 22 and July 2, 1958 and underwent surgery for osteomyelitis.

Defendant insurance company refused payment under the policy, basing its decision upon the boy's pre-existing condition. The court disagreed with defendant and maintained that the sickness had become manifest more than fifteen days after the issuance of the policy. The opinion stated that a sickness begins when it first manifests itself or becomes active or "when sufficient symptoms existed to allow a reasonably accurate diagnosis of the case."<sup>15</sup> The phrase "hospital confinement resulting from sickness" does not mean a general diseased condition or ill health, but a condition which manifests into the cause of the hospital confinement. Furthermore, the term sickness refers to a condition wherein the patient cannot conduct his usual activities. In this case, plaintiff's son attended school, participated in athletics, and was generally able to engage in normal activities until May 17. The court concluded that:

. . . The pre-existing condition had not manifest itself by anything more substantial than an occasional pain or spasm . . . [and] was latent and inactive within the meaning of *Fohl*. . .<sup>16</sup>

The most recent California case concerning pre-existing conditions is *Bower v. Roy-Al Corporation*<sup>17</sup> which incorporated the other three cases in its decision. This case involved an insurance policy effective April, 1966, which provided for continued automo-

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14. 181 Cal. App. 2d 840, 5 Cal. Rptr. 850 (1960).

15. 181 Cal. App. 2d at 842, 5 Cal. Rptr. at 851.

16. 181 Cal. App. 2d at 843, 5 Cal. Rptr. at 852.

17. 33 Cal. App. 3d 1027, 109 Cal. Rptr. 612 (1973).

bile payments in case the insured suffered from total and continuous disability caused by accidental bodily injury or sickness, but excluded from coverage accidents occurring or disease contracted prior to the effective date of the policy. Since the policy was issued prior to the California Insurance Commissioner's Regulation § 2248.9 (C) (2) (F), that section could not be relied upon by the court. Three weeks after the policy went into effect, plaintiff was working at the top of a telephone pole and his legs "went to sleep". He later complained of limping and lameness in his legs. In June, 1966, surgery was performed, and the doctor concluded that plaintiff suffered from total and continuous disability due to vascular insufficiency in his lower extremities. The insurance company refused payment, contending that the condition was pre-existing and must have developed over an extended period of time.

The court distinguished this case from *Fohl*, noting that in *Fohl* the disease (epilepsy) originated after the policy date, and it was a different disease from the syphilis. However, the *Fohl* case was significant in that it stated the general rule that a "... sickness originates when it becomes manifest or acute rather than at the time of its medical cause or origin".<sup>18</sup> The court maintained that this rule applied "... even though the medical cause may have antedated the policy. ...".<sup>19</sup>

The *Bower* case, in holding for the plaintiff, not only relied on the three previous California cases on the subject, but also utilized decisions from other states to support its position. In *United Insurance Co. of America v. Wall*,<sup>20</sup> the facts were strikingly parallel to *Bower*. Plaintiff had had circulatory problems in his right leg for about eleven months prior to the issuance of the insurance policy. The policy had an exclusionary clause allowing payment only for sickness originating more than thirty days after the policy date. Seven months after the effective date of the policy, plaintiff's legs were amputated due to his ailment. The court held for plaintiff, ordering the defendant to pay the \$100 per month coverage. The court ruled that a sickness does not become manifest or active even though the disease was present in the system prior to the date of the insurance policy if the condition was inactive, latent, or undiscovered. Even though plaintiff had experienced difficulty with his legs, his doctors had not discovered any sickness or disease. The court noted that this fact indicated that the disease had not been

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18. 33 Cal. App. 3d at 1035, 109 Cal. Rptr. at 616.

19. 33 Cal. App. 3d at 1033, 109 Cal. Rptr. at 615.

20. 233 Ark. 554, 345 S.W.2d 927 (1961).

sufficiently manifest to allow a reasonable diagnosis. In *Hovis v. Industrial Hospital Association*,<sup>21</sup> plaintiff had a similar condition and his symptoms had been getting progressively worse in the five years prior to surgery. He did not have a duty to seek medical advice or treatment. The Supreme Court of Washington in this case held for plaintiff, stating that the disease had not become manifest even though an expert testified that had plaintiff been examined by a vascular specialist five years before, his condition would have been discovered.

In *Reiser v. Metropolitan Life Insurance Company*,<sup>22</sup> defendant refused to issue benefits for total and permanent disability, contending that the disability had not originated *after* the issuance of the policy. The disability was caused by calcium deposits in the feet, a result of manipulations performed during plaintiff's infancy to correct congenital club feet. The plaintiff was forty years old and, except for this period during infancy, had never experienced any difficulty with his feet prior to the time of his disability. The court stated that a disease, within the meaning of the policy, did not exist prior to issuance of the policy. Instead, the disease must be:

. . . [S]o considerable or significant that it would be characterized as such in the common speech of men. . . . It does not include a latent condition which . . . fails to manifest itself until after the lapse of almost forty years. A disease does not occur or originate within the meaning of the policy, until it becomes a disease in the general acceptance of that term; a bodily injury does not occur or originate within such meaning, at least until it reveals itself.<sup>23</sup>

*Skroopka v. Royal Indemnity Co.*,<sup>24</sup> the only case which held for the insurance company, seems to conflict with the other California cases. The *Bower* court maintained that there was no conflict, at least between *Skroopka* and *Cimino*.<sup>25</sup> The only factual difference between *Skroopka* and the other three cases was that Mrs. Skroopka knew of her condition for a more extended period of time and had experienced chronic pain throughout that long period. But in *United Insurance Company of America v. Wall* and *Hovis v. Industrial Hospital Association*, which relied upon the *Bower* case, both

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21. 71 Wash. 2d 169, 426 P.2d 976 (1967).

22. 262 App. Div. 171, 28 N.Y.S.2d 283 (1941).

23. 28 N.Y.S.2d at 286.

24. 132 Cal. App. 2d 910, 283 P.2d 111 (1955).

25. 33 Cal. App. 3d 1027, 1035, 109 Cal. Rptr. 612, 617.



circumstances existed. Furthermore, in *Bower* plaintiff had complained to his doctor of pains in his neck, back, and shoulders, some eighteen months before the effective date of the policy.<sup>26</sup> However, one can argue that the three cases just mentioned all involved a circulatory ailment known as atherosclerosis which exists in everyone to a certain extent and is not normally treated unless some outward manifestation of the condition is discovered. Mrs. Skroopka had a different ailment which was not quite as common but one which frequently prompts women to immediately seek medical advice.

The majority of jurisdictions recognize the enforceability of exclusionary clauses which allow insurance companies to refuse payment of benefits.<sup>27</sup> However, the question may now be moot in California because of the Insurance Commissioner's regulation<sup>28</sup> restricting the application of such clauses. Today therefore, the most significant legal application of pre-existing conditions may be their effect upon the insured in obtaining new insurance after his present disability policy has been rescinded or terminated. This issue will be discussed at a later point in this comment.

### *B. Incontestability*

The California Insurance Code has two provisions which serve to protect the insured from overdue claims by the insurer that he had a pre-existing condition. The incontestability clause can be crudely described as a "statute of limitation on a defense". The statutory provisions limit the insurer's ability to use the pre-existing condition defense except within three years from the date of issuance of the policy.

California Insurance Code § 10350.2 is a "compulsory standard provision" which must be present in every California disability insurance policy.

#### **Form A**

. . . (b) No claim for loss incurred or disability . . . commencing after three years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed *prior* to the effective date of coverage of this policy. (Emphasis added.)

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26. 33 Cal. App. 3d 1027, 1030, 109 Cal. Rptr. 612, 613.

27. See 53 A.L.R.2d 686, 688.

28. However, some people are still complaining about insurance companies refusing payment based upon a pre-existing condition—KNBC News Los Angeles, California, May 1, 1974, "Action 4," 5:00 p.m.

As for noncancelable policies, Form A, as just recited, or Form B, must be inserted.

California Insurance Code § 10350.2 Form B reads as follows:

. . . (b) No claim for loss incurred or disability commencing after three years from the date of issue of this policy shall be reduced or denied on the ground that a disease or description effective on the date of loss had existed prior to the effective date of coverage of this policy.

Form A has a more limited application because it concerns only diseases or physical conditions that were not excluded from coverage by name, whereas Form B has no such provision.

The application of the incontestability clause was demonstrated in *McMachin v. Great American Reserve Insurance Company*.<sup>29</sup> In this case, defendant insurance company attempted to use the defense of a pre-existing condition in relation to a policy which was a few years old. The court ruled that,

Not having challenged plaintiff's application within the . . . period, defendant may be said to have taken plaintiff as it found him and cannot now urge plaintiff's disability resulted from a pre-existing disease, illness or injury not covered by the policy.<sup>30</sup>

In essence, it appears that the court is speaking of this defense in estoppel terms.

#### CANCELLATION

##### A. Statutes

In purchasing disability insurance, one may choose from among three different types of policies. Two of these policies, "noncancelable" and "guaranteed renewable", are defined by the California Insurance Code.

The term "noncancelable" . . . means a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums in the amount originally set forth in the policy (a) until at least age 50, or (b) in the case of a policy issued after age 44, for at least five years from its date of issue, during which period the insurer has no right to make unilateral any change in any provision of the policy while the policy is in force.<sup>31</sup>

A noncancelable policy is not in fact what its name implies. Ac-

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29. 22 Cal. App. 3d 428, 99 Cal. Rptr. 227 (1971).

30. 22 Cal. App. 3d at 440, 99 Cal. Rptr. at 234-35.

31. CAL. INS. CODE § 10273 (West 1972).

according to the code section, the policy can be changed or canceled either at age fifty or five years after issuance if purchased after age forty-four. Consequently, an older person who requires greater medical care can be prevented from obtaining benefits from the purchase of such a policy.

A "guaranteed renewable" policy is similar to a noncancelable policy except that the insurer can make changes, in accordance with the provisions of the policy, ". . . in premium rates as to all insureds who were placed in the same class for purposes of rate determination in the process of issuance of the policy. . ." <sup>32</sup> Again the title of the policy is deceiving. In reality, the policy is not guaranteed renewable because here, just as in the noncancelable policy, unlimited changes or unilateral cancellation can occur when the insured reaches age forty or, if the policy was issued after age forty-four, five years from that time.

The third type of disability insurance is called a "cancelable" policy. The code defines this type of insurance by describing the provisions which are permitted in such an insurance contract. The insurer has two optional provisions, either of which he may insert into the contract. The first such provision reads as follows:

The insurer may cancel this policy at any time by written notice delivered to the insured or mailed to his last address, as shown by the records of the insurer, together with cash or the insurer's check for the unearned portion of the premiums actually paid by the insured, and such cancellation shall be without prejudice to any claim originating prior thereto. <sup>33</sup>

The second optional cancellation provision is similar to the one just quoted except that the insured can also cancel, upon proper notice, if the policy was continued beyond its original term; furthermore, this provision determines how unearned premiums are to be computed for purposes of reimbursement should the insured cancel under this provision. <sup>34</sup>

The insured may cancel the policy in another manner, according to California Insurance Code § 10343. This code section is a "compulsory standard provision" and must be incorporated into every California disability insurance policy except transportation ticket policies. The section reads as follows:

If the insured shall at any time change his occupation to one classified by the insurer as less hazardous than that stated in the policy, the insurer, upon written request of the insured, and surrender

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32. CAL. INS. CODE § 10273.3 (West 1972).

33. CAL. INS. CODE § 10363 (West 1972).

34. CAL. INS. CODE § 10369.9 (West 1972).

of the policy, will cancel the same and will return to the insured, the unearned premiums.

### B. Effective Cancellation

The optional provisions contained in the California Code §§ 10363 and 10369.9 enable the insurer to cancel by mailing or delivering notice to the insured at his last address. In *Superior Insurance Company v. Restituto*,<sup>35</sup> this cancellation was declared effective even though the notice was never received by the insured. The case then explained the effect a refund has upon cancellation. California Insurance Code § 481 provides that a person insured is "entitled to a return of premium if the policy is cancelled or rescinded" unless the contract provides otherwise. This code section explains the scheme by which these premiums can be refunded.<sup>36</sup> *Superior Insurance Co. v. Restituto* explains that where the policy provides that the insurer can cancel upon giving notice and refunding the unearned portion of the premium, cancellation is *only* effective upon refund and is, therefore, a condition precedent. However, the court ruled that in California, where the policy provides for the return of unearned premiums on surrender of the policy and retention of a pro rate premium only, the return of the unearned premium is not a condition precedent to cancellation.<sup>37</sup> Consequently, these two code sections, 10343 and 10369.9, whereby the insured can cancel his policy, are more restrictive in application than the two code sections 10363 and 10369.9, which enable the insurer to cancel. Since the return of unearned premiums is not a condition precedent the insurer can more easily cancel a policy.

In California the "... parties to an insurance policy are free, subject to legislative restriction, to arrange the occasions, method

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35. 124 F. Supp. 392 (1954).

36. CAL. INS. CODE § 481 (West 1972):

... [A] person ... is entitled to a return of premium ... as follows:

1. To the whole premium, if no part of his interest in the thing insured is exposed to any of the perils insured against.

2. Where the insurance is made for a definite period of time, and the insured surrenders his policy, to such proportion of the premium as corresponds with the whole premium any claim for loss or damage under the policy which has previously accrued. ...

37. *Jensen v. Traders & General Ins. Co.*, 52 Cal. 2d 786, 799, 345 P.2d 1, 8 (1959); *Superior Ins. Co. v. Restituto*, 124 F. Supp. 392, 395-6 (1954).

and means of cancellation by private agreement".<sup>38</sup> And this rule applies whether the insurance is a disability policy or otherwise.<sup>39</sup> However, in the law of contracts it is traditionally held that if one party has the ability to cancel or terminate the agreement, the contract is illusory and unenforceable.<sup>40</sup> In *Naify v. Pacific Indemnity Co.*,<sup>41</sup> which involved an automobile liability policy, the court stated as follows:

Parties are, within reason free to contract as they please, and to make bargains which place one party at a disadvantage; but a contract must have mutuality of obligation, and an agreement which permits one party to withdraw at his pleasure is void. . . . By analogy, it seems questionable whether a contract can validly provide that A is bound thereunder unless B decides to withdraw.  
. . . .<sup>42</sup>

However, this view expressed in *Naify*, although offered at times to challenge the insurer's ability to cancel, is not generally recognized as a competent defense in California. It appears that the courts allow an exception to the general contract rules when insurance is involved because of legislative enactment, and can find no violation of public policy in such legislative directives.

In *Jensen v. Traders and General Insurance Company*,<sup>43</sup> the court quoted the Wisconsin Supreme Court case of *Putman v. Deinhamer*<sup>44</sup> on this subject.

But we do not find from such authorities that when the policy terms are as they are here, and there is no conflicting statute, and the notice and its mailing complies with the policy provisions, the courts have refused to recognize the cancellation. In the absence of statutory declarations there appears to be no public policy removing the right to cancel in this manner from the field of contract.<sup>45</sup>

The California Supreme Court in *Jensen* expressed the public policy reasons for allowing an insurer to cancel an automobile insurance policy.

The practice and custom of granting coverage immediately upon the request of insurance agents and brokers, leaving all opportunity to examine the acceptability of the insured to a future date, is an

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38. *Jensen v. Traders & General Ins. Co.*, 52 Cal. 2d 786, 790, 345 P.2d 1, 3.

39. *Id.* at 797, 345 P.2d at 7.

40. WILLISTON, *CONTRACTS*, § 104 (3d ed. 1957).

41. 11 Cal. 2d 5, 76 P.2d 663 (1938).

42. 11 Cal. 2d at 11, 76 P.2d at 667.

43. 52 Cal. 2d 786, 345 P.2d 1 (1959).

44. 270 Wis. 157, 70 N.W.2d 652 (1955).

45. *Jensen v. Traders & General Ins. Co.*, 52 Cal. 2d 786, 796, 345 P.2d 1, 6-7.

advantage to the business community and to the motoring public.

If insurers cannot cancel coverage in an equally prompt and certain manner, they will be forced to withhold this advantage. . . .

Insurance companies have endeavored to insure rapidly and provide for a concomitant prompt and certain method of cancellation.<sup>46</sup>

The same analogy could be used in the area of disability insurance. However, the courts have set rather strict guidelines which affect the insurer's ability to cancel. Initially, in order to establish cancellation, the insurance company must show either that the conditions upon which the company was allowed to cancel were strictly complied with, or that the insured, knowing all the facts, waived such compliance.<sup>47</sup> At times the insured will terminate an old policy thinking he is still covered. The courts have ruled that the policy was cancelled conditionally upon new insurance first being procured.<sup>48</sup> In this case a breakdown in communication arises between the insured and the insurer or agent, and the insured is temporarily without insurance. In the intervening period the insured suffers a loss and the company refuses payment, claiming that no policy was in effect. A similar situation arises when the prospective insured undergoes a physical examination and pays his first premium in anticipation of receiving coverage. Then the applicant dies before the insurance company has formally accepted him as an insurable risk. The California courts have ruled that, under these circumstances, the insurer cannot cancel or rescind the policy after the prospective insured's death.<sup>49</sup> The right to rescind the contract exists only during the life of the insured, and that right terminates upon his death in the absence of material misrepresentation. If the applicant ". . . had no present knowledge of the facts sought, or failed to appreciate the significance of information related to him, his incorrect or incomplete responses would not constitute grounds for rescission".<sup>50</sup>

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46. 52 Cal. 2d at 798, 345 P.2d at 7-8.

47. *Quong Tue Sing v. Anglo Nevada Assur. Corp.*, 86 Cal. 566, 25 P. 58 (1890).

48. *K. C. Working Chemical Co. v. Eureka Security Fire and Marine Ins. Co.*, 82 Cal. App. 2d 120, 185 P.2d 832 (1947).

49. *Ranson v. Penn Mutual Life Ins. Co.*, 43 Cal. 2d 420, 274 P.2d 633 (1954); and *Thompson v. Occidental Life Ins. Co.*, 9 Cal. 3d 904, 513 P.2d 353, 109 Cal. Rptr. 473 (1973).

50. *Thompson v. Occidental Life Ins. Co.*, 9 Cal. 3d at 916, 513 P.2d at 360, 109 Cal. Rptr. at 480.

### C. Damages

The term of an insurance policy can end in a variety of ways. The policy can expire by reaching the end of the term for which it was written, or the insurance can be terminated upon a prescribed statutory notice or by mutual agreement.<sup>51</sup> However, if the policy is cancelled or repudiated after benefits accrue to the insured, the question arises as to what damages the insured is allowed. California Insurance Code § 650 states that an insurer may rescind the contract, under provisions of the Code, "at any time previous to the commencement of an action on the contract".

In *Cobb v. Pacific Mutual Life Insurance Company*<sup>52</sup> the insured purchased a *noncancelable* disability policy providing for payment of health indemnity at \$250.00 per month for the period throughout which disability consists of "continuous, necessary and total loss of business time". Two and one-half years later, plaintiff became totally disabled as defined by the policy. However, defendant insurance company refused payment, claiming that plaintiff had made fraudulent misrepresentations and suppressions of material information bearing on the insured's health. The insurer then repudiated the contract and gave notice of rescission.

The trial court held that none of the acts or omissions which defendant had complained of materially affected the acceptance of the risk assumed by the insurer. Furthermore, the trial court allowed damages based upon future unpaid benefits for the life expectancy of plaintiff. On appeal, the issue centered around the trial court's awarding of these future installments. The appellate court did not dispute the trial court's finding lack of material misrepresentation. However, the appellate court reversed the decision and allowed recovery of \$250.00 per month only for the time from the insurer's repudiation to the commencement of trial.

The *Cobb* court held that in an action for breach of an insurance contract where payment is to be made in periodic installments, only those installments in default at the time the suit was brought may be recovered. Consequently, the insured's damages for his life expectancy cannot be awarded. The court based its decision upon the legal theory that no anticipatory breach of a unilateral contract is allowed. Since the promisee has fully performed on this originally bilateral contract, the agreement now becomes

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51. *Clausen v. Industrial Indem. Co.*, 241 Cal. App. 2d 440, 50 Cal. Rptr. 615 (1966).

52. 4 Cal. 2d 565, 51 P.2d 84 (1935).

unilateral. Therefore ". . . no repudiation can amount to an anticipatory breach of the rest of the installments not yet due".<sup>53</sup>

The *Cobb* case relied on two previous California decisions for its authority. These two prior cases, *Robinson v. Exempt Fire Company*<sup>54</sup> and *Brix v. Peoples Mutual Life Insurance Company*,<sup>55</sup> came to the same conclusion as *Cobb* based upon analogous factual situations. The *Robinson* case held that a disability insurance agreement providing for periodic payment was a severable contract. Consequently, the insured could only recover upon installments which were in default until the time of commencement of trial, and he would have to institute separate individual suits thereafter, since each default constitutes a separate cause of action.

*Brix v. Peoples Mutual Life Insurance Company* (supra) concerned a cancelable accident insurance policy which provided for periodic payment should plaintiff become wholly and continuously disabled. Upon plaintiff's disability, insurer made four monthly payments and then refused payment of further installments; plaintiff then instituted suit. The court, relying on *Robinson v. Exempt Fire Company* (supra), stated that defendant's action did not work as a breach of future benefits since the liability of the insurer does not become fixed as long as plaintiff's condition could change.<sup>56</sup> The court did rule, however, that the insured was entitled to recover the "installments accruing between the commencement of the action and the date of the trial".<sup>57</sup>

In a more recent federal court decision, *John Hancock Mutual Life Insurance Company v. Cohen*,<sup>58</sup> the Ninth Circuit relied upon the three cases previously discussed to award plaintiff "an amount equal to payments due to the date of judgment plus interest," decreeing that future installments shall be paid when they fall due. The decision discussed both Corbin and Williston on the subject of anticipatory breach, and the case is an excellent commentary on that subject as it relates to periodic payment of insurance benefits.

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53. *Id.* at 573, 51 P.2d at 88.

54. 103 Cal. 1, 36 P. 955 (1894).

55. 2 Cal. 2d 446, 41 P.2d 537 (1935).

56. *Id.* at 454, 41 P.2d at 541.

57. *Id.* at 456, 41 P.2d at 542.

58. 254 F.2d 417 (9th Cir. 1958).



However, the court relied on Williston's argument for disallowing recovery of future installments.

The only argument for allowing immediate recover of a future payment due under such a (disability) policy is the hardship supposedly imposed on the insured of bringing successive suits.<sup>59</sup>

Williston then maintains that this problem can be avoided by the courts' "full exercise of equitable powers".<sup>60</sup> He cites the United States Supreme Court case of *Mobley v. New York Life Insurance Company*<sup>61</sup> which states that the insurance industry would be harmed if future installments were allowed as damages:

[T]he calculations on which insurance business is done would be upset, and the purposes for which the benefits were made payable only in installments would often be defeated.<sup>62</sup>

The *John Hancock* decision, unlike the *Brix*, *Robinson* and *Cobb* cases, ordered the payment of future installments "when they fall due". This solution, although not preventing the insurance company from refusing to pay those future installments, could subject the insurer to a contempt of court charge for such a refusal. This ruling by the court is a more equitable and progressive decision than those which required the insured to continuously come back into court to recover subsequent installments. However, the *John Hancock* case does not directly overrule the other three cases on this subject. Therefore, the method used in *Brix*, *Robinson*, and *Cobb* of not ordering payment of future installments when they come due appears still allowable, especially since the *John Hancock* case, although decided in a California federal court, did not involve a party who was a resident of California. The *John Hancock* decision was based upon New Mexico law, as the case had been removed to California.<sup>63</sup>

In both the *Cobb* and *Brix* cases, actual cancellation did not occur. The insurer merely refused further payments rather than technically canceling the policy before the accrual of benefits. Furthermore, only *Cobb* involved a noncancelable policy. In such a situation the question arises whether the insured is damaged from the very act of cancellation of a noncancelable policy and, if so, whether he is entitled to any recovery. In *Caminetti v. Pacific Mutual Life Insurance Company*,<sup>64</sup> the holders of noncancelable disability insurance policies were forced to cancel those policies because of insol-

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59. *Id.* at 425.

60. *Id.* at 425.

61. 295 U.S. 632 (1935).

62. 254 F.2d at 425.

63. *Id.* at 425.

64. 23 Cal. 2d 94, 142 P.2d 741 (1943).

vency. Contrary to the other decisions mentioned, the court here held that anticipatory breach existed and stated that the proper measure of damage in this situation was the value of the policy at the time of cancellation. The court dismissed the notion that this value would be too uncertain to determine and felt that the effect of that argument would "... render wholly valueless the noncancelable feature of the policy. . . ." <sup>65</sup> Consequently, the court allowed future damages if proof could be established with "reasonable certainty and probability that damages will result in the future". <sup>66</sup> However, this case presents a unique situation, since an insolvent insurance company cannot pay future installments and, therefore, must pay all damages in one lump sum.

In *Garage and Service Station Employee's Union, Local 665 v. Pacific Mutual Life Insurance Company* <sup>67</sup> the plaintiff attempted to use the *Caminetti* case to show anticipatory breach on the part of the defendant, where plaintiff had cancelled the insurance policies.

*Caminetti* is distinguishable from the instant case. . . . The court was concerned with a total involuntary repudiation of the contract, i.e., insolvency of the insurance company which rendered it beyond its power to respond in the future to damages. The insureds there were deprived of the protection against possible future loss which had been secured by the policy of insurance.

In the case before us, there was not involved the issue of damages for total repudiation. There is no contention that Pacific Mutual cannot in the future respond for future damages. There is no suggestion that Pacific Mutual is insolvent or is about to terminate its affairs. <sup>68</sup>

As a result of *Garage Etc. Employees Union* and the other cases prior to *Caminetti*, the cause of action for anticipatory breach and recovery for future damages is quite limited. However, upon the wrongful cancellation of a disability policy, whether it be cancelable or non-cancelable, isn't the insured damaged by the very act of cancellation? And shouldn't that fact be taken into consideration when assessing damages, regardless of the cause of the cancellation? The *Caminetti* court discussed that problem in relation to its peculiar factual situation.

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65. *Id.* at 102, 142 P.2d at 745.

66. *Id.* at 103, 142 P.2d at 745.

67. 2 Cal. App. 3d 706, 82 Cal. Rptr. 821 (1969).

68. *Id.* at 711, 82 Cal. Rptr. at 823.

The insured may or may not be acceptable as a risk by any other insurer although he does not qualify for benefits under the canceled policy. It may be that similar insurance in another company is not available. In the case of a life policy, the measure may be altered to cover such a situation. . . . But there is no fixed amount to be paid in any event in a disability policy. Where the company is insolvent and there are many policy holders, the difficulty of determining whether or not each insured is still an insurable risk would be practically insurmountable.<sup>69</sup>

I maintain that upon the insurer's cancellation of a noncancelable policy, for whatever reason, the health of the policy-holder may have become so impaired between the purchase of the policy and the act of cancellation that he is no longer re-insurable or, at the minimum, unable to obtain insurance except at a greatly increased cost. The insured has depended upon this insurance and has purchased a non-cancelable policy for a particular reason. He is adversely affected by its cancellation. Therefore, damage to the insured by the wrongful cancellation is inevitable. Although the same damages may not be said to occur with a cancelable disability policy which is canceled properly, it is submitted that the disability insurance consumer must be more adequately informed of the type of disability policy he is purchasing, and the manner in which it may be terminated.

#### CASE STUDY

The following case study is presented as a further example of the activities of the health insurance industry.

In January, 1973, Stuart Silverman purchased a student sickness and accident insurance policy upon registration for the second semester of the school year at the university he attended. This policy was typical of those purchased by students on other college campuses, and the policy provided for payment, at certain specified rates, for hospitalization, operations, and treatment due to sickness and accident.

In February, 1973, Mr. Silverman became ill due to a kidney ailment which required surgery. He was admitted to the City of Hope Hospital in Duarte, California for extensive tests, and in March, 1973, surgery was performed. The City of Hope Hospital is a world famous medical institution which conducts extensive research and performs numerous operations to extend the scope of medical knowledge. This facility is a non-profit charitable hospital, supported through contributions and organized auxiliaries which raise large sums for the hospital.

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69. 23 Cal. 2d at 107, 142 P.2d at 748.

In light of its philanthropic and research-oriented philosophy, the City of Hope does not charge its patients for treatment at its facilities, but will accept insurance assignments. Consequently, Mr. Silverman, upon discharge from the hospital, received a bill which was marked paid by one of the auxiliaries. However, wishing to compensate the City of Hope, Mr. Silverman assigned his claim to the hospital.

Continental Casualty Company was the underwriter for this student sickness and accident insurance policy #PI-63877-B04. The company received the claim in April or May, 1973, and subsequently refused payment. The insurance company based its refusal upon the fact that, according to the contract, no "reasonable expenses" were incurred (see Appendix I). They maintained that since Mr. Silverman was not legally obligated to pay the City of Hope, there were no "expenses" on his part; consequently they were not obligated to pay him.

After further negotiations broke down, and after the City of Hope declined to institute legal action based on its philanthropic philosophy, Mr. Silverman filed suit *in propria persona* in the Superior Court of Orange County, California.<sup>70</sup> Silverman sued for breach of contract, anticipatory breach of contract, breach of third party creditor contract, intentional infliction of emotional distress, negligent infliction of emotional distress, and fraud. The suit was for \$208,000 in general damages and \$100,000 in punitive damages. The real intent of the suit was to recover compensation for the City of Hope and to persuade Continental Casualty to change its policy toward the Hospital.

Legally, there may be some basis by which to dispute this claim, primarily on the issue of standing. Since Mr. Silverman did not incur liability, there may be no controversy for which he may sue. However, it appears that the California Attorney General has ruled to the contrary. The California Insurance Code § 10176 states as follows:

In disability insurance the policy may provide for payment of medical, surgical, chiropractic, physical therapy . . . expenses upon a reimbursement basis, or for the exclusion of any such services, and provision may be made therein for payment of all or a portion of

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70. Silverman v. Continental Casualty Co., #207849, filed with the Superior Court of Orange Co., California, Oct. 25, 1973.

the amount of charge for such services without requiring that the insured first pay such expenses. . . .

The Attorney General of California responded to this section by stating that it "does not permit issuance of disability insurance contracts which require payment of medical, surgical, or hospital expenses by the insured as a condition precedent to recovery thereof from insurer".<sup>71</sup> It would appear from Continental Casualty's refusal to pay that they created a contract which required the insured to pay "as a condition precedent to recovery".

Later in the negotiations it became apparent that the plaintiff and the insurance company agreed on a monetary figure for settlement. Mr. Silverman, however, was more interested in obtaining a change in the policy of Continental Casualty. But it was not until after the Orange County Superior Court granted defendant's demurrer giving plaintiff leave to amend that Silverman was informed by defendant that Continental had changed their policy in July, 1973. Legal counsel for Continental Casualty had sent a letter to the California Insurance Commissioner telling him of their change in policy toward the City of Hope. However, the City of Hope was not aware of that letter, and it was only through great difficulty that Mr. Silverman was able to obtain a copy.

Upon inquiry with the California Insurance Commission, he was informed that the letter was "confidential and privileged" and could not be disclosed. However, a letter confirming the existence of such a communication from Continental to the Insurance Commissioner was received (see Appendix II). Shortly thereafter, Mr. Silverman received a copy of the original letter from opposing counsel (see Appendix III). The copy was sent with a cover letter from the attorney, indicating that Continental felt that the communication was privileged and requested that its contents not be made public. However, the California Insurance Commissioner is an employee of the state and works for the people. Secret communications and confidential inquiries do little to serve the public. This letter and the change in Continental's policy was so secret that not even the City of Hope knew of it. Furthermore, this information was so hidden within the corporate walls of Continental Casualty that only after demurrer did they disclose it. This secret deal by the California Insurance Commissioner does not appear to be an isolated incident.

On one occasion, the California Insurance Department issued a cease-and-desist order against Penn Life charging that a sampling

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71. 7 Ops. Cal. Att. Gen. 227 (1946).

of claims showed all kinds of "adverse, mistaken or unfair treatment". Penn Life consented to the order without admitting any wrongdoing. This agreement between the two contained a provision that the insurance department would issue only one press release about the matter and 'will not participate in or encourage any further publicity' . . . . The press release, when it was issued was ten lines long and said that Penn Life was told to make an audit of certain California claims. There wasn't any mention of the cease-and-desist order or the reason for it.<sup>72</sup>

In late April, 1974, over one year after his operation, Silverman settled the case for \$2000.00 plus a copy of the original letter from Continental to the Insurance Commissioner (see Appendix III) and a confirming letter from the Insurance Commission (Appendix II).

### CONCLUSION

This comment is a look at three perhaps unrelated areas; however, in the light of recent proposed legislative reform in the health insurance industry, these three areas are interrelated as one major problem. The problem is the disability insurance companies' refusal of benefits for various reasons, some of them often frivolous.

Today, when health insurance has become such a major issue, reform is desperately needed to prevent denial of compensation and benefits. A national, mandatory health system, wherein the insured is adequately protected and the insurer must maintain that protection without failure, is desperately needed in this country.

If disability insurance is required by law, it becomes extremely difficult for such insurance to be canceled or for benefits to be denied.<sup>73</sup> Today the insured does have some protection because the insurance contract has been defined by the court as an adhesion contract, wherein the insurer has the dominant position.<sup>74</sup> As a result, insurance agreements are construed liberally in favor of the insured<sup>75</sup> and all doubts and ambiguities are resolved against the insurer.<sup>76</sup> However, even with these advantages, the insured is in

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72. Wall Street Journal, January 28, 1974, at 14, col. —.

73. Ohran v. National Auto. Ins. Co., 82 Cal. App. 2d 636, 187 P.2d 66 (1947).

74. Clausen v. Industrial Indem. Co., 241 Cal. App. 2d 440, 50 Cal. Rptr. 615 (1966).

75. Brubaker v. Beneficial Standard Life Ins. Co., 130 Cal. App. 2d 340, 278 P.2d 966 (1955).

76. Paramount Prop. Co. v. Trans. Title Ins. Co., 1 Cal. 3d 562, 463 P.2d 746, 83 Cal. Rptr. 394 (1970).

an unsatisfactory position. By delaying or refusing a large number of claims, as illustrated throughout this comment, disability insurance companies can create a windfall in profits. Those who are denied recovery seldom take legal action to rectify the situation. And if they do, the resolution of the problem could take years. As in the case study illustrated, it took over one year to resolve a relatively minor problem.

The average American is not adequately protected from the financial strains of serious illness. Often he cannot rely upon the very insurance he has purchased to prevent financial disaster or to pay an obligation incurred due to illness. This comment has attempted to discuss and illustrate three typical problems and how state regulation has affected these areas. It is the purpose of this comment to stimulate prompt action in the legislative halls of this country to create a better, more responsive health insurance industry, dedicated to the well-being of all Americans.

JAN MARK DUDMAN

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## APPENDIX I

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Hereby Agrees With

PEPPERDINE UNIVERSITY  
LOS ANGELES, CALIFORNIA

(Herein Called The Policyholder)

To insure under this Policy eligible students of the Policyholder as defined in Part II of this Policy (herein individually called the Insured) and their eligible dependents, if any, as defined in Part VI (herein individually called the Insured Dependent) and, subject to the exceptions, limitations and provisions of this Policy, promises to pay for loss resulting from injury or sickness other than expenses incurred for (A) first-aid treatment for injury sustained while participating in athletic activities; (B) treatment for injury sustained while participating in the play or practice of inter-scholastic football, and (C) services rendered without charge for the Insured by the school's infirmary employees or salaried physicians of the school.

## SCHEDULE

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Name and Address of Policyholder	Policy Number SR-99246
PEPPERDINE UNIVERSITY	
23200 PACIFIC COAST HIGHWAY	
MALIBU, CALIFORNIA 90265	

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Effective Date: AUGUST 29, 1972

### PART I. EFFECTIVE DATE AND POLICY TERM

This Policy takes effect on the effective date stated in the Schedule, from which date all insurance years and months shall be calculated. It continues in force for the period for which premium has been paid, subject to the grace period provided in Part IX. It may be renewed for further consecutive periods by payment of premium as herein provided, subject to the Company's right to decline renewal of this Policy as of the first anniversary date or any anniversary date thereafter by giving written notice to the Policyholder of such declination at least 31 days prior to such date.

All periods of insurance hereunder shall begin and end at 12:01 A.M., Standard Time, at the Policyholder's place of business as stated herein.

P1-63877-B04

### PART II. ELIGIBILITY

All students who register for attendance as full time students at the Policyholder as regularly enrolled graduate or undergraduate students and dependents of Insured Students.

### PART III. EFFECTIVE DATE OF INDIVIDUAL INSURANCE

The insurance of eligible Students and their Dependents for whom written application is made on or before the effective date of this Policy shall take effect on said effective date. The insurance of eligible Students and Dependents for whom written application is made after the effective date thereof shall take effect on the date stated in the name list furnished to the Company by the Policyholder.

The Policyholder agrees to submit to the Company within 20 days after the effective date of this Policy and the first day of each subsequent school term the name of each student and Dependent insured hereunder and the effective date of insurance as to each Insured Person.



#### PART IV. INDIVIDUAL TERMINATIONS

The insurance of any Insured Student shall immediately terminate on the earliest of the following dates:

- (A) on the date this Policy is terminated;
- (B) on the premium due date next following the date the Insured Student ceases to be an eligible student;
- (C) on the premium due date next following the date the Insured Student gives notice to the Policyholder of the termination of coverage, or
- (D) on the premium due date if the Policyholder fails to pay the required premium for the Insured Person, except as the result of inadvertent error.

The insurance of any Insured Dependent shall immediately terminate:

- (A) on the date the insurance of the Insured Student is terminated;
- (B) on the premium due date next following the date the Insured Student of whom the Insured Dependent is a Dependent gives notice to the Policyholder of termination of coverage of such Insured Dependent;
- (C) on the date such person ceases to be an eligible Dependent; or
- (D) on the premium due date if the Policyholder fails to pay the required premium for the Insured Person, except as the result of inadvertent error.

#### CONTINUATION OF COVERAGE FOR INCAPACITATED DEPENDENT CHILD WHEN TERMINATION AGE LIMIT FOR CHILDREN IS ATTAINED

Notwithstanding anything to the contrary stated in this Policy, it is hereby agreed that if an unmarried dependent child is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapable prior to attainment of age nineteen and who is chiefly dependent upon the Insured for support and maintenance and if, within thirty-one days of the date such dependent child's coverage under the policy would otherwise terminate due to attainment of the termination age for children, the Company receives due proof of such incapacity, the coverage of such dependent child under the policy may be continued at the option of the Insured for so long as this Policy remains in force and the dependent remains in such condition. The premium applicable to such incapacitated dependent child shall be at the premium rate applicable for such coverage to adult insureds at issue age twenty-two and shall thereafter be subject to the same adjustments applicable to the adult rate in accordance with the terms of this Policy.

Insurance of any Insured Person shall not be prejudiced by the failure on the part of the Policyholder to transmit reports, pay premium, or comply with any of the provisions of this Policy when such failure is due to inadvertent error or clerical mistake.

## PART V. PREMIUM AND PREMIUM RATES

This Policy is issued in consideration of the payment of a premium equal to at least the first term premium under the policy. The premium rate is:

	<u>Per Trimester</u>	<u>Per Semester</u>
Student Only	\$15.00	\$17.00
Student and Spouse	\$40.00	\$45.50
Student, Spouse and Children	\$50.00	\$56.75

The Policyholder agrees to make an audit within twenty days after the effective date of this Policy, and within twenty days after the end of each subsequent insurance term to submit to the Company, subject to the grace period provided in Part IX the premium for the period covered by such audit.

## PART VI. DEFINITIONS

"Injury" wherever used in this Policy means bodily injury caused by an accident occurring while this Policy is in force and resulting directly and independently of all other causes in loss covered by this Policy as to the Insured Person whose injury is the basis of claim.

"Sickness" wherever used in this Policy means sickness or disease causing loss commencing while this Policy is in force as to the Insured Person whose sickness is the basis of claim.

"Insured Person" as used herein means either the Insured Student or the Insured Dependent.

"Insured Dependent" as used herein means the Insured's lawful spouse (if not eligible as a Student) and each unmarried child or children, who are not self-supporting and are under 19 years of age and, if attending a college or other school on a full time basis, between the ages of 19 and 22 years of age inclusive, insured hereunder.

"Hospital" means an institution which meets all of the following requirements: (1) holds a license as a hospital (if licensing is required in the state); (2) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (3) provides 24-hour a day nursing service by registered or graduate nurses; (4) has a staff of one or more licensed physicians available at all times; (5) provides organized facilities for diagnosis and surgical facilities; and (6) is not primarily a clinic, nursing, rest or convalescent home and is not, other than incidentally, a place for alcoholics or drug addicts. Confinement in a special unit of a hospital used primarily as a nursing, rest or convalescent home is deemed with respect to the coverages provided by this Policy, to be confined in an institution other than a hospital.

"Reasonable Expense" means the usual and customary fee or charge for the services rendered and the supplies furnished in the area where such services are rendered or supplies furnished, provided such services and supplies are recommended and approved by a physician or surgeon, other than the Insured Person.

## PART VII. DESCRIPTION OF BENEFITS

### SECTION I. PHYSICIAN, SURGEON, DENTAL, HOSPITAL, NURSE, X-RAY, LABORATORY AND AMBULANCE EXPENSE—ACCIDENT

When injury shall require treatment by a currently licensed physician or surgeon, dental treatment to natural teeth, confinement within a hospital, use of ambulance or employment of a graduate or licensed nurse, the Company will pay, in addition to any other indemnity payable, the reasonable expense incurred by the Insured Person within 26 weeks after the date of the accident for such treatment, hospital confinement, ambulance and nurse services, not to exceed \$1,000.00 as the result of any one accident.

With respect to x-ray and laboratory expense incurred as the result of an accident, and when such treatment is rendered as an out-patient in a hospital or in the office of a currently licensed physician the Company will pay the reasonable expenses incurred in excess of the first \$15.00, not to exceed \$50.00 as the result of any one accident.

### SECTION II. HOSPITAL ROOM AND BOARD EXPENSE—SICKNESS

When sickness shall require confinement within a hospital, commencing while the policy is in force as to the Insured Person, the Company will pay the reasonable expense incurred for hospital room and board by the Insured for the period of such confinement, not to exceed \$40.00 per day nor to exceed 30 days of hospital confinement as the result of any one sickness.

### SECTION III. MISCELLANEOUS HOSPITAL EXPENSE—SICKNESS

The Company will pay the reasonable expense incurred by the Insured Person during the period of hospital confinement for which expense is payable in the Hospital Room and Board Expense—Sickness provision for anesthetics, anesthetist's fee when charged by the hospital, operating room, laboratory tests, x-rays, oxygen tent, drugs, medicines and dressings not to exceed in the aggregate \$250.00 as the result of any one sickness.

In the event an anesthetist's fee is not charged by the hospital, the Company will pay the reasonable expense incurred not to exceed 25% of the maximum amount applicable to the operation performed as provided in Schedule of Operation, subject however to aggregate payable under this Part.

#### SECTION IV. SURGICAL EXPENSE—SICKNESS

When sickness of the Insured Person shall, during the period the policy is in force as to the Insured Person require a surgical operation listed in the following Schedule of Operations, the Company will pay the reasonable expense incurred for such operation, including post-operative care, but not in excess of an amount represented by the Relative Unit Value set opposite the operation multiplied by \$5.00 nor in excess of \$500.00 for all operations as the result of any one sickness.

#### SECTION V. PHYSICIAN EXPENSE WHEN HOSPITAL CONFINED—SICKNESS

When by reason of sickness the Insured Person shall require the services of a currently licensed physician or surgeon while confined within a hospital for which expense is payable under the Hospital Room and Board Expense provision, the Company will pay the reasonable expenses incurred for such treatment, exclusive of surgical procedure and post-operative care, not to exceed \$7.00 per visit for each visit such treatment is rendered nor to exceed in the aggregate \$175.00 as the result of any one sickness.

#### SECTION VI. PHYSICIAN EXPENSE WHEN NOT HOSPITAL CONFINED—SICKNESS

When by reason of sickness the Insured Person shall be necessarily and personally treated by a currently licensed physician or surgeon while not confined in a hospital, the Company will pay the reasonable expense incurred for such treatment, exclusive of surgical procedures and post-operative care, not to exceed \$7.00 per visit, beginning with the second visit, for each visit such treatment is rendered nor to exceed in the aggregate \$175.00 as the result of any one sickness.

#### SECTION VII. AMBULANCE EXPENSE—SICKNESS

When by reason of sickness an ambulance is necessary to transport any Insured Person to or from a hospital on account of hospital confinement for which expense is payable under the Hospital Room and Board Expense provision, the Company will pay the reasonable expense incurred for such ambulance services, not to exceed in the aggregate \$25.00 as the result of any one sickness.

## SCHEDULE OF OPERATIONS

	Relative Unit Value
<b>Abdomen</b>	
Surgical puncture of abdomen	
adhesions, division of .....	30
appendectomy .....	30
Joining gall bladder to intestine .....	50
Colon resection—Removal of large intestine	
Total including colostomy .....	100
Cutting out of intestinal lesions, without rejoining .....	50
Removal of stomach	
Total .....	70
Partial .....	50
Joining of intestine to stomach .....	50
Inguinal or femoral repair of hernia	
Single .....	30
Bilateral .....	40
Hiatus or diaphragmatic repair of hernia .....	60
<b>Amputations</b>	
Amputation at elbow joint .....	30
Amputation at knee .....	30
Amputation of arm, including bones of shoulder .....	75
<b>Bones</b>	
Removal of bone spur with autogenous bone implant .....	30
Union operation	
Unilateral .....	20
Bilateral .....	30
Shortening of Bone Including Bone Grafting	
Femur .....	60
Tibia, Humerus .....	50
Radius, Ulna .....	40
<b>Eye, Ear, Nose and Throat</b>	
<b>Ear</b>	
Cutting into cardum, under general anesthesia .....	4
Cutting into cardum, not under general anesthesia .....	3
Cutting away of inner ear .....	80
Freeing of adhesion of inner ear .....	50
<b>Eye</b>	
Plastic Repair of Eye Socket .....	60
Repair of Squinting Eye	
One Eye .....	40
Both Eyes .....	50
<b>Nose and Throat</b>	
Cutting into Sinus Cavity	
Simple .....	15
Radical .....	25
Tonsillectomy, with or without adenoidectomy .....	15
Cutting into windpipe .....	20

Gynecology	
Removal of uterus, vaginal approach .....	50
Uterus, suspension of, any type, with or without dilation and curettage or surgery on tubes or ovaries .....	35
Heart and Blood Vessels	
Artery Graft or Cutting	
Inter-Abdominal .....	80
Intrathoracic .....	80
Extremities .....	50
Joining or Forming a Connection Between Arteries	
Aortic Anastomosis .....	100
Pulmonary Anastomosis .....	100
Veins	
Removal of clot from Vein	
Extremities .....	25
Varicose Veins	
Litigation with or without division Saphenous Vein with Stripping on same or successive days	
Unilateral .....	20
Bilateral .....	30
Forming Connection Between Veins	
Porto-Caval .....	100
Mesenteric .....	80
Neurosurgery	
Drainage of Subdural, Epidural or Brain Abscess or Hematoma .....	50
Repair or freeing of adhesions of nerve	
One Nerve .....	15
More than one Nerve .....	25
Surgical Division of Nerves of Spinal Cord .....	100
Removal of Posterior Arch of a Vertebra .....	70
Tapping at Lower Part of Spinal Canal .....	3
Cutting away of Sympathetic Nerve of the Neck	
Unilateral .....	50
Bilateral .....	75
Cutting away of the Base of the Spine	
Unilateral .....	50
Bilateral .....	70
Plastic Surgery	
Plastic Operation on Lip	
Unilateral .....	60
Bilateral .....	80
Repair of Claw or Clubfoot—Bilateral .....	7
Proctologic Surgery	
Removal of Fistula	
Single .....	20
Multiple .....	35

Hemorrhoidectomy, External and Internal .....	20
Tendons	
Graft, Transfer or Transplant of Tendon, Distal to Shoulder or Hip	
Single .....	30
Each Additional Tendon .....	5
Lengthening or Shortening of Tendon .....	20
Thorax or Chest	
Esophagus	
Removal of Pocket from Gullet	
Cervical Approach .....	40
Thoracic Approach .....	70
Lung	
Partial Removal of Lobe of Lung .....	70
Removal of Membrane covering Lung and Lining Chest Cavity .....	70
Tumors or Cysts	
Drainage of Cyst at Base of Spine .....	3
Removal of Benign Tumors by Surgical Procedure	
Superficial, including warts by Excision, Tumors of Face, Neck, Genitalia, Hands or Feet	
One Tumor .....	3
Each Additional Tumor .....	3
Urologic Surgery	
Operation for Abcess of Prostate Gland .....	30
Suture of Kidney .....	60
Removal of Prostate Gland	
Perineal .....	65
Transplant Operation on Tube from Kidney to Bladder	
Unilateral .....	55
Bilateral .....	70

The Company will pay, subject to the limit provided, for dental surgery covered hereunder and for operations not named above amounts objectively determined on the basis of comparative severity with operations which are named, but not less than the minimum nor more than the maximum provided for operations named.

## PART VIII. EXCLUSIONS

The policy does not cover the expense of (1) dental treatment except as provided in Part VII, Section I, (2) services rendered by the School's Infirmary, infirmary employees or salaried physicians of the School; (3) replacing eyeglasses or prescriptions therefor; (4) preventive medicines or vaccines; (5) first-aid treatment for injuries sustained while participating in athletic activities; nor does this Policy cover any loss caused by or resulting from (6) sickness resulting from pregnancy, childbirth or miscarriage; (7) accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by an established concern organized to operate an airplane service and licensed for the carriage of passengers for hire; (8) declared or undeclared war or any

act thereof; (9) injury sustained in consequence of participating in the play or practice of interscholastic football; or (10) injury sustained or sickness contracted while in the service of the armed forces of any country. Upon any Insured entering the armed forces of any country, a pro-rata refund of premium will be made; (11) injury or sickness for which benefits are payable under any Workmen's Compensation or Occupational Disease Act or Law; (12) suicide or any attempt thereat while sane or self-destruction or any attempt thereat while insane.

#### PART IX. UNIFORM PROVISIONS

**ENTIRE CONTRACT: CHANGES:** This Policy constitutes the entire contract between the parties, and no statement made by the Policyholder or any Insured Person whose eligibility has been accepted by the Company shall void the insurance or reduce the benefits under this Policy or be used in defense to a claim hereunder.

No change in this Policy shall be valid unless approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**GRACE PERIOD:** Unless not less than 31 days prior to the premium due date the Company has delivered to the Policyholder or has mailed to the last address as shown by the records of the Company written notice of its intention not to renew this Policy beyond for which the premium has been accepted a grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the policy shall continue in force, but the Policyholder shall be liable to the Company for the payment of the premium accruing for the period the policy continues in force.

If any premium be not paid within the days of grace, this Policy shall thereupon be discontinued, but the Policyholder shall, nevertheless, be liable to the Company for the payment of all premiums then unpaid, together with the premiums for the days of grace. If however, written notice is given by the Policyholder to the Company, during the grace period, that this Policy is to be discontinued, this Policy shall then be discontinued on the date of receipt by the Company of such written notice, but the Policyholder shall, nevertheless, be liable to the Company for the payment of all premiums then unpaid, together with a pro rata premium for the period commencing with the date on which the last premium became due ending with the date of receipt of such written notice by the Company.

**NOTICE OF CLAIM:** Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of



any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Company at 310 South Michigan Avenue, Chicago, Illinois, or to any authorized agent of the Company, with information sufficient to identify the Insured Person shall be deemed notice to the Company.

**CLAIM FORMS:** The Company, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

**PROOFS OF LOSS:** Written proof of loss must be furnished to the Company within 90 days after the termination of the period for which the Company is liable. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

**TIME OF PAYMENT OF CLAIM:** Indemnities payable under this Policy for any loss other than loss for which this Policy provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which this Policy provides periodic payment will be paid each month and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

**PAYMENT OF CLAIMS:** All indemnities becoming payable hereunder will be payable to the Insured.

If any indemnity of this Policy shall be payable to the estate of an Insured Person or to an Insured who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity up to an amount not exceeding One Thousand Dollars to any relative by blood or connection by marriage of the Insured Person or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this Provision shall fully discharge the Company to the extent of such payment.

**PHYSICAL EXAMINATION:** The Company at its own expense shall have the right and opportunity to examine the person of any Insured Person whose injury or sickness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the

requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

**CONFORMITY WITH STATE STATUTES:** Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which this Policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute.

This Policy is not in lieu of and does not affect any requirements for coverage by Workmen's Compensation Insurance.

IN WITNESS WHEREOF, the Continental Casualty Company has caused this Policy to be signed by its President and Secretary; but the same shall not be binding upon the Company unless countersigned by its duly authorized agent.

Secretary	President
Countersigned by _____	_____
Licensed Resident Agent	

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## APPENDIX II

April 22, 1974  
Stuart Silverman  
2022 Victoria  
Anaheim, California 92804

Dear Mr. Silverman:

This letter is in response to your telephone inquiry of April 17, 1974. Please be advised that Continental Casualty Company has informed us that as of July 11, 1973 they will pay for charges made by the City of Hope when such charges are covered under their policies.

I trust this information will enable you to resolve your pending law suit regarding Continental Casualty's procedures in regard to City of Hope claims.

Very truly yours,  
GLEESON L. PAYNE  
Insurance Commissioner  
By *John M. Fogg*  
Counsel

### APPENDIX III

July 11, 1973

Hon. Gleeson L. Payne  
Insurance Commissioner  
Department of Insurance  
1 407 Market Street  
San Francisco, California 94103

Re: *City of Hope Medical Center*

Dear Commissioner Payne:

As I had previously advised in my letter of June 22, 1973, our Companies were studying your request for recognition of assignments by our insureds to the City of Hope Medical Center.

We are pleased to advise that the following companies will henceforth honor assignments made by our insureds to the City of Hope Medical Center recognizing such assignment as representing "expenses incurred" under the contract even though in the absence of insurance the patient incurs no obligation for such expenses:

Continental Assurance Company  
Continental Casualty Company  
American Casualty Company  
Transportation Insurance Company  
Valley Forge Life Insurance Company

While we agree to henceforth consider charges made by the City of Hope as being "expenses incurred" under the contract, payment of benefits will only be made if the confinement in one otherwise covered under the terms of the contract and that confinement in such institution is not specifically excluded under the terms of the contract.

Very truly yours,  
Donald M. Lowry  
Assistant General Counsel  
DML:ck

bcc: H. Parsons        20W  
      I. Silchuck       9E  
      W. Shomaker     12W