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Yes, You Can Rescind a Policy After Two Years—A Disability Policy: A Framework

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There is a significant amount of litigation regarding when and whether an insurer may rescind a life policy after the two-year contestable period has passed. The two-year contestability clause to rescind a life insurance policy is mandated by virtually every state. Some states will also allow rescission of a life policy after two years upon a showing of intentional fraud, especially with respect to the insurability requirement. Investor funded Stranger Owned Life Insurance ("STOLI") polices, which violate important public policy against wagering on the life of the insured, are also subject to rescission in some states. What is not widely litigated is the rescission of disability policies two years after issuance. Rescission of disability policies after two years is authorized both by state statutes and insurance department approved language in the policy, so long as the material misrepresentations rise to the level of fraud.[1]

In refusing to extend the two-year contestability period in a life policy to matters where there was no insurable interest, the New York Court of Appeals in *New England Mut. Life Ins. Co. v. Caruso* pointed to the language of the New York statute which permitted rescission of certain accident and disability polices after two years. *New England Mut. Life Ins. Co. v. Caruso,* 73 N.Y.2d 74, 535 N.E.2d 270, 538 N.Y.S.2d 217 (1989). The Court of Appeals held that if the legislature had intended that the incontestability clause not bar such claims with respect to life policies, "it could have stated so." The states which rescind life insurance policies after two years typically apply a heightened standard as compared to the ordinary fraud standard applied to actions to rescind disability policies after two years. *See, e.g., Sadel v. Berkshire*, 476 Fed. Appx. 152, 2012 WL 3644735 (3rd Cir. 2012) (rejecting plaintiff's argument that a "special higher burden" applies where rescission of a disability policy is sought after expiration of contestability clause because plaintiff only cited and relied on cases involving life policies. The Third Circuit held that with respect to disability rescission matters, the typical fraud requirements and clear-and-convincing standard of proof apply.).

Disability policies are underwritten in a manner similar to life policies. The proposed insured answers a series of questions about financial and medical history. The underwriter reviews the completed application and requests additional information if the application includes disclosures: for example, an attending physician's statement will be requested from a physician identified by the applicant. Phone interviews to the prospective insured asking the application questions again is another tool used by underwriters.

Duty to Investigate

As with life policies, the disability insurer "has an absolute right to rely on the representations in the written application as long as the application is signed by the insured and attached to the policy." *N.W. Mut. Life Ins. Co. v. Cupo*, 1995 WL 117892, *2 (S.D.N.Y. 1995).

An insurer has no duty to undertake a more extensive investigation because:

1 Typical policy language: "after two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year periods."

> the "duty to disclose" clearly rests with the insured . . ., not the insurer. The insured is required to reveal "every fact bearing on or pertaining in any way to the insurability of [his] life, especially where specific questions are put to the applicant calling for such information. . . ." "An insured cannot remain silent while cognizant that his insurance application contains misleading or incorrect information."

Schondorf v. SMA Life Assurance, Co., 745 F.Supp. 866, 870–71 (E.D.N.Y. 1990) (emphasis supplied)(citations omitted); *see also New England Life Insurance Co. v. Taverna,* 2002 WL 718755, *7 (E.D.N.Y. 2002) (It is the insured's "'duty to disclose . . . every fact bearing on or pertaining in any way to the insurability of [his] life, especially where specific questions are put to the applicant calling for such information.'") (citations omitted).

For example, in *In Re Green,* 241 B.R. 550 (N.D. Ill., 1999), the federal district court held that the justifiable-reliance requirement imposes no duty to investigate unless the falsity of the representation is obvious upon cursory glance. Citing Restatement (second) of Torts, §541 cmt. a.

Thus, an application that does not contain questionable history (aka a "clean app") triggers no duty to investigate. "Absolutely nothing about the applications [at issue in *In Re Green*] indicates that [the insured's] representations of health were false and that he had a long and complex medical history." Id at 565. The insurer justifiably relied upon the application. *Id. See also Bhakta v. Hartford,* 673 Fed.Appx. 762, 765, 2016 WL 7448766 (9th Cir. 2016) (where the beneficiary argued that evidence in the underwriting file of depression, respiratory infection, no work history and elevated ALT & HDL levels should have caused Hartford to conduct further investigation, the court held that that evidence did not "flatly contradict the insured's answers"); *Kerrigan v. Metropolitan Life Ins. Co.*, 2013 WL 2110828, 2013 N.Y. Slip Op. 33591(U) (N.Y. Sup. Ct. 2013) *aff'd*, 117 A.D.3d 562, 986 N.Y.S.2d 99 (1st Dep't 2014)) *lv to app denied*, 24 N.Y.3d 912, (Dec. 18, 2014) (court held EKG results were not sufficient to prove actual notice of serious heart disease.).

In *Chawla v Transamerica*, 440 F.3d 639 (4th Cir. 2006), the Fourth Circuit held that "although Transamerica had knowledge of some facts, it was limited to the least significant facts the insured was obligated to disclose . . ." and

> Transamerica was not aware of the meningioma surgery, the shunt surgery, or Giesinger's three hospitalizations. Moreover, because Transamerica was unaware of these events, it did not possess the records made in connection with them, several of which suggested that Giesinger's drinking problems exceeded the consumption of a bottle of wine per day. Because Transamerica lacked awareness of material facts concealed by Giesinger's misrepresentations, it could not and did not waive the defense of misrepresentation.

Id. at 646.

When Misrepresentations Are Identified

Evidence of material misrepresentations on a life application is typically identified during the usual two-year contestability investigation conducted by the insurer if an insured dies within two years of issuance. Evidence of material misrepresentations on a disability policy application is often identified after a disability claim is made based on medical records that are submitted in support of the claimed disability. If a review of the medical records reveals material misrepresentations made in the application, and the claim is made within the contestability period, the insurer can rescind without a showing of fraud. If the claim is filed after the contestability period, the insurer can still rescind if it satisfies the additional burden of establishing that the misrepresentation was made fraudulently. This hurdle (absent claims of not understanding the question, waiver or duty to investigate further) may be readily met because the misrepresentation was made by the insured in writing and is signed and verified by the insured. Clear and material misrepresentations can be the basis of a successful motion for summary judgment.

The Elements That Must Be Established

A party seeking to rescind a disability insurance policy beyond the initial two-year contestability period must prove the following elements:

> (1) a material misrepresentation or omission of fact, (2) made with knowledge of its falsity, (3) with an intent to defraud, and (4) reasonable reliance on the part of the [party seeking to establish fraud], (5) that causes damage to [that party].

Ehrlich v. Berkshire Life Insurance Co., 2002 WL 368444, *8 (S.D.N.Y. Mar. 7, 2002); *see Dwyer v. First Unum Life Ins. Co.,* 41 A.D.3d 115, 837 N.Y.S.2d 635, 636 (1st Dep't 2007). (An insurer may only rescind an insurance policy that has been in effect for over two years if the insurer can "identify a material misrepresentation in the [insured's] application that was intended to defraud the insurer.") (Citing N.Y. Ins. Law §3216(d)(1)(B)(i)).

Intent to Deceive

The first question to be resolved is not whether the plaintiff understood that she should have disclosed her treatment, but whether a reasonable person would have believed that these facts were significant and should have been disclosed as a response to the questions in the application. *See Falcon Crest Diamonds, Inc. v. Dixon,* 173 Misc.2d 450, 458, 655 N.Y.S.2d 232, 237 (N.Y. Co. 1996). In determining whether or not a plaintiff has improperly failed to disclose a particular fact, the court is required to employ an objective standard, *i.e.*, whether "'a reasonable person in the insured's position would know that the particular fact is material' . . . or something which would have controlled Underwriters' decision to accept the risk." *Id.* (citation omitted). *See also Spencer v. Minnesota Life Ins. Co.*, 493 F.Supp.2d 1035, 1041 (S.D. Ohio 2007) ("Where an applicant knowingly makes a false statement on an application for insurance regarding prior medical treatment . . . the false statement is presumed to be willfully and fraudulently made, [and the claimant] has the burden of going forward with evidence tending to prove . . . that such consultation was not for or not known by the insured to be for any serious ailment or condition, or that the false answer was an honest mistake.")

A misrepresentation is thus material and intentional if a reasonably careful and intelligent person would believe that the omitted facts substantially increased the insurer's risk under the policy and might cause the insurer to reject the application. *In Re Green, supra*, 241 B.R. 550, 566 (N.D. Ill. 1999), citing *Methodist Medical Center of Illinois v. American Medical Sec. Inc.,* 38 F.3d at 320 (7th Cir. 1994). Where a person knowingly or recklessly makes false representations which the person knows or should know will induce another to act, the finder of fact may logically infer an intent to deceive. In *In Re Green, supra*, the court concluded "a reasonable person would have to believe that a long history of serious illness and serial hospitalizations substantially increased [the insurer's] risk under the disability policies." *Id.* at 567. The Court held it "had no choice but to infer that [the insured] intended to deceive" the insurer by omitting significant portions of his medical and hospitalization history to obtain the disability policies at issue. *Id.* at 565.

Furthermore, "absent direct evidence, intent 'may be proven by circumstantial evidence.'" *Ehrlich v. Berkshire Life Insurance Co.*, 2002 WL 368444, at *10, citing *Cofacredit, S.A. v. Windsor Plumbing Supply Co. Inc.*, 187 F.3d 229, 241 (2d Cir.1999). In *Ehrlich v. Berkshire Life Insurance Co.*, the plaintiff/insured was unable to recall at his deposition the source of his representations concerning his income and net worth statement. The plaintiff claimed that "the statement of his income was a good faith projection" of income for that year. In fact, the representation as to current year income was made with fewer than two weeks left in the year. Thus, the Court found it was not a "good faith projection" because he should have been able to better project the income for that year. The financial misrepresentations made by the plaintiff in *Ehrlich* allowed him to improperly obtain a policy with a higher monthly benefit than he would have received had he answered truthfully.

Case Study: *Dormer v. Northwestern*

Dormer v. Northwestern Mut. Life Ins. Co., 408 Fed. Appx. 452 (2d Cir. 2011) illustrates the various permutations of a disability rescission case from discovery of the misrepresentations, through a motion for summary judgment, trial and appeal. *Dormer* involved a doctor who made material misrepresentations and omissions concerning her medical history in the applications for two disability policies. These misrepresentations became known to Northwestern Mutual ("NWM") after she submitted a claim of disability from her medical practice, shortly after the expiration of the two year contestability period. The medical records submitted in connection with her claim of disability due to myasthenia revealed that Dormer had a significant medical history, including numerous additional conditions. Specifically, in addition to the symptoms of myasthenia (including muscle weakness, facial weakness and difficulty with eyelid elevation), she suffered from intermittent facial paralysis and Bell's Palsy; recurrent low back pain and disc herniation at the L3-L4 levels; episodes of severe fatigue including a diagnosis of chronic fatigue syndrome; asthma; neurogenic hypotension; and chronic cystitis. While, as a medical professional, Dormer should have had full knowledge and understanding of her own medical condition, none of these ailments was disclosed in the application process.

The underwriting process included a personal history interview. Also, as part of the underwriting process, NWM requested and received medical records from the doctor Dormer had identified on the application, Dr. Lipschitz. After its review of the records submitted, NWM denied Dormer's claim, rescinded the policies and returned the premiums. Dormer sued NWM and the case was removed to the Southern District of New York and assigned to Judge Rakoff. After discovery, NWM moved for summary judgment because there was no issue of material fact that Dormer had intentionally misrepresented her medical condition. In opposition, plaintiff raised an issue as to

whether a one-page handwritten report by Dr. Lipschitz (which listed certain medical conditions Dormer omitted from the application) had been received by NWM during the underwriting process. Judge Rakoff held:

> The disputed issue of whether Northwestern Mutual received the Statement before or after the issuance of the policies is crucial to resolving the defendant's allegation that Dr. Dormer intentionally and fraudulently misled the defendant in her various application for disability insurance. For this reason, the Court hereby denies Northwestern Mutual's motion for summary judgment.

Dormer v. Northwestern Mut. Ins. Co., 2009 WL 2603123, *2 (S.D.N.Y. 2009) aff'd 408 Fed.Appx. 452, 2011 WL 310268 (2nd Cir. 2011).

Because the remedy of rescission is equitable, the case was tried before Judge Rakoff, and not a jury. As later noted by Judge Rakoff, Dr. Dormer convincingly affected a credible demeanor. During the course of the trial, however, plaintiff's counsel could not refute the clear misrepresentations made when compared to the medical records, or their materiality. The NWM witnesses, including employees from the document receiving department, established the materiality of the misrepresentations. The witnesses further established that the underwriter had never received the handwritten page sent by Dr. Lipschitz's office, and thus had no knowledge of the disclosures in that document.

The most stunning of Dormer's misrepresentations occurred during her redirect when she fabricated an event—a "second" personal history interview ("PHI")—in which she falsely claimed, for the first time in the litigation, to have disclosed her entire medical history to NWM during the underwriting period. Dormer had not previously mentioned a second PHI in the pleading stage, during extensive discovery, including her own deposition, during motion practice or on direct or cross examination. In the end, the undeniable documentary evidence established that plaintiff had simply made up an imaginary second PHI on the stand when she realized that she was losing.

After a five-day bench trial, Judge Rakoff concluded that:

> It's hard not to have sympathy for Dr. Dormer. It's hard also not to have admiration. She clearly is a woman not only of intelligence but of drive, who despite her physical problems, has successfully had two careers and plainly is a person of talent, of even some charisma; *but her testimony on the stand indicated to the court that she had a less than total punctiliousness about the truth.* . . .
>
> There are numerous other examples of Dr. Dormer's giving false or misleading testimony here in court, corroborative of the inference that the misstatements in her application about material matters were made with fraudulent intent: They were well spelled out in the defense summation. *So, I am forced to conclude, reluctantly,* that she with fraudulent intent sought to mislead Northwestern about highly material health problems relating to chronic fatigue, to Bell's Palsy and to the condition of the disks in her back, and that she carried that fraud into this court.

Dormer v. Northwestern Mut. Ins. Co., Case No. 08 Civ. 8725 (S.D.N.Y.) (emphasis added), Unpublished Transcript dated November 20, 2009, 9:11–18; 11:16–25, available on request. Judge Rakoff held he did not need to resolve the legal issue with respect to the handwritten note from Dr. Lipschitz. Instead, he held that while EMSI apparently did fail to get all of the records to NWM:

> the court does not reach the argument made by the defendant that the company cannot be charged with that information. I'm going to assume arguendo that the company constructively knew what was in Dr. Lipschitz's submission, or handwritten notes really, of his examination back in February. . . . And I will assume that the company constructively received that, *even though I think the law in this area might well go in the opposite direction.* . . . . So, there is more disclosure here, but even here an attempt was made, particularly with respect to Bell's Palsy and the chronic fatigue, to misrepresent the true extent of the problem.

Id., pp. 8:10 – 9:9 (emphasis added). The Second Circuit affirmed Judge Rakoff's decision, holding that:

> A reasonable factfinder could easily infer that this pattern of minimizing an adverse medical history, in connection with a disability insurance application, could not have been accidental and must have been intended to reduce the risk that the application would be denied.
>
> Moreover, Dormer's misrepresentations continued in her trial testimony. The district court noted numerous examples of "false or misleading" testimony and concluded that Dormer's answers "seemed designed . . . to place the best possible gloss on a momentary issue even if it was inconsistent with testimony she gave on some other related issue." These credibility findings by the trier of fact are entitled to deference, *Wade v. County Sheriff's Office,* 844 F.2d 951, 955 (2d Cir.1988), and in any event we see no error in them. This lack of candor supports the inference created by the factual record that Dormer acted with fraudulent intent.

2011 WL 310268, **1–2. It is notable that four years later, the New York Appellate Court conclusively held that only actual, not constructive, notice of the misrepresented response can bar rescission of the policy based on material misrepresentations. *Kerrigan v. Metropolitan Life Ins. Co.*, 2013 N.Y. Misc. LEXIS 6489 (N.Y. Sup. Ct. 2013), *supra.*

Conclusion

Rescinding a disability policy after the expiration of the contestability period is a very good option if the insurer can establish a material misrepresentation, even though the insurer must also prove intent by clear and convincing evidence. Assuming the plaintiff cannot present a winning argument that the insurer was on notice of the condition misrepresented, proving intent using the objectively reasonable person standard logically flows from the established facts.

For over 20 years, Michelle J. d'Arcambal, a partner of d'Arcambal Ousley and Cuyler Burk, has defended a wide variety of life, health, and disability product and plan litigations. She provides strategic advice aligned with the client's litigation and business goals, including resolution. As a result of her in-house litigation experience at MetLife, Ms. d'Arcambal understands the needs of her clients and focuses on achieving their objectives in the most efficient way possible. When a matter cannot be resolved by motion or mutual agreement, Ms. d'Arcambal leverages her trial and appellate experience in from of appellate judges and trial courts. Ms. d'Arcambal was previously a commercial litigation partner at Ross & Hardies, now known as McGuire Woods, LLP, and an associate at Brown & Wood, LLP, now known as Sidley Austin, LLP. She is a 1985 graduate of the University of Wisconsin Law School and graduated from Smith College in 1981.

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