2009 ACLI COMPLIANCE AND LEGAL SECTIONS ANNUAL MEETING LITIGATION UPDATE

RECENT DEVELOPMENTS THAT WILL HELP YOUR COMPANY PREVAIL IN LITIGATION

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I. *Glenn* and Its Progeny

In *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343 (2008), the Supreme Court held that where an insurance company administers an ERISA plan *and* is given discretionary authority by the plan to determine eligibility for benefits, a conflict of interest exists. The court further held that this conflict of interest "should be 'weighed as a factor in determining whether there is an abuse of discretion.'" The court explained that a conflict of interest is just one of many factors that judges should consider when reviewing a benefits denial. The court emphasized, however, that this holding does not change the standard of review from deferential to, for example, a *de novo* review. Although the court did not address the scope of discovery under ERISA, it suggested that when weighing the conflict of interest judges should consider "circumstances" such as "a history of biased claims administration" or, conversely, steps taken by an administrator "to reduce potential bias and to promote accuracy."

A. Post-*Glenn* Cases Addressing Standard of Review

In *Schwing v. Lilly Health Plan*, No. 06-4671, 562 F.3d 522 (3d Cir. April 14, 2009), the Court held that in light of the Supreme Court's decision in *Glenn*, "our 'sliding scale' approach is no longer valid." Instead, courts reviewing ERISA benefits determinations "should apply a deferential abuse of discretion standard of review across the board and consider any conflict of interest as one of several factors in considering" whether the decision constituted an abuse of discretion. The Court stated that after *Glenn*, "it is clear that courts should 'take account of several different considerations of which a conflict of interest is one,' and reach a result by weighing all of those considerations." In reversing the district court's judgment in favor of the participant, the Court observed that "[e]ven if we considered the purported conflict of interest here to be serious, the decision to deny [the plaintiff's] claim for severance benefits was not so close that this factor would act as 'tiebreaker' tipping the scales in favor of finding that the [defendant] abused its discretion."

In *Sanders v. Unum Life Ins. Co. of America*, 553 F.3d 922 (5th Cir. 2008), the court affirmed summary judgment in favor of the insurer, holding that while the administrator's conflict of interest must be taken into account, "the conflict is only one of several considerations" and that "[a]ny one factor can act as a tiebreaker when the other factors are closely balanced." Because the Court ultimately did "not find a particularly close balance," it did "not use the inherent conflict as a tiebreaker."

In *Stone v. UNOCAL Termination Allowance Plan*, No. 08-20254, 2009 WL 1479405 (5th Cir. May 28, 2009), the court held that *Glenn* "has no relevance" to the first step of the Fifth Circuit's two-part analysis, which is to determine whether the administrator's decision was legally correct. In this first step, even after *Glenn*, the court does not consider "whether there was a conflict of interest or an abuse of discretion." The court ultimately concluded that the administrator's decision was legally correct, but that even if had not been correct, there was no evidence of a conflict or of an abuse of discretion.

In *Young v. Wal-Mart Stores, Inc.*, 293 Fed. Appx. 356 (5th Cir. 2008), the plaintiff brought a claim under ERISA against her employer and a life insurer for accidental death benefits. The Fifth Circuit reversed the award of policy benefits to the plaintiff, holding that

"based on the record as a whole, the conflict of interest factor is not of great importance." The court concluded that the insurer's decision was supported by substantial evidence and "was not arbitrary, capricious, or an abuse of discretion."

In *Smith v. Health Services of Coshocton*, No. 08-3620, 2009 WL 481603 (6th Cir. Feb. 25, 2009), the Sixth Circuit affirmed the judgment in favor of the plan administrator. The court stated that it considered *Glenn* an "extension" of the decision in *Firestone*. The court rejected plaintiff's argument that *Glenn* required "a more penetrating scope of judicial review than has previously been utilized" and stated that it would be a "serious misreading" of *Glenn* to suggest that the opinion creates a heightened standard of review in a fully-insured case, much less in a self-funded case.

In *Gutta v. Standard Select Trust Ins. Plans*, 285 Fed. Appx. 302 (7th Cir. 2008), the Seventh Circuit held that under *Glenn*, a conflict of interest was "just one of many factors that might help demonstrate an abuse of discretion." The court found that "even acknowledging [the administrator's] dual role and thus conflict of interest, we do not find the other factors to be closely balanced." As a result, the court held the application of the conflict under *Glenn* did not change its previous decision in favor of the defendant.

In *Jenkins v. Price Waterhouse Long Term Disability Plan*, 564 F.3d 856 (7th Cir. 2009), the plaintiff brought suit under ERISA alleging that his benefits had been wrongfully terminated. On appeal, the Seventh Circuit affirmed the district court's order granting summary judgment in favor of defendants. Noting the applicable arbitrary or capricious standard, the court explained that "[t]his doesn't make us a rubber stamp, but it does mean that we cannot reverse course unless a decision is 'downright unreasonable.'" Measured against this standard of review, the court found that the plaintiff's appeal "stands little chance." All that is required for judgment in favor of the administrator is "rational support in the record." The court found that because the record offered rational support for the administrator's decision to terminate benefits, the district court was correct in entering summary judgment for the administrator.

In *Wakkinen v. UNUM Life Ins. Co. of America*, 531 F.3d 575 (8th Cir. 2008), an ERISA participant brought suit against the plan administrator seeking to recover long-term disability benefits. On appeal, the Eighth Circuit affirmed summary judgment in favor of the administrator, holding that because this was not a close case, the administrator's conflict of interest could not act as a tiebreaker to tip the scale in the plaintiff's favor under the applicable abuse of discretion standard.

In *Daic v. Hawaii Pac. Health Group Plan*, 531 F.3d 575 (9th Cir. 2008), the Ninth Circuit affirmed the district court's award of summary judgment to the defendant. The court held that under *Glenn*, the district court did not "err in holding that the importance of [the administrator's] conflict was low" where the record did not "contain evidence of malice, self-dealing, or other circumstances suggesting a higher likelihood that the structural conflict affected the benefits decision." The court specifically noted that ERISA does not require plan administrators to "'accord special deference to the opinions of treating physicians.'"

In *Doyle v. Liberty Life Assurance Co. of Boston*, 542 F.3d 1352 (11th Cir. 2008), the court held that *Glenn* modified the sixth step of the Eleventh Circuit's ERISA decision review

process, which mandated heightened arbitrary and capricious review for decisions of conflicted fiduciaries, by eliminating heightened review, making the conflict of interest "merely a factor," and eliminating the burden on the conflicted fiduciary to show its decision was not tainted by self-interest. The court also rejected plaintiff's argument that *Glenn* imposes a burden upon conflicted fiduciaries "to offer evidence of … efforts to assure accurate claim assessment."

B. Post-*Glenn* Cases Addressing Scope of Discovery

In *McGahey v. Harvard Univ. Flexible Benefits Plan*, No. 08-10435-RGS, 2009 WL 799464 (D. Mass. March 25, 2009), the plaintiff brought suit against a self-insured employee benefit plan to recover disability benefits. The court denied plaintiff's motion for discovery "to determine whether Harvard's dual role as both Plan Administrator and funder of claims influenced an improper denial of benefits in her case." Plaintiff sought "extensive discovery into: (1) the historical record of Harvard's disability claims decisions (including statistical and financial information); (2) Harvard's policy of demanding reimbursement of Social Security benefits while at the same time denying continued benefits; and (3) the extent to which Harvard has implemented procedures to ensure that a presumptive conflict of interest does not taint the benefits decision-making process." The court held that there must be "'some very good reason" to overcome the "strong presumption" that the review is limited to the administrative record. Finding nothing in *Glenn* that upset this standard, the court declared that it "would not permit discovery where a plaintiff can point to nothing more than a structural conflict of interest." Due to the absence of a preliminary showing "suggesting that the conflict is actually *enhanced* by some organizational factors," the court denied the plaintiff's motion to compel discovery.

In *Christie v. MBNA Group Long Term Disability Plan*, No. 1:08-CV-44, 2008 WL 4427192 (D. Me. Sept. 25, 2008), the Court held that *Glenn* "was not a case about discovery" and that the First Circuit's existing ERISA discovery cases still applied. Under that standard, the court found that the plaintiff had not adequately explained why she needed discovery that involved "exploring the contours of the structural conflict of interest that exists for Prudential." The court found that because the conflict of interest was already established, the plaintiff did not need to conduct discovery beyond the administrative record.

In *Weiss v. First Unum Life Ins. Co.*, No. 02-4249, 2008 WL 5188857 (D.N.J. Dec. 10, 2008), the court affirmed the magistrate's order limiting discovery, holding that *Glenn* and *Firestone* do not "address the specific issue of discovery under the heightened arbitrary and capricious standard of review in ERISA cases."

In *Marszalek v. Marszalek & Marszalek Plan*, No. 06 C 3558, 2008 WL 4006765 (N.D. Ill. August 26, 2008), the Court rejected plaintiff's argument that *Glenn* mandated discovery thereby changing the law set forth in *Semien v. Life Ins. Co. of N. America*, 436 F.3d 805 (7th Cir. 2006), *cert denied*, 127 S. Ct. 53 (2006). The court held, in accordance with *Semien*, that discovery is allowed only in "exceptional" circumstances when the claimant is able to identify a specific conflict of interest or instance of misconduct. The court rejected plaintiff's assertion that bonuses paid to certain executives of the defendant supported discovery. The court also rejected plaintiff's speculation that discovery would show a history of lawsuits against the defendant that would demonstrate its bias against LTD claimants. Finally, the court noted that the defendant's decision to "act against its own self interest" by allowing an amendment of the

terms of coverage that favored the plaintiff supported an argument that the conflict had been reduced nearly to the "vanishing point."

In *Samuel v. Citibank, N.A., Long Term Disability Plan*, No. CIV. 07-4051, 2008 WL 4138174 (D.S.D. Sept. 3, 2008), the district court denied the plaintiff's motion to compel discovery outside the administrative record. Quoting *Wakkinen v. Unum Life Ins. Co. of America*, 531 F.3d 575 (8th Cir. 2008), which was decided after *Glenn*, the court held that "'[w]e examine only the evidence that was before the administrator when the decision was made.'"

In *Bartholomew v. Unum Life Ins. Co. of America*, 579 F. Supp. 2d 1339 (W.D. Wash. 2008), the Court held that prior Ninth Circuit cases affording less deference to administrators with a structural conflict say nothing about expanding the scope of discovery within the ERISA process. "When the appellate courts refer to supplementing the administrative record, they are referring to information which the plaintiffs already had in their possession. Furthermore, the references to extrinsic evidence concern the court obtaining more information on which to base its decision, not to a plaintiff obtaining larger amounts of information through the discovery process." The court found that plaintiff's requests for guidelines, compensation information for claims personnel, defendants' organizational structure and reports of profitability amounted to little more than a fishing expedition and therefore should be denied.

In *Allen v. Metropolitan Life Ins. Co.*, No. 7:08-CV-B-0752-W (N.D. Ala. March 3, 2009) (slip opinion) (Blackburn, J.) and *Blankenship v. Metropolitan Life Ins. Co.*, No. 2:08-CV-BE-0639-S (N.D. Ala. April 2, 2009) (slip opinion) (Bowdre, J.), two different judges in the Northern District of Alabama held that under *Glenn*, discovery was limited to the administrative record. In *Allen*, the court denied the plaintiff's motion to compel the deposition of a claim adjustor. In *Blankenship*, the court cited *Allen* and denied plaintiff's motion to compel discovery responses on the issue of conflict of interest.

II. Tort Claims Barred by the Receipt of Documents

A. Documents Negate Reasonable Reliance Element of Fraud

In *AmerUs Life Ins. Co. v. Smith*, 5 So. 3d 1200 (Ala. 2008), the Supreme Court of Alabama set out the general rule that a plaintiff's reliance on representations of a defendant is unreasonable when the plaintiff was in possession of documents inconsistent with the representations. In 1987, Carl Jeffery, an agent for Central Life Insurance Company (a predecessor of AmerUs), sold Smith two life insurance policies worth $3,500,000 in benefits. Jeffery allegedly represented to Smith that the policies would last for 42 years, the annual premium would be $42,840, and the annual premium would remain level for the entire 42-year length of the policies. Due to Smith's medical history, Central Life issued the polices in April and May, 1987, each with a "Class C" rating, which altered the rate of the policies. With a Class C rating, the policies would last 26 and 27 years, respectively, instead of the 42 years Jeffery allegedly represented. Though Jeffery never informed Smith of the "Class C" rating, the rating appeared on the face of both life insurance contracts, along with a warning to "read [the] policy carefully." Moreover, Central Life sent Smith annual policy statements, and an agent informed Smith of his misapprehension as to the length of the policy in early 1991. After Smith's policy lapsed in 2002, he filed suit against AmerUs for breach of contract and fraud. He ultimately

obtained a $6,500,000 jury verdict. AmerUs appealed, claiming Smith's reliance on Jeffery's representations was unreasonable based on the specific language of the contract received in 1987 and the policy statements received through the life of the policy. The court held that the conflict between Jeffrey's representations and the express language of the policy caused Smith's reliance to be unreasonable. Concluding that the case should not have gone to the jury, the court reversed the jury's verdict and rendered judgment in favor of AmerUs.

In *Paine v. Jefferson Nat'l Life Ins. Co.*, No. 2:07CV00124, 2008 WL 4809824 (E.D. Ark. Oct. 28, 2008), an elderly plaintiff brought suit for fraud, breach of contract and various other claims arising out of the sale and administration of thirteen single-premium endowment at age 95 life insurance policies that he purchased in 1988. The single premium for each policy was $100,000. Plaintiff alleged that the agent made misrepresentations at the point of sale regarding the plaintiff's ability to make loans against the policy, as well as the degree to which the interest credited to the policy's cash value would service the interest accruing on the policy loans. Plaintiff further contended that the cash value, loan balance and resulting death benefit for each of the policies had been improperly calculated. The defendants moved for summary judgment on multiple grounds, including statute of limitations. The court granted summary judgment, holding that the plaintiff's claims were time-barred because the policies, annual statements and various correspondence with the insurer put the plaintiff on notice of his claims and triggered the running of the applicable limitations periods. This case is currently on appeal to the Eighth Circuit.

In *Alvarez v. Insurance Co. of North America*, No. 07-1102, 2008 WL 647784 (3d Cir. 2008), the plaintiff purchased a long-term care policy in 1992 from the Insurance Company of North America (INA) based on INA's alleged representations that the policy was "guaranteed renewable" for life, that premiums "may" change, and that premiums were "expertly-priced," supposedly leading the plaintiff to believe that his premiums would remain level for the life of the policy. But the policy and the promotional materials delivered with the policy specifically disclosed that INA reserved the right to raise rates based on a class rate increase. In 2004, the plaintiff's rates were increased. The plaintiff filed suit against INA for fraud and various other tort claims based on the representations that the premiums would remain level. The Third Circuit affirmed the dismissal of the plaintiff's claims, holding that the explicit provisions in the policy and promotional materials precluded reliance.

In *Waldrup v. Hartford Life Ins. Co.*, 598 F. Supp. 2d 1219 (N.D. Ala. 2008), Waldrup purchased a life insurance policy from Hartford Life based on the agent's alleged representation that the premiums would vanish. In 1999, Waldrup skipped the annual premium payment, purportedly in reliance on the agent's representations. Hartford sent a letter to Waldrup confirming his decision to skip the annual premium payment and stating that the ability to skip future premiums was not guaranteed. Despite this correspondence, Waldrup continued to skip premium payments until September 2006, when Hartford informed Waldrup that premium payments would be required to keep the policy in force. Waldrup brought suit against Hartford Life and the agent for fraudulent misrepresentation. Citing the policy and the correspondence Hartford sent to Waldrup, the court held that the insured's fraud claim was barred due to lack of reasonable reliance, as well as the statute of limitations.

In *Rakes v. Life Investors Ins. Co. of America*, 2008 WL 2518717 (N.D. Iowa 2008), Rakes purchased a long-term care insurance policy from Life Investors after meeting with John Moysey, an insurance agent. The policy, as well as the outline of coverage and annual statements, included language indicating that the policy premiums could change based on the insured's premium class. However, Moysey allegedly represented that the premiums would remain level and that the language in the policy stating otherwise was "boilerplate." After the policy was issued, Life Investors raised rates on several occasions pursuant to the terms of the policy. In 2006, Rakes filed suit against Life Investors, claiming he and other purchasers of Life Investors' policies were fraudulently induced into purchasing the policies, which were under-priced and sold with the intention of raising premiums. The court granted summary judgment in favor of the defendant, holding that the "repeated, unequivocal disclosures in the various insurance documents [Rakes] received prior to and during the insurance contracts notifying [him] of the possibility of rate increases" made Rakes' reliance on the agent's misrepresentations unreasonable. Accordingly, the court entered summary judgment on Rakes' fraud claims due to a lack of reasonable reliance.

In *National Fire & Marine Ins. Co. v. AT Equipment, Inc*., 2008 WL 5505513 (Mass. Dist. Ct. 2008), Alexander Topolewski, the President of AT Equipment, purchased a general liability insurance policy from National through AT's insurance broker, Insurance Professionals of New England ("IPNE"). The information used to create the quote and secure the policy was incorrectly based on AT's sales figures from previous years, instead of recent gross sales. Furthermore, the contract contained a provision allowing National to increase premiums based on an audit of the sales of the company. National audited AT and discovered that AT's sales were much higher than indicated on the application, leading to an increase in the annual premium from $5,500 to $107,905. After AT refused to pay the higher premium, National terminated the agreement and filed suit to recover the premium. AT sought indemnification in the suit from IPNE, alleging that IPNE made false representations that the insurance form was filled out correctly, that National charged reasonable premiums, and that AT would pay $5,500 for the National policy. Upholding the trial court's grant of summary judgment, the appeals court held that AT could not justifiably rely on the statements of IPNE, which directly contradicited the language of the policy.

In *Jeffries v. Pat A. Madison, Inc*., 269 S.W.3d 689 (Tex. Ct. App. 2008), the plaintiff brought suit for negligent misrepresentation, alleging that the agent misrepresented the coverage under the policy. The Texas Court of Appeals held that the plaintiff was "charged with the knowledge of the provisions of [her] policy" and, therefore, the delivery of the policy and the plan brochure should have put the plaintiff on notice that her claim would not be covered. As a result, the plaintiff's reliance on the agent's purported misrepresentations was not reasonable.

In *Brown & Brown of Texas, Inc. v. Omni Metals, Inc.*, No. 01-05-01190, 2008 WL 746522 (Tex. Ct. App. 2008), the court held that the insured's reliance on statements allegedly made by agents of the insurance company which contradicted the actual policy and subsequent annual statements was not reasonable. Port Metal purchased insurance from Brown & Brown of Texas in 1992. The policy excluded coverage for property held in storage or property for which a storage charge was made. Port metal subsequently renewed the policy from 1993-1995. During the time Port Metal was covered by the contract, they stored and charged storage fees to Omni Metals, Inc. for large steel coils. Omni's bank required certificates from Brown & Brown

to document Port Metal's coverage of their stored materials. The requested certificates incorrectly indicated that Omni's stored material was covered, but also contained disclaimers indicating that the certificates were for "information only" and could not amend or alter the terms of the actual policy. Relying on the incorrect certificates indicating that Omni's stored property was covered and representations from Brown & Brown's agents indicating the same, Omni made a claim to Brown & Brown after a 1995 fire at Port Metal's storage facility destroyed their coils. After Brown & Brown denied Omni's claim, Omni sued Brown & Brown under a theory of negligent misrepresentation based on the certificates and the statements made by Brown & Brown's representatives that the stored material was covered. On appeal from a jury decision in Omni's favor, the court held that, as a matter of law, Omni's reliance on the certificates and statements was not reasonable given the fact that they failed to read the actual policy issued in 1992 or any of the subsequent renewals, which would have allowed them to discover that the stored material was not in fact covered.

In *City Blueprint & Supply Co., Inc. v. Boggio,* 3 So. 3d 62 (La. Ct. App. 2008), an agent allegedly assured the plaintiff that it was "fully covered" under its liability policy. During Hurricane Katrina, floods damaged the plaintiff's building. The plaintiff made a claim for the damage under its liability policy, which the insurer denied pursuant to the policy's flood exclusion. The plaintiff sued for, among other things, negligent misrepresention. The trial court dismissed the case. On appeal, the Lousiana appellate court held that the flood exclusion in the policy made the plaintiff's reliance on the alleged statements unreasonable.

B. Documents Trigger Running of Limitations Period

In *Beavers v. Metropolitan Life Ins. Co.*, No. 08-40076, 2009 WL 1067035 (5th Cir. April 22, 2009), the plaintiffs brought claims on behalf of a putative class alleging that a MetLife had breached the terms of their participating policies by misallocating surplus profits to other lines of business, thereby improperly reducing the policy dividends to the plaintiffs from 1984 to 2000. The plaintiffs argued that their claims were not time-barred because the limitations period was tolled by the discovery rule. On appeal, the Fifth Circuit affirmed the dismissal of the action, holding that the plaintiffs' claims were not "inherently undiscoverable". As the court noted, the plaintiffs and class members "could have studied their policies, contacted MetLife, or posed inquiries to the appropriate insurance regulatory boards concerning the smaller dividends."

In *Weathers v. Metropolitan Life Ins. Co.*, 2008 WL 2806666 (Miss. Ct. App. 2008) [1], Weathers purchased a MetLife insurance policy in 1994 from MetLife agent, who allegedly represented to Weathers that the policy would become self-sustaining after 10 years. Contrary to the agent's alleged misrepresentations, the policy stated that it would be "paid up at age 98" and stated that premium payments were required for fifty-six years. After giving the policy a cursory reading, Weathers contacted the agent and inquired as to the meaning of the inconsistent terms. The agent allegedly reiterated his prior representation that the policy would be self-sustaining after 10 years. Weathers filed suit against MetLife in 1999 after being notified of a class action lawsuit involving similar "vanishing premiums" policies. Affirming the trial court's grant of summary judgment, the Mississippi Court of Appeals held that the three-year statute of

[1] Certiorari was granted by Mississippi Supreme Court on January 29, 2009, with the results of the action still pending at the time of this paper's submission.

limitations began to run when the policy was delivered. The court found that Weathers was put on notice of his claims by the language in the policy and thus failed to exercise due diligence to discover his cause of action within the statutory limitation period.

In *Grasselino v. First Unum Life Ins. Co.*, No. 08-CV-635, 2008 WL 5416403 (D.N.J. Dec. 22, 2008), Grasselino brought suit to recover long-term disability benefits under an ERISA plan. The plan limited mental health claims to 24 months and contained a three-year limitations period for bringing claims. On April 24, 2001, Grasselino became disabled within the meaning of the plan as a result of Bi-Polar disorder and began receiving short-term disability benefits for the permitted 24-month period. Grasselino requested long-term disability benefits on September 1, 2001, but was denied. After appealing the decision, Grasselino was ultimately granted long-term disability benefits on April 1, 2002. The letter granting him coverage contained virtually the same language as the original denial letter. Namely, it defined the term "disability," stated that the benefits were subject to a limitation period, and included a copy of the mental illness limitation as found in the policy. On February 27, 2003, Unum sent Grasselino a letter informing him that his benefits were subject to the mental illness limitation and would be terminated on October 21, 2003, per the October 22, 2001 accrual date. Grasselino filed suit on February 2, 2008 in an attempt to restore the benefits. The court held that the three-year limitations period in the contract barred the claim because the October 16, 2001 and April 2, 2002 documents sent to Grasselino constituted a "clear repudiation" of benefits.

In *Steadfast Ins. Co. v. SMX 98, Inc.*, No. H-06-2736, 2009 WL 890398 (S.D. Tex. March 30, 2009), Steadfast issued SMX, a general contractor, an insurance policy with endorsements requiring SMX's subcontractors' insurance policies to conform to certain requirements. If the subcontractors' coverage failed to meet the requirements delineated by the policy, the subcontractors would be considered employees of SMX for purposes of computing SMX's premium rate. A copy of the insurance policy delivered to SMX on May 29, 2002 clearly included these requirements. After an audit revealed that many of SMX's subcontractors held inadequate insurance, Steadfast reevaluated SMX's policy and increased the annual premiums. Steadfast filed suit to recover the increased premiums when SMX refused to pay, and, in response, SMX filed a counterclaim, alleging deceptive insurance practices. Steadfast moved for partial summary judgment on SMX's counterclaims, alleging that the two-year statute of limitation began to run upon delivery of the policy and the documents demanding payment for the increased premiums, thus making the action untimely. Agreeing with Steadfast, the court held that the applicable limitations period on the pre-audit acts began to run with the delivery of the insurance contract and the period began to run on the post-audit claims with the delivery of letters demanding payment of the increased rates. Therefore, all claims of deceptive acts were barred by the two-year statute of limitations based on the delivery of the policy and delivery of the letters demanding payment for the increased premiums.

In *Jadczak v. Assurant, Inc.*, No. 08C-05-028, 2009 WL 1277965 (Del. Super. Ct. April 30, 2009), fire destroyed a hangar on Jadczak's property which was covered under "Part B" of his insurance agreement with Homesite, providing significantly less coverage than if it were under "Part A." After settling a claim for the damage to the hanger with Homesite, Jadczak sued Assurant, the placer of the insurance, for negligence in placing an insurance policy that did not provide what Jadczak considered to be adequate coverage. Assurant claimed the three-year statute of limitations had run, as the injury was discoverable upon the delivery of the insurance

contract on August 16, 2005, and Jadczak did not file the suit until September 2, 2008. The court agreed, holding that because Jadczak could have discovered his coverage by reading the policy, the limitations period for his negligent procurement claim was not tolled.

In *Scott & Jones, Inc. v. Carlton Ins. Agency, Inc*., No. COA08-745, 2009 WL 910424 (N.C. App. April 7, 2009), Scott & Jones purchased general liability and umbrella insurance policies from Carlton on January 24, 2002. The policies excluded coverage for completed projects. After falling from a ladder attached to a silo completed by Scott & Jones in 1998, an employee of C&M Hog Farms sued Scott & Jones. Carlton refused to indemnify Scott & Jones for the incident, claiming the incident was not covered by their insurance contract under the "completed projects" exclusion. Consequently, Scott & Jones sued and, as an affirmative defense, Carlton alleged that the three-year statute of limitations barred Scott & Jones' professional malpractice, negligence, and breach of contract claims. The trial court granted summary judgment for Carlton and, on appeal, the court affirmed, finding that the claims accrued on the date Scott & Jones received the policy that excluded completed-projects coverage.

C. Other Statute of Limitations Cases

In *Abena v. Metropolitan Life Ins. Co.*, 544 F.3d 880 (7th Cir. 2008), the Seventh Circuit held that claims brought under ERISA by a long term disability plan participant were barred by the statute of limitations where the plan provided that such claims must be brought within three years of filing proof of disability. The plaintiff argued that this provision was unreasonable and should not be enforced because it would allow a plan to "pay benefits for three years and then stop paying without any recourse for the employee." The court acknowledged that this result was possible, but pointed out that that was not situation in this case. The court reasoned that "[a] poorly drafted contract term is still a contract term." The court went on to note, however, that "[w]e can certainly imagine circumstances in which the application of this provision would not be reasonable."

In *Mirabile v. Life Ins. Co. of North America*, 293 Fed. Appx. 213 (4th Cir. 2008), the Fourth Circuit held that the three-year limitations period provided for in the plaintiff's long term disability plan barred his claim under ERISA. The plan at issue provided that the limitations period would be three years *or* the minimum limitations period permitted by the law of the state of residence. The plaintiff argued that his claim was not time-barred because Virginia law provided a five-year limitations period for breach of contract, which he contended should control instead of the three-year period set forth in the plan. The court rejected the plaintiff's argument, finding instead that a different Virginia statute applied. This statute provided that the minimum limitations period for filing suit on an insurance contract was one year. Accordingly, the court held that the plaintiff's claim was governed by the three-year limitations provision set forth in the plan, which rendered the plaintiff's claims time-barred.

In *Lunn v. Prudential Ins. Co. of America*, 283 Fed. Appx. 940 (3d Cir. 2008), the plaintiff alleged on behalf of himself and a putative class that Prudential had breached the waiver of premium provision of their policies by paying policy dividends at the end of the year that were equal to the policy premiums without paying plaintiffs interest on the amount of the dividend. The Third Circuit affirmed the dismissal of the case on statute of limitations grounds, finding

that the plaintiff had failed to present any evidence that he had exercised due diligence to discover his claims.

III. Agent Litigation

In *Hopkins v. Cornerstone America*, 454 F.3d 338 (5th Cir. 2008), the Fifth Circuit held that management-level "sales leaders" in the marketing division of a health insurance company were "employees" under the Fair Labor Standards Act and were thus entitled to overtime pay. The sales leaders, who were contracted with the company as independent contractors, were responsible for recruiting, training and managing subordinate sales agents and were compensated with an overwrite commission. The court found that in light of the degree of control the insurer exercised over the sales leaders, they could not reasonably be considered "in business for [themselves]."

In *Walker v. Bankers Life and Cas. Co.*, No. 06 C 6906, 2008 WL 2883614 (N.D. Ill. Jul. 28, 2008), a class action suit, the agents claimed that Bankers Life misclassified them as independent contractors rather than as employees, thereby denying them rights and benefits to which they were entitled under California law. The court decertified the class upon finding conflicting evidence of the alleged employer's right to control the agents' activities, which is a dispositive factor in determining the existence of an employment relationship. The court found that "resolving the common issue of misclassification would require an onerous inquiry into each agent's relationship with Bankers Life." A class action was therefore improper because liability determinations would be individualized and fact-intensive.

In *AXA Distributors LLC v. Bullard*, No. 1:08-CV-188, 2008 WL 5411940 (M.D.Ala. Dec. 24, 2008), the plaintiff company brought suit to enjoin an arbitration under ERISA. The defendants were agents under one of the plaintiff's broker dealers. Because there was no previous arbitration agreement between the parties, the case would be arbitrated only if defendants were "customers" of the plaintiff under FINRA rules. The court reasoned that the defendants were not customers unless they were "associated persons", and that they were not associated persons unless they were directly controlled by AXA when marketing. After identifying "control" as the dispositive issue, the court conducted an extensive analysis of the meaning of the term "control" under the FINRA rules. Ultimately, the court concluded that FINRA was inapplicable because AXA did not "control" the agents. The court primarily based its decision on the fact that: 1) the contractual relationship was between AXA and the broker dealer, not the agents; and 2) any control AXA had over the broker dealer rested with plaintiff's parent company, AXA Equitable, not with the plaintiff.

In *Marlow v. Allianz Life Ins. Co. of N. America*, No. 08-cv-00752, 2009 WL 1328636 (D. Colo. May 12, 2009), one of the defendant's leading producers in the state of Colorado brought suit in federal court under the federal RICO statute and also asserted various state law claims relating to his alleged wrongful termination. The plaintiff, whose Colorado insurance license had been suspended for seven years as a result of "preying on the elderly," claimed that he had been made the target of a conspiracy between Allianz and the Colorado DOI, the purpose of which was essentially to make him the scapegoat for the insurer's misleading sales practices in the state. The court dismissed the plaintiff's RICO claim with prejudice, holding that he had

failed to state a claim under the statute. The court also dismissed the plaintiff's pendent state law claims without prejudice for lack of jurisdiction.

In *Flanagan v. Allstate Ins. Co.*, 581 F. Supp. 2d 920 (N.D. Ill. 2008), a class of former employee-agents sought redress for alleged ERISA violations and breach of contract. The court granted the defendant's motion for summary judgment because: (1) the employer did not constructively discharge employees as required to show breach of contract/adverse action by longer office hours; (2) the employer's given reasons for longer office hours were not pretextual; and (3) employer did not act with specific intent to deprive employees of benefits as required for the ERISA claim.

In *Total Benefits Planning Agency, Inc. v. Anthem Blue Cross and Blue Shield*, 552 F.3d 430, 435 (6th Cir. 2008), the plaintiffs alleged that the defendant insurers conspired to boycott and blacklist them from selling group life and health insurance policies in violation of Sherman and Clayton Acts and state law. On appeal, the Sixth Circuit affirmed the dismissal of the action, holding that because the defendants were wholly owned by the same parent company (Wellpoint, Inc.), they were incapable of conspiring to form a horizontal group boycott in violation of the Sherman Act. The court further held that the plaintiff failed to state a claim under the Sherman Act because it did not identify in the complaint the relevant product and geographic markets so that the court could assess the area of competition and "whether the alleged unlawful acts have anticompetitive effects in that market."

In *Noyes v. State Farm General Ins. Co.*, No. C08-5032, 2009 WL 927706 (W.D. Wash. Apr. 1, 2009), the plaintiff claimed that the defendant fraudulently induced his retirement by threatening his retirement benefits. This followed investigation of the plaintiff for sexual harassment. Plaintiff also claimed that defendant negligently misrepresented that it could jeopardize retirement benefits if he did not retire immediately. The court granted the defendant's motion for summary judgment upon finding that the plaintiff's claims of common law fraud and negligent misrepresentation were not supported by the evidence. The court further held that the plaintiff enjoyed no protection under Washington's Franchise Investment Protection Act (FIPA) because insurance matters are expressly exempted from FIPA. Similarly, plaintiff's claim under Washington's Consumer Protection Act failed because a contract dispute between private parties did not affect the public interest.

In *Giddings v. Principal Fin. Group. Inc.*, No. 07-CV-370, 2009 WL 742681 (E.D. Wis. Mar. 18, 2009), plaintiff, a career agent and independent contractor with principal, was forced to resign after he engaged in improper conduct in connection with the sale of a security. The agent was purportedly told that if he resigned, the matter would be handled internally and would not be disclosed to any other entities. After his resignation, Principal sent letters to four insurance commissioners informing them of the reason for the termination. The agent then filed suit for breach of contract (i.e., the agreement not to disclose the reason for the termination), defamation, and tortious interference. The court granted defendants' motion for summary judgment on all claims. The court held that the breach of contract claim failed because the alleged agreement was not supported by any consideration. The court further held that the defamation claim lacked merit because defendants did not publish a false statement about the plaintiff. Finally, the tortuous interference claim failed because Principal had a right to protect its legal interests.

In *Holden v. Northwestern Mut. Fin. Network*, No. 07-C-0930, 2009 WL 440937 (E.D. Wis. Feb. 23, 2009), the plaintiff agent brought suit against Northwestern Mutual and two other individuals, alleging that the defendants terminated his employment contract in violation of the Americans with Disabilities Act (ADA). The court dismissed the claim because the ADA applies only to employees, not independent contractors, and the plaintiff was an independent contractor.

In *Mercury Companies, Inc. v. First American Corp.*, No. 08-cv-00911, 2008 WL 4861950 (D. Colo. Nov. 10, 2008), three of the plaintiffs moved for a preliminary injunction prohibiting defendants from directly selling or offering to sell title insurance policies in Colorado, an alleged violation of defendant's exclusivity agreements with plaintiffs. The court held that the plaintiffs were not entitled to a preliminary injunction to block the insurer from entering the market and no longer selling through agents. The court found that the plaintiffs had failed to establish two of the required elements for obtaining a preliminary injunction—namely, that it was likely they would prevail on the merits, and that they would suffer the greatest hardship if the court did not grant the injunction.

IV. STOLI

One of the many challenging issues currently facing the life insurance industry is the growing prevalence of STOLI transactions. Increasingly, life insurers are fighting back by instituting lawsuits to rescind STOLI policies on grounds that they are void due to a lack of an insurable interest in the life of the insured and/or based on material misrepresentations in the application. Although the results of this litigation has been mixed, the cases in this area offer some valuable lessons on how to successfully rescind STOLI policies.

In *First Penn-Pacific Life Insurance Co. v. Evans*, 2009 WL 497394 (4th Cir. Feb. 26, 2009) (unpublished), the Fourth Circuit Court of Appeals held that an insurable interest existed in a STOLI transaction, even though the insured intended to assign the policy when he submitted the application. The insured in *Evans* fraudulently obtained seven life insurance policies that provided $8.5 million in coverage. The insured then falsely represented to a viatical settlement broker that he was terminally ill and sold six of the seven policies. One of the policies he sold was issued by First Penn-Pacific Life Insurance Company ("First Penn"). First Penn filed a lawsuit in federal court seeking to rescind the policy due to the lack of an insurable interest. The district court entered summary judgment in favor of the defendants.

On appeal, the primary issue was whether an insurable interest existed under Arizona law at the time the policy was issued. The Fourth Circuit found that it did and affirmed the order granting summary judgment. The court held that even though the insured planned to sell the policy at the time he applied for it, an insurable interest existed because an individual clearly has an insurable interest in his own life. The court rejected First Penn's argument that it should consider the insured's intent, reasoning that "evaluating insurable interest on the basis of the subjective intent of the insured at the time the policy issues, as First Penn would have us do, would be unworkable and would inject uncertainty into the secondary market for insurance."

On its face, the bright-line test employed by the *Evans* court (i.e., whether an insurable interest existed at the time of application) would seemingly result in approval of all STOLI

transactions. Policies could even be assigned within the two-year contestability period (which was arguably the case in *Evans*) because an insurable interest would always exist at the time of application. Read more closely, however, the *Evans* opinion is not necessarily the panacea the STOLI community would like for it to be. Although the court rejected the evaluation of insurable interest based on the subjective intent of the applicant, the court also noted that there was "no evidence that anyone other than [the insured] was a participant in the scheme at the time [he] obtained the First Penn policy." In other words, "[n]o third party participated in the procurement of [the] policy and therefore no one was 'wagering' on [the insured's] life in violation of public policy." The court seems to be implying here that if a third party had been involved from the beginning, and if there had been objective evidence of an agreement to assign the policy after issuance, then the court may have sided with the insurer and found that the insurable interest requirement was lacking.

In fact, the court even went so far as to cite in a footnote a Minnesota case that reached that very holding. In *Sun Life Assurance Co. of Canada v. Paulson*, 2008 WL 5120953 (D. Minn. Dec. 3, 2008), the court dismissed Sun Life's claims on the basis that Sun Life had not adequately alleged that the applicant and a third party shared a "mutual intent" at the time of application to subsequently assign the policy. The court held that under Minnesota law, an insurer must be able to show that there was a mutual intent between the applicant and a third party in order to establish that the insurable interest requirement is lacking.

The *Evans* court also cited *Life Product Clearing LLC v. Angel*, 530 F. Supp. 2d 646 (S.D.N.Y. 2008). Although the court cited *Angel* for the proposition that "a third party must be involved in the procurement of the policy to eliminate the insurable interest," the court apparently read more into the *Angel* decision than was there. In fact, the court in *Angel* specifically explained that the insurable interest analysis requires courts to consider "the intent of the insured… at the time the policy is procured." The court did not specifically require the involvement of a third party as suggested in *Evans*, though evidence of such involvement certainly helps in establishing the applicant's intent to subsequently assign the policy. In fact, *Angel* could just as easily be cited for the proposition that insurable interest is determined by the subjective intent of the applicant, which, ironically, is the very holding that the *Evans* court rejected. Nevertheless, ample evidence that a third party was complicit in a STOLI transaction at the time of application will almost always bolster an insurer's argument that the policy should be declared void for lack of an insurable interest.

In *American General Life Ins. Co. v. Schoenthal Family, LLC*, 555 F.3d 1331 (11th Cir. 2009), the Eleventh Circuit held that under Georgia law the insurer was entitled to rescind a $7 million life insurance policy within the two-year contestability period where the applicant misrepresented his net worth and annual income on the policy application. The court found that the misrepresentations were objectively material and that actual reliance on the misrepresentation was not required where the application provided that "any misrepresentation" could be used to void the policy.

In *Lincoln Nat'l Life Ins. Co. v. Calhoun*, 596 F. Supp. 2d 882 (D.N.J. 2009), the insurer brought a rescission action on a $3 million STOLI policy on grounds that the policy was void due to material misrepresentations on the application, as well as the absence of an insurable interest. The defendants moved to dismiss, making the familiar argument that the policyholder

possessed an insurable interest on his own life. The court denied the motion, finding that Lincoln National had sufficiently stated a claim for rescission. The court implied, however, that the rescission action would not ultimately be successful unless the insurer could establish that the policyholder "had arranged to sell the policy at the time the application was submitted to Lincoln National."

In *Jefferson-Pilot Life Ins. Co. v. Marietta Campbell Ins. Group*, Nos. 07-1359/07-4534, 2008 WL 3582751 (D. Minn. Aug. 12, 2008), Jefferson-Pilot sought to rescind a $3 million life insurance policy based on the policyholder's failure to disclose that she had submitted applications for several million dollars in life insurance that were "pending" with other companies. The defendants moved for summary judgment, arguing that the applications were not yet pending at the time the policyholder signed the Jefferson-Pilot application. The court denied the motion for summary judgment, finding that under the common law doctrine of *uberrimae fidei*, "if an applicant for insurance discovers facts that make portions of his application no longer true while the company deliberates, he must make full disclosure of the newly discovered facts.

In *AXA Equitable Life Ins. Co. v. Infinity Financial Group*, No. 08-80611-CIV, 2009 WL 901496 (S.D. Fla. March 31, 2009), the insurer brought various claims seeking the rescission of several STOLI policies with large face amounts. The defendants filed a motion to dismiss arguing that the insurer failed to state a claim. The court denied the defendants' motion to dismiss. The court first held that the insurer had adequately stated a claim for fraudulent misrepresentation, even though the policy had been assigned to a third party, because "an assignment of an insurance policy places the assignee in the same status with respect to all rights and liabilities under it which the insured occupied before the transfer; the assignee is effectively substituted as the insured." Next the court found that the insurer had sufficiently alleged that the policies were void for lack of an insurable interest because the assignment of a life insurance policy is invalid if it is a "sham assignment made simply to circumvent the law's prohibition on 'wagering contracts.'"

V. Non-STOLI Rescission Cases

In *West Coast Life Ins. Co. v. Hoar*, 558 F.3d 1151 (10th Cir. 2009), the insurer sought a declaratory judgment that a $3 million life insurance policy was void due to a misrepresentation on the policy application regarding whether the applicant engaged in a "hazardous avocation or hobby." The applicant disclosed that he skied, but did not divulge that his skiing included frequent "heli-skiing" trips, where he was dropped off on a remote backcountry mountain and skied his way down. It was on one of these heli-skiing adventures in British Columbia that he was caught in an avalanche and swept into the trees. He died of a broken neck. The court held that the applicant's failure to disclose that he heli-skied was a material misrepresentation that voided the policy. Notably, the court reached this conclusion even though the underwriter who reviewed the application was new to the job and failed to consult the underwriting manual, which treated various kinds of skiing differently. The court essentially found that it was reasonable for the underwriter to assume that the insured was referring to resort skiing.

In *PHL Variable Ins. Co. v. Fulbright McNeill, Inc.*, 519 F.3d 825 (8th Cir. 2008), the Eighth Circuit affirmed summary judgment in favor of the insurer in a suit to rescind a $3

million life insurance policy where the insured failed to disclose the results of a cardiac test taken after submission of his insurance application. The court based its decision on the common law doctrine of *uberrimae fidei*, "which states that, as a matter of utmost good faith and fair dealing, if an applicant for insurance discovers facts that make portions of his application no longer true while the company deliberates, he must make full disclosure of the newly discovered facts."

VI. Class Action Litigation

A. Denial of Class Certification

Romberio v. UnumProvident Corp., No. 07-6404, 2009 WL 87510 (6th Cir. Jan. 12, 2009) involved seven consolidated class actions concerning the alleged wrongful denial and termination of long term disability benefits under ERISA. The plaintiffs filed a motion for class certification, which the district court granted. On appeal, the Sixth Circuit reversed the district court's decision, holding that "[a]bsent a showing that benefits were wrongfully denied, there can be no causal link between an alleged breach and a denial of benefits; and whether a claim for benefits is wrongfully denied depends on a number of factors peculiar to the claimant's case." The court also found that the typicality requirement was lacking because the class members "had different vocational skills, had different impairments, and experienced different disability review procedures managed by different claim representatives."

In *Walker v. Bankers Life and Cas. Co.*, No. 06 C 6906, 2008 WL 2883614 (N.D. Ill. Jul. 28, 2008), a class action suit, the agents claimed that Bankers Life misclassified them as independent contractors rather than as employees, thereby denying them rights and benefits to which they were entitled under California law. The court decertified the class upon finding conflicting evidence of the alleged employer's right to control the agents' activities, which is a dispositive factor in determining the existence of an employment relationship. The court found that "resolving the common issue of misclassification would require an onerous inquiry into each agent's relationship with Bankers Life." A class action was therefore improper because liability determinations would be individualized and fact-intensive.

In *Avritt v. Reliastar Life Ins. Co.*, No. 07-1817, 2009 WL 455808 (D. Minn. Feb. 23, 2009), the plaintiffs filed suit on behalf of themselves and a putative class alleging that the insurer improperly credited interest to its fixed deferred annuity policies by paying higher interest rates on "new money" than on "old money". On plaintiffs' motion for class certification, the court held that plaintiffs failed to meet the predominance requirement under Rule 23(b)(3). The court reasoned that because the written policies did not "contain any formulaic interest-crediting requirements," but instead such practices were allegedly "undisclosed or misrepresented, … the expectations of the individual members of the putative class can be expected to be varied rather than largely uniform." Accordingly, the court found that the predominance requirement was not satisfied. The court also found that the superiority requirement was lacking due to the need for individualized proof, as well as the existence of a previously-filed class action.

In *Ruppert v. Principal Life Ins. Co.*, 252 F.R.D. 488 (S.D. Iowa 2008), the trustee of a 401(k) retirement savings plan brought suit against the plan provider for allegedly breaching its fiduciary duty and engaging in prohibited self-dealing in violation of ERISA as a result of the

provider's alleged participation in revenue sharing fee arrangements with the mutual funds included in its pre-packaged 401(k) plans. The plaintiff moved for class certification. The court denied plaintiff's motion based on its finding that the plaintiff had failed to satisfy the commonality and typicality requirements. The court placed considerable emphasis on the fact that the provider's mutual fund offerings and revenue sharing fees varied from plan to plan. As a result, any breach of the provider's fiduciary duty would have to be determined on a plan-by-plan basis, rendering class treatment inappropriate.

B. SLUSA Preclusion

In *Instituto De Prevision Militar v. Merrill Lynch*, 546 F.3d 1340 (11th Cir. 2008), an agency of the Republic of Guatemala that administered pension funds brought suit against Merrill Lynch, one of its affiliates and one of its employees, asserting state law tort claims and a federal securities fraud claim for the defendants' alleged role in a fraud committed by an investment advisor, namely the misappropriation of investment funds. The case was then consolidated for purposes of discovery with three other cases arising out of the same series of events, one of which was a class action. Merrill Lynch filed a motion to dismiss, arguing that the plaintiff's claims were precluded by the Securities Litigation Uniform Standards Act, which prohibits parties from bringing securities fraud class actions under state law. The district court dismissed the state law claims under SLUSA and found that the plaintiff failed to state a claim under the Securities Exchange of 1934. On appeal, the Eleventh Circuit agreed, holding that the state law claims were precluded by SLUSA because the action was part of a "group of lawsuits" under SLUSA as a result of the consolidation with the other three cases, even though the consolidation was for discovery purposes only. In addition, the court also found that the claims were based on misrepresentations or omissions "in connection with the purchase or sale" of a security, which is also a requirement for SLUSA preclusion, despite the fact that some of the allegations were based on post-sale conduct. According to the court, SLUSA "does not require district courts to act like a prospector panning for a few non-precluded theories amid a river of precluded ones." Finally, the court concluded that the products at issue constituted "covered securities" under SLUSA, even though they contained a life insurance component.

In *Davis v. John Hancock Life Ins. Co.*, 295 Fed. Appx. 245 (9th Cir. 2008), the plaintiffs brought a class action against the insurer, alleging fraud in the sale of variable whole life insurance policies. The plaintiffs argued that because their amended complaint demanded only equitable relief, SLUSA did not apply because it extends only to those actions seeking money damages. The Ninth Circuit rejected this argument and affirmed the dismissal of the action on the basis of SLUSA preclusion. The court held that the complaint arguably included a request for monetary relief. Moreover, the court noted that SLUSA "'stands as an express exception to the well-pleaded complaint rule, and [therefore] its preemptive force cannot be circumvented by artful drafting.'"

VII. Alcohol Exclusions

In *Smith v. Liberty Life Ins. Co.*, 535 F.3d 308 (5th Cir. 2008), the surviving spouse of an insured, who died in automobile accident, brought suit in Louisiana against an insurer seeking coverage under a credit life insurance policy. The autopsy report identified acute ethanol and multi-drug intoxication as contributing causes of the insured's death. The insurer moved for

summary judgment, arguing that the claim was barred by the policy's intoxication exclusion, which excluded coverage for death caused "directly or indirectly, in whole or in part" from "injury occurring while under the influence" of alcohol or drugs. On appeal, the Fifth Circuit affirmed the district court's order granting summary judgment, rejecting the plaintiff's argument that the exclusion should not apply due to the insurer's failure to deliver the policy. The court held that the certificate of insurance did not have to be delivered by certified mail under Louisiana law and that the district court properly considered the insurer's evidence of delivery. Finally, the court concluded that coverage for the insured's death was excluded under the policy because the evidence clearly showed that intoxication was a contributing cause of the accident.

In *Kay-Woods v. Minnesota Life Ins. Co.*, No. 08-cv-0211, 2009 WL 960076 (S.D. Ill. April 8, 2009), the plaintiff brought suit to recover accidental death benefits under a credit life insurance policy after her husband died in a single-vehicle accident. The policy excluded coverage for death that results from or is caused directly by the commission of a felony. At the time of the accident, the insured's blood/alcohol level was above the legal limit and he was driving under a revoked license, a combination which results in a class 4 felony under Illinois law. The court granted summary judgment to the insurer based on the felony exclusion, rejecting the plaintiff's argument that the felony exclusion requires a criminal conviction. The court relied heavily on the Seventh Circuit's recent decision in *Steele v. Life Ins. Co. of North America*, 507 F.3d 593 (7th Cir. 2007) (holding that a felony exclusion applied to conduct punishable as a felony under Illinois law, whether or not a conviction was obtained for that conduct).

In *Ronshagen v. Reliance Standard Life Ins. Co.*, No. 3:07-cv-976, 2009 WL 378638 (D. Conn. Feb. 13, 2009), the plaintiff brought suit under ERISA to recover benefits under a group accident policy provided by her employer. The insured died in an automobile accident. The police report stated that cocaine and ethanol consumption, with a blood alcohol level of .230, "significantly contributed" to the accident. The court held that the insurer's decision to deny the claim under the policy's felony exclusion was not arbitrary or capricious and entered summary judgment in favor of the defendant.

VIII. ACLI Litigation

In *Harvey v. Nebraska Life and Health Ins. Guaranty Ass'n*, No. S-08-520, 2009 WL 1351783 (Neb. May 15, 2009), viatical settlement investors brought a declaratory judgment action against the Nebraska Life and Health Insurance Guaranty Association, seeking a declaration that the Association was required to guarantee purchase request agreements between a viatical settlement broker and life settlement investors. The broker allegedly breached the purchase request agreements by failing to name the investors as beneficiaries under the subject life insurance policies. The Nebraska Supreme Court held that the purchase request agreements were not covered by the Nebraska Life and Health Insurance Guaranty Association Act because the broker was not a "member insurer" under the Act.

In *Wuliger v. Manufacturers Life Ins. Co.*, No. 08-3342 (6th Cir. May 28, 2009), the receiver for a viatical investment company brought suit against an insurer seeking rescission of three STOLI policies and the return of premiums paid on them after they were fraudulently procured for the benefit of a viatical investment company in receivership. The insurer opposed the rescission because the policies had lapsed. The district court granted summary judgment to

the receiver based on its finding that no insurable interest existed in the policies and instructed the insurer to rescind the policies and return the premiums paid to date, plus interest. On appeal, the Sixth Circuit reversed the order granting summary judgment and rendered judgment in favor of the insurer. The court held that under Ohio law, the right to rescind a policy for lack of an insurable interest is available only to the insurer. Moreover, the court reasoned that it would be inequitable to give a party who commits fraud the option of announcing the fraud and rescinding the policy if the premiums subsequently became unaffordable.

In *Fairbanks v. Superior Court*, 205 P.3d 201 (Cal. 2009), the plaintiffs brought an action behalf of themselves and a putative class against a life insurer alleging, among other things, violation of California's Consumer Legal Remedies Act ("CLRA"). After the trial court granted the insurer's motion for judgment on the pleadings, the plaintiffs appealed. The California Court of Appeal affirmed, and the California Supreme Court granted the plaintiffs' petition for review. The court held that life insurance is not subject to the remedial provisions of the CLRA because it is not a "good" or "service" under the Act.

IX. Litigation Concerning Amount in Controversy for Federal Jurisdiction

A. Jurisdiction Under the Class Action Fairness Act

Courts have rejected attempts by plaintiffs' counsel to avoid the $5 million dollar amount in controversy requirement under CAFA by filing multiple suits. In *Freeman v. Blue Ridge Paper Products*, 551 F.3d 405 (6th Cir. 2008), plaintiffs filed five separate suits covering distinct six-month periods, each limiting class damages to less than $4.9 million. The court held that, although the plaintiff is master of the complaint, "CAFA was clearly designed to prevent plaintiffs from artificially structuring their suits to avoid federal jurisdiction." Since there was "no colorable reason for breaking up the lawsuits," the court aggregated the suits and denied plaintiffs' motion to remand.

Similarly, in *Proffitt v. Abbott Laboratories*, 2008 WL 4401367 (E.D. Tenn. September 23, 2008), plaintiffs filed eleven suits, identical except for the time periods that they covered. Each suit claimed less than $5 million dollars in damages. Like the Sixth Circuit in *Freeman*, *supra*, the court held that "the intent of CAFA [is] being undermined by the device of filing multiple lawsuits based on completely arbitrary time periods." Accordingly, the suits were aggregated and remained in federal court.

In *Manson v. GMAC Mortgage, LLC*, 602 F. Supp. 2d 289 (D. Mass. 2009), plaintiff homeowners who had recently faced foreclosure brought a class action against defendants mortgage companies and law firms. Plaintiffs claimed they sought primarily injunctive relief, and that monetary damages were about $1,200 per every member of the approximately 1,000 member class. The complaint thus valued the amount in controversy around $1.2 million. Defendants submitted an affidavit arguing that this amount represented only a portion of the amount assessed against foreclosed borrowers in costs and fees, with the actual amount assessed to each account around $8,000 (which would bring the amount in controversy to 8 million). The court held that the affidavit was enough to meet the "preponderance of the evidence" standard and thus denied the motion to remand.

In *Hamdy v. Guardsmark, LLC*, 2009 WL 961375 (C.D. Cal. April 8, 2009), the plaintiffs amended their complaint after removal. The initial complaint alleged that defendant did not provide meal or rest breaks for plaintiffs, did not pay for all unused vacation time upon termination, and did not timely pay wages upon termination. After the case was removed, plaintiffs amended their complaint to drop the meal, rest, and vacation pay claims, arguably bringing the case below the $5 million amount in controversy. The court, applying the *Red Cab* rule, held that "events occurring subsequent to the institution of a suit which reduce the amount recoverable do not oust federal jurisdiction."

B. Diversity Jurisdiction under Section 1332

In *McPhail v. Deere & Co.*, 529 F.3d 947 (10th Cir. 2008), the Tenth Circuit considered the history and purpose of federal diversity jurisdiction in determining the amount in controversy. In doing so, the court weighed the importance of giving out-of-state defendants a fair forum in which to try their cases against the exceptional nature of federal jurisdiction. It found the "preponderance of the evidence" standard for the amount in controversy to "raise a… puzzle: in most removal cases, there is little 'evidence' one way or another." The court held that the preponderance of the evidence standard "applies to jurisdictional facts, not jurisdiction itself, as…jurisdiction itself is a consequence of the facts rather than a provable 'fact.'" In applying this conclusion, the court held that "once the estimate [of the amount in controversy] has been made—and contested factual allegations that support the estimate have been established…then the case stays in federal court unless it is legally certain that the controversy is worth less than the jurisdictional minimum." In *McPhail*, a wrongful death action, the court found the amount in controversy to have been met. While the plaintiff did not specify damages in her complaint, the court held that "a complaint that presents a combination of facts and theories of recovery that may support a claim in excess of $75,000 can support removal." Additionally, the defendant may introduce "interrogatories obtained in state court before removal was filed, or affidavits or other evidence submitted in federal court afterward." Finally, a plaintiff's proposed settlement amount can be introduced as evidence to support an amount in controversy above $75,000.

In *In re 1994 Exxon Chemical Fire*, 558 F.3d 378 (5th Cir. 2009), the 5th Circuit dealt with a set of consolidated cases against Exxon after a chemical fire in Louisiana. The plaintiffs pleaded below the jurisdictional amount, and Exxon removed the case to federal court based on diversity jurisdiction. In refusing to grant plaintiffs' motion to remand, the court held that "Exxon had met its burden of establishing, by a preponderance of the evidence, that the amount in controversy exceeded the jurisdictional amount." To satisfy the "preponderance of the evidence" standard, Exxon simply pointed to the face of the complaint, which alleged a variety of theories of compensation (such as injuries to physical and mental health, emotional distress, property damage, and punitive damages), which the court found to be sufficient evidence to meet Exxon's burden. The court then held that the plaintiffs failed to "demonstrate to a legal certainty that they cannot recover more than the jurisdictional amount," thus, remand would be inappropriate.

In *Chrin v. Ibrix, Inc.*, 293 Fed. Appx. 125 (3d Cir. 2008), the court had to determine the value of a suit seeking a declaration that an assignment of patent rights was null and void. The defendant submitted an affidavit averring that the value of the patent was between $300,000 and $1,000,000. The plaintiff contested this amount, but did not submit any information to determine

the actual value of the patent or to support his stance. The court held that "because [plaintiff] did not contest the affidavit before the District Court, we apply the 'legal certainty test' to the facts presented, and, having do [sic] so, conclude that it does not appear to a legal certainty that [plaintiff] cannot recover more than $75,000."

In *Kok v. Kadant Black Clawson, Inc.*, 274 Fed. Appx. 856, 876 (11th Cir. 2008), Kok "filed a motion to remand and to disavow any recovery beyond $74,999, but he did not assert that the amount in controversy was less than the jurisdictional threshold when he filed his complaint." After defendant introduced evidence of plaintiff's past salary, the court concluded that Kok would be able to recover back benefits over the amount in controversy. Thus, when some case-specific evidence (not, for example, the amount normally recovered in such a case) is introduced to suggest that the amount in controversy is above the jurisdictional minimum, even post-*Lowery*, federal diversity jurisdiction is still appropriate in the Eleventh Circuit.

In *Fainer v. State Farm Mutual Auto. Ins. Co.*, 2009 WL 911724 (E.D. Mo. April 1, 2009), plaintiff sought to recover benefits under an underinsured motorists policy with a limit of $100,000. After defendant removed the case to federal court, plaintiff filed a motion for remand in which he "aver[red], in a cursory fashion, that the amount in controversy in this case…is under $75,000." However, when the court looked at the claims alleged in the complaint ("serious, permanent, and disabling injuries…severe pain of the body and mind"), it concluded, contrary to plaintiff's own estimate, that it "cannot find, as a matter of law, that a fact finder could not legally conclude that Plaintiff's damages will not exceed" the amount in controversy. Therefore, the court denied plaintiff's motion to remand.

In *Johnson v. Carmax Auto Superstore, Inc*., 2008 WL 5686083 (W.D. Tex. December 22, 2008), the court allowed for statutorily permitted treble damages to be factored into the amount in controversy, even though such damages were not expressly claimed.

In *Temploy, Inc. v. Nat'l Council on Compensation Ins.*, 2009 WL 1097807 (S.D. Ala. April 21, 2009), the court held that a previous action by the same plaintiffs with the same facts that named a different defendant insurance company could be used as an "other paper." In that case, plaintiff had brought a suit for $6 million earlier against a different insurance company. After that case settled, plaintiff brought this case against NCCI, but this time without specifying a damages amount. The court held that the $6 million figure from the earlier, nearly identical case could be used to establish the amount in controversy in this case.

In *Hardesty v. State Farm Mutual Auto. Ins. Co.*, 2009 WL 1423957 (M.D. Fla. May 18, 2009), the court allowed the defendant to use plaintiff's settlement demand to prove that the amount in controversy exceeded $75,000. In the demand, the plaintiff itemized past and anticipated future medical expenses, as well as pain and suffering, totaling $190,795. In the actual complaint, the plaintiff did not plead a specific amount of damages, and in her motion for remand argued that she did not presently believe that the amount in controversy exceeded $75,000. Because she gave no reason for the decrease, the court denied her motion for remand. *See also Fernandes v. Home Depot U.S.A., Inc*., 2009 WL 247870 (S.D. Fla. February 2, 2009) (holding that plaintiff's pre-suit demand letter alleging $135,000 in damages was sufficient evidence to show that the amount in controversy exceeded the jurisdictional minimum); *Valdez v. Byers*, 2009 WL 1440090 (D. Colo. May 20, 2009) (allowing defendant to use both a

settlement letter and a state court Civil Cover Sheet in which plaintiff claimed over $75,000 in damages to meet the preponderance of the evidence standard to remain in federal court); *cf. Bunch v. Wal-mart*, 2009 WL 1076162 (N.D. Ind. April 20, 2009) (accepting defendant's good-faith estimate that the amount in controversy is met, contrary to plaintiff's settlement demand letter for $50,000).

In *Security Storage Properties v. Safeco Ins. Co. of America*, 2009 WL 1440248 (D. Kan. May 18, 2009), plaintiff sued for declaratory judgment regarding an insurance policy. On removal, defendant introduced the estimate for repairs it would be required to pay should it lose, totaling $118,657. The court found that such an estimate satisfied the "preponderance of the evidence" standard.

In *Gleason v. Roche Laboratories, Inc.*, 2009 WL 728531 (M.D. Fla. March 19, 2009), plaintiff asserted retaliatory discharge and sought "lost wages and benefits, severe emotional distress, emotional pain, suffering, inconvenience, mental anguish, and non-pecuniary loss." After plaintiff's motion for remand, defendant introduced plaintiff's past income to show that the amount in controversy was met. Plaintiff "assert[ed] that the information provided by the defendant does not provide a reliable basis for determining the amount in controversy because it does not include any estimate for mitigation of damages by replacement income, and any estimate regarding the other amounts of damages she seeks is entirely speculative." The court found this assertion unconvincing and allowed the case to remain in federal court. *See also Harrison v. Emerald Foam Control, L.L.C.*, 2009 WL 1405056 (E.D. La. May 19, 2009) (using evidence showing plaintiff's past bonuses to estimate the amount in controversy in a wrongful termination case).

In *Henderson v. Dollar General Corp.*, 2009 WL 959560 (S.D. Ala. April 7, 2009), plaintiff alleged $66,328 in medical bills and lost earnings in her complaint. The complaint also included claims for future lost earnings, pain and suffering, emotional distress, loss of companionship, and punitive damages. The court found that, since the quantified damages approached the jurisdictional minimum, "the defendant need only make up a difference of less than $10,000 in controversy to keep this case in federal court. Although the evidence before the court is not impregnable, 'a fair and impartial mind' would clearly find that years of pain in addition to the other elements of damage that the plaintiffs claims add up to a dispute of at least that amount." *See also Watson v. Provident Life & Accident Ins. Co.*, 2009 WL 1437823 (N.D. Tex. May 22, 2009) (holding that, although the amount owed under a policy was $47,869, the Texas statutory scheme allowed it to be raised to $68,689 when plaintiff alleged bad faith; that same statute allowed for attorney's fees, which were not specified in the complaint, and the court found that these fees would bring the amount to the minimum to stay in federal court); *Newby v. State Farm Mutual Auto. Ins. Co.*, 2009 WL 1364819 (S.D. Miss. May 14, 2009) (holding that a potential arbitration award would not reduce the amount in controversy, quantified at $71,213 plus punitive damages, which was close enough to the jurisdictional minimum to allow the court to speculate that other damages would meet the amount in controversy).

In *Macy's Florida Stores, LLC v. Illinois Nat'l Ins. Co.*, 2008 WL 2741132 (S.D. Fla. July 11, 2008), the court had to determine the amount in controversy for an indemnity claim. In its Notice of Removal, defendant claimed that plaintiff had already spent over $70,000 defending the underlying claim for $15,000 and that the coverage limit of the insurance policy is $1

million. The court found this to be sufficient evidence to show the amount in controversy exceeded the jurisdictional minimum and keep the case in federal court.

In *Carstarphen v. Deustche Bank Nat'l Trust Co.*, 2009 WL 1035490 (S.D. Ala. April 17, 2009), plaintiff alleged that defendant was foreclosing on her home without standing to do so and sought injunctive relief. Her property was appraised at $86,000. The court found this figure to reasonably approximate the amount in controversy, because "if no injunction is granted, then Carstarphen may lose her home and still remain obligated to pay her mortgage debt. By contrast, if injunctive relief is granted…then she will keep her home even as she remains obligated to pay the mortgage debt." Thus, from plaintiff's perspective, the amount in controversy was the value of the home. *See also Mapp v. Deutsche Bank Nat'l Trust Co.*, 2009 WL 435069 (M.D. Ala. February 18, 2009) (holding that "the proper measure of the amount in controversy was the subject property's market value"); *Roper v. Saxon Mortgage Services, Inc.*, 2009 WL 1259193 (N.D. Ga. May 5, 2009) (holding that plaintiff must show the value of injunctive relief to be less than the property value).

X. Miscellaneous Cases

A. Fiduciary Duty in Suitability Case

In *Allstate Life Ins. Co. v. Parnell*, 292 Fed. Appx. 264 (5th Cir. 2008), the insurer brought an interpleader action against the beneficiaries of a decedent's annuity. One of the claimants filed a counterclaim alleging breach of fiduciary duty, fraud, unfair and deceptive trade practices, and other various claims. On appeal, the Fifth Circuit affirmed the district court's grant of summary judgment. The court first held that no fiduciary duty existed under Mississippi law because "[r]eliance on the advice of an insurance agent during the purchase of insurance does not create a fiduciary relationship" and that "mere unilateral trust in an agent selling an annuity does not create a fiduciary duty to inform the client of all implications of the transaction." As for the policyholder's contention that the agent failed to disclose "information concerning the suitability of the annuity for a man of his age, health, and expenses," the court held that the agent owed no duty to disclose absent a fiduciary relationship, which did not exist.

B. Interpleader Protection

In *Prudential Ins. Co. of America v. Hovis*, 553 F.3d 258 (3d Cir. 2009), the insurer filed an interpleader complaint against multiple claimants to determine distribution of proceeds of a life insurance policy. One of the defendants filed a counterclaim alleging that the insurer acted negligently and in bad faith in its handling of policy changes that gave rise to the dispute. On appeal, the Third Circuit affirmed summary judgment in favor of the insurer on the counterclaims, holding that they fell within the scope of interpleader protection. The court noted that while interpleader protection is normally limited to counterclaims regarding the interpleaded funds, it extended in this case to what was essentially an allegation that the company failed to properly investigate the disputed claim.

C. Blended Smoker Rates for Juvenile Life Insurance

In *Ross v. Metropolitan Life Ins. Co.*, 297 Fed. Appx. 187 (3d Cir. 2008), the plaintiffs sued MetLife on behalf of themselves and a putative class for using a blend of smoker and non-

smoker mortality rates for juvenile life insurance policies where the insured was designated as a non-smoker on the policy application. On appeal, the Third Circuit affirmed summary judgment in favor of MetLife on grounds that there was no ambiguity in the policy, which clearly set forth the applicable premium. The court found that the policy illustration, which identified the risk class as "standard nonsmoker" was nothing more than inadmissible parol evidence.

D. Representations Regarding Future Events

In *Turner v. Milliman*, 671 S.E.2d 636 (S.C. Ct. App. 2009), a former policyholder and his wife filed a complaint against multiple life insurance companies, an agent, and others for fraud, negligent misrepresentation, and violation of the South Carolina Unfair Trade Practices Act. The court affirmed summary judgment in favor of defendants, holding that the agent's alleged representations regarding the group health insurance policy were "mere unfulfilled promises or statements as to future events" and were "not actionable."

E. Suicide Exclusion

In *Officer v. Chase Ins. Life and Annuity Co.*, 541 F.3d 713 (7th Cir. 2008), the beneficiary of a life insurance policy brought suit to recover death benefits that were denied by the insurer on the basis of the policy's suicide exclusion. The insured died of suicide resulting from a self-inflicted gunshot wound. This issue was not in dispute. Instead, the plaintiff contended that the suicide exclusion was ambiguous because the amount payable in the event of suicide (i.e. the amount of premiums paid) could be interpreted two different ways. The Seventh Circuit disagreed and affirmed summary judgment in favor of the insurer. The court also rejected plaintiff's arguments that the suicide exclusion worked as a forfeiture and that the exclusion should be subject to the doctrine of substantial performance.