IN THE COURT OF APPEALS OF IOWA

STEPHEN R. MOULTON,

Plaintiff-Appellee,

vs.

UNITED FIDELITY LIFE INSURANCE CO.,

Defendant-Appellant.

Filed April 30, 1985

5-70
84-1128

Appeal from the Iowa District Court for Polk County - Rodney J. Ryan, Judge.

Defendant insurer appeals from judgment for plaintiff in an action for breach of an insurance contract. REVERSED.

David L. Phipps and Kevin M. Reynolds of Whitfield, Musgrave, Selvy, Kelly & Eddy, Des Moines, for defendant-appellant.

Donald W. Baird of Baird, Bowers & Oliver, Des Moines, for plaintiff-appellee.

Heard by Donielson, P.J., and Snell and Sackett, JJ.

SNELL, J.

On July 16, 1981, plaintiff, an Arizona resident, applied for an income disability policy with defendant company. The insurance agent, who was a friend of plaintiff, filled in the application based on plaintiff's responses to questions asked. The application, signed by plaintiff, did not disclose other disability insurance coverage and claims made under such other policies. The application was for $1,500 in monthly benefits under occupational class "AA" but the policy issued on October 9, 1981, was for a maximum of $1,000 per month under occupational class "A." At the time of application, plaintiff paid a premium in exchange for a "conditional receipt" providing that under certain conditions coverage would be provided from the date of application.

Plaintiff was injured on or about August 23, 1981. In a medical questionnaire signed by plaintiff and submitted to defendant insurer in connection with his claim for policy benefits, plaintiff again failed to disclose the existence of other disability coverage. The insurer paid monthly benefits through April 1982, but subsequently tendered a return of premiums and ceased further payments due to what were alleged to be material misrepresentations made by plaintiff.

Plaintiff commenced a breach of contract action seeking $4,000 in benefits alleged to have been wrongfully withheld. Defendant counterclaimed for the amount of benefits paid under a policy alleged to have been void from its inception. Plaintiff and his wife testified at trial that, on other occasions, they had told the Arizona agent about the other policies not disclosed on the application. Their testimony was contradicted by the agent.

Following trial, the court entered judgment for plaintiff upon both his claim and defendant's counterclaim.

On appeal, defendant insurer asserts: (1) that Arizona law should govern the policy in question; (2) that the trial court based its decision on a clearly erroneous finding of fact; (3) that under any applicable law the evidence was insufficient to

establish coverage at the time of injury; (4) that the evidence of material misrepresentation was sufficient to render void any policy otherwise applicable; and (5) that the evidence was sufficient to establish a right to recover amounts paid pursuant to the policy.

Both parties agree that with respect to the construction of the written documents, Arizona law applies. At the time the policy was applied for, plaintiff was an Arizona resident. The policy was applied for and executed in Arizona. The "most significant relationship" test used in determining choice of law questions in contract matters indicates that Arizona law is applicable. See, Lindstrom v. Aetna Life Insurance Co., 203 N.W.2d 623, 628 (Iowa 1973).

Defendant insurer's first claim is that the trial court made an erroneous finding of fact when it made the following statement in the Findings of Fact, Conclusions of Law and Judgment: ". . . the Plaintiff was issued a policy by Defendant which approved only $1000.00 monthly benefit on occupation Class A and he was subsequently injured . . . ." A tracing of the history of the parties' relationship indicates that while the court might be technically incorrect, such a finding was not prejudicial. On July 16, 1981, the plaintiff applied for a policy paying $1,500 in monthly benefits at an occupational class rate of "AA." At that time, plaintiff paid a premium of $38.70 and received a conditional receipt. This receipt provided:

> FIRST, CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY. If each and every one of the following conditions shall have been fulfilled exactly—
>
> (a) The amount of the premium paid with the application must be not less than the full premium for the mode checked in Premiums Payable for the amount of life and health insurance and any additional benefits applied for; and
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> (b) the medical examination, (or if required by the Company's published examination rules for the age of the applicant and amount of insurance requested, any additional examinations, electro-

cardiograms, X-rays or other special studies) must be completed within 60 days from the date of the application; and

(c) all Proposed Insureds must be on the Effective Date, as defined below, a risk acceptable to the Company under its rules, limits and standards on the plan and for the amount applied for without modification and at the rate of premium paid with the application—

"Effective Date" as used herein means the latest of: (a) the date of the application, or (b) the date of the medical examination (or additional examinations and special tests if required by the Company's published medical examination rules), or (c) the date of issue requested in the application, if any.

A medical examination was done on July 17, 1981.

On August 29, 1981, plaintiff was injured and thereafter applied for policy benefits. On October 9, 1981, plaintiff was issued a policy on terms that varied from the coverage sought. Instead of receiving $1,500 in monthly benefits at an occupational classification of "AA," plaintiff was issued $1,000 in monthly benefits on an occupational classification of "A." Plaintiff accepted these changes and began receiving monthly benefit payments until April 20, 1982, when plaintiff was notified that defendant insurer was going to terminate the benefits because of misrepresentations by plaintiff in the initial application.

Defendant insurer initially argues that the conditional receipt was null and void because it varied from the terms of the policy actually issued.

When the meaning and intent of an insurance contract are clear, it is not the prerogative of the court to change or rewrite the policy to avoid harsh results. Lawrence v. Beneficial Fire & Cas. Ins. Co., 8 Ariz. App. 155, 159, 444 P.2d 446, 449-50 (1968). However, when an ambiguity exists in a policy, it must be construed against the insurer, particularly when an exclusionary clause is concerned, but the words in the policy must be given meaning which they ordinarily would have in order to effectuate the purpose of the policy. State Farm

Mutual Auto. Ins. Co. v. Paynter, 122 Ariz. 198, 204, 593 P.2d 948, 954 (Ct. App. 1979).

When any policy provision is subject to more than one reasonable interpretation, that interpretation which favors the insured is adopted, since the insurer authors the contract. Prudential Ins. Co. of America v. Barnes, 285 F.2d 299, 300 (1960).

In John Hancock Mutual Life Ins. Co. v. McNeill, 27 Ariz. App. 502, 556 P.2d 803 (1976), the Arizona Court of Appeals discussed the effect to be given to conditional receipts of an insurance contract:

> There is no doubt that insurable risk type of conditional receipts can give rise to a contract of insurance, even in the absence of the issuance of an insurance policy provided the conditions precedent to such coverage are met.
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> * * *
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> Arizona has expressly held that under an insurable risk conditional receipt, temporary insurance coverage is not afforded until the applicant complies with the conditions precedent to coverage under the plain and unambiguous terms of the conditional receipt.
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> A concept of "objectivity" has been adopted by the Maryland courts in construing insurable risk conditional receipts in life insurance cases. We interpret this objectivity doctrine to apply to what the contracting parties (including the applicant) can objectively determine from the face of the contracting document to be conditions precedent to effective coverage under that document.
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> Certainly the undisclosed, unascertainable subjective workings of an underwriter's mind, cannot be objectively ascertained by the applicant for the purpose of having such a determination be a condition precedent to the effective date of the coverage afforded under the conditional receipt.

Id. at 505-07, 556 P.2d at 806-08 (citations omitted).

McNeill was followed in Cain v. Aetna Life Ins. Co., 135 Ariz. 189, 659 P.2d 1334 (1983). In finding that a clause which stated "if the insurance company shall be satisfied that on such effective date the eligible person (and his covered

dependents, if any) are insurable as standard risks in accordance with the regular rules and practices of the Company for the amount of benefits applied for" to be subjective the court reasoned:

> Several principles emerge from the foregoing authorities. In an insurable risk type of conditional receipt, such as we have here, a temporary contract of insurance can arise even absent the issuance of an insurance policy, provided the conditions precedent to such coverage are met. Such conditions, however, must be objective and must be ascertainable by the applicant for insurance. Noncompliance with a condition which requires the applicant to delve into the "subjective workings of an underwriter's mind," McNeill, 27 Ariz. App. at 507, 556 P.2d at 808, will not prevent a contract for temporary insurance from coming into effect.
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> We find the terms of this conditional receipt to be subjective. Insurance coverage is to be retroactive to the date of the conditional receipt (or the date of enrollment if later) "if the insurance company shall be satisfied that on such effective date the eligible person (and his covered dependents, if any) are insurable as standard risks in accordance with the regular rules and practices of the Company for the amount of benefits applied for." We find this condition to be subjective because the applicant for insurance is not capable of ascertaining with any degree of certainty whether he or she is insurable as a standard risk in accordance with the regular rules and practices of the insurance company.

Id. at 193-94, 659 P.2d at 1338-39.

On the basis of these cases, we find that the following clause, relied upon by the defendant insurer to support its claim that the conditional insurance was null and void, to be subjective:

> (c) all Proposed Insureds must be on the Effective Date, as defined below, a risk acceptable to the Company under its rules, limits and standards on the plan and for the amount applied for without modification and at the rate of premium paid with the application—

While this clause is nearly identical to that set forth in Cain, we do not base our conclusion on that case alone. The court in Cain expressly limited the rule to contracts for group health insurance and based its conclusions on the facts of the

case. However, a reading of Cain and McNeill, which involved an application for life insurance, together with the facts of this case, supports such a finding.

Primarily, the fact that the defendant issued a formal policy and made benefit payments for several months defies a finding that the conditional receipt was null and void. In fact, plaintiff was not aware of this claim until after this cause of action was commenced. The conditional receipt provides that "all Proposed Insureds must be on the Effective Date, (the date of the medical examination in this case) a risk acceptable to the Company under its rules, limits and standards on the plan and for the amount applied for without modification and at the rate of premium paid with the application." There is no description in the policy from which the plaintiff could have discerned whether he met these requirements. Such a determination relied on the "subjective" decision of the defendant insurer. We reject the argument that the plaintiff should not be allowed to recover because the policy issued was different than the policy applied for. Again, there is nothing in the information available to the plaintiff from which he can objectively ascertain whether he will qualify for the coverage applied for.

Defendant-insurer also argues that plaintiff gave materially false answers to questions on the application and that he is therefore estopped from claiming benefits under the policy.

Under Arizona law, if the plaintiff conceals or misrepresents material facts in procuring an insurance policy, he may be denied recovery under the policy. Keplinger v. Mid-Century Ins. Co., 115 Ariz. 387, 391, 565 P.2d 893, 897 (Ct. App. 1977). In Marine v. Allstate Insurance Co., 12 Ariz. App. 229, 469 P.2d 121 (1970), the Arizona Court of Appeals clearly set forth the rule that the insured is bound by misstatements appearing in an application. Id. at 230, 469 P.2d at 122.

In Marine, the insured was suing to recover disability benefits and the company refused to pay claiming that the insured had failed to disclose the fact

that he had multiple sclerosis on the application. The insured claimed that he had told the agent filling out the application that he had "diffused" sclerosis and that he had seen several doctors in California. The agent denied that the insured ever gave him such information. The Arizona Court of Appeals relied on Greber v. Equitable Life Assur. Soc. of United States, 43 Ariz. 1, 28 P.2d 817 (1934), in finding that the insured was bound by the misstatements:

> The general rule is that the insured is bound by misstatements appearing in an application attached to the policy delivered to and retained by him. Greber v. Equitable Life Assur. Soc. of United States, supra; Appleman, Insurance Law and Practice § 9405; 7 Couch on Insurance § 35.211 (2nd Ed.). The reason for the rule as expressed in Greber is that the insured has the opportunity of examination and is under a duty to read over his application attached to the policy and correct any errors in the application. Does the fact that the insured gave truthful answers which are incorrectly recorded on the application by the insurance agent change the operation of the general rule? We think not.

Marine, 12 Ariz. App. at 230, 469 P.2d at 122.

In this case, the application failed to indicate that the plaintiff had two other income disability policies with another company. The application also stated that the plaintiff had never suffered from any intestinal or stomach ailments when in fact the plaintiff had suffered from gastritis several years earlier. The plaintiff and his wife both testified that they told the agent these facts and that the agent failed to record them. The agent denies that the plaintiff revealed these facts. After the plaintiff was injured, he applied for benefits and again failed to reveal the existence of these two other policies. Plaintiff concedes that he read the application after the agent completed it and signed it. The application bearing plaintiff's signature states: ". . . the Proposed Insured . . . declares that he has read the questions and answers contained in this application, and that the answers are complete and true to the best of his . . . knowledge and belief . . . ."

The test of materiality is whether the facts omitted might have influenced a

reasonable insurer in deciding whether to accept or reject the risk or in deciding the amount of the policy. Keplinger v. Mid-Century Ins. Co., 115 Ariz. 387, 391, 565 P.2d 893, 897 (Ct. App. 1977). In this case, company officials testified that the existence of other disability insurance would have affected the size of the policy issued.

We find that the facts omitted were material. Under the holding of Marine, the insured is bound by those statements in the application and should not be allowed to recover the benefits.

The findings of the trial court are reversed. Judgment is entered for the defendants on the counterclaim for $7,466.66 for benefits paid to the plaintiff. Defendant is ordered to return to the plaintiff all premiums paid.

REVERSED.