Life Insurance and Accidental Death and Dismemberment Update

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Note from the Author

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I. Introduction

This update focuses on cases, under both ERISA and state law, involving life insurance and accidental death and dismemberment ("AD&D") coverage. The cases on life insurance are primarily those decided in the last year, roughly since the last life insurance update at the 2008 DRI Life, Health, Disability and ERISA seminar in San Francisco. There is also a discussion of stranger-owned or originated life insurance. The AD&D section of this paper supplements and updates the materials provided at the DRI Life, Health, Disability and ERISA seminar in 2006. The paper is not intended to be an exhaustive or all-inclusive study of either topic. The scope of this update is far more limited, as it is intended to address selected issues through a discussion of some recently decided cases.

II. Life Insurance Update

A. Insurable Interest

1. *In Loco Parentis*

In *First Colony Life Ins. Co. v. Sanford*, 2009 U.S. App. LEXIS 341 (5th Cir. 2009), at issue was the validity of a policy on the life of Emmanuel Morris. Morris was seventeen years old and homeless; his father was dead, his mother was incarcerated serving a life sentence; and no family member was willing or able to care for him. Bobby Sanford took Morris into his home, and cared for him along with Sanford's three children. Sanford took steps to become guardian for Morris, even obtaining a final judgment appointing him guardian, but Sanford never took the oath and no letters of guardianship were issued to him. Nevertheless, with Morris' permission, Sanford applied for and obtained the policy on Morris' life. The district court entered summary judgment for the insurer, finding that Sanford lacked insurable interest in the life of Morris. On appeal, the Fifth Circuit reversed and remanded the case. The court stated, "We have found no Mississippi authority, and the parties have directed us to none, holding that the relationship of an individual standing *in loco parentis* to a minor establishes that the individual has an insurable interest in the minor, nor have we found any authority to the contrary." *Id*. at *14. After discussing Mississippi law on *in loco parentis*, the court ruled that "[i]n light of the fact that Mississippi recognizes the legal relationship of *in loco parentis*, finding an *in loco parentis* relationship between Sanford and Morris and considering that relationship along with other factors could lead to Sanford's having an insurable interest in Morris's life." *Id*. at *16-17. It remanded the case directing the district court to "determine whether Sanford stood *in loco parentis* to Morris's life and if so, whether that relationship alone or along with other factors vested Sanford with an insurable interest in Morris." *Id*.

2. Continuing Interest after Issuance

In *Gray v. Nash*, 259 S.W.3d 286 (Ct. App. Tex. 2008), the insured named his wife as beneficiary. They subsequently divorced. The insured's child support

obligations were later terminated. At the time of his death, the insured had remarried. The widow argued the ex-wife did not have an insurable interest at the time of the insured's death. The court noted that, under the common law, the designated beneficiary of a life insurance policy must have an insurable interest in the insured's life when the policy is issued and when the insured dies. *Id*. at 291. While the insurable-interest rule is still followed by Texas courts, the legislature has enlarged the class of persons deemed to have an insurable interest. *Id.* at 292. Under the insurance code, an individual may apply for a life insurance policy on the individual's own life and designate as beneficiary any individual. *Id*. The statutory provisions further provided that a beneficiary of a life insurance policy who is designated in accordance has, at all times after the designation, an insurable interest in the life of the individual who is insured under the policy. *Id*. Thus, the court found that the legislature had conferred an insurable interest on those persons named by an insured as beneficiaries in a policy on the insured's own life. *Id*. In this case, the insured, himself, applied for the life insurance policy on his own life and designated the ex-wife as a beneficiary. *Id*. The court held that the ex-wife had a continuing insurable interest in his life.

B. Disclosure of Health Status

1. The Doctrine of *Uberrimae Fidei*

In *PHL Variable Ins. Co. v. Fulbright McNeill, Inc*., 519 F3d 825 (8th Cir. 2008), a diversity case decided under Arkansas law, the insurer sought rescission of a policy based on an alleged misrepresentation regarding the insured's health. The insured's personal physician pronounced him healthy after an examination. The insured then completed and signed an application for life insurance. The insured underwent a paramedic examination and completed and signed Part II of the policy application. Based on the examination, the paramedic examiner also considered the insured to be in good health and without heart problems. The insurer relied upon the information and answers to the questions in Part II of the application in issuing the policy. However, before the policy was issued, the insured voluntarily submitted to a coronary test with a different physician. This test revealed that he had a 90% likelihood of having a heart attack and a high risk of cardiovascular disease. The insured was informed of these results. The policy was issued and delivered to the insured. The insurer's agent told the insured that he need not read the acceptance form because the form merely confirmed delivery of the policy. However, the policy acceptance form actually contained an express affirmation that the insured's representations regarding his health condition remained unchanged since he completed Part II of the application. The form also acknowledged that the policy acceptance had been incorporated into the policy application and the insurance contract. The insured signed the acceptance form but did not disclose the results of his recent tests, which showed his high risk for cardiovascular disease. The insured died of a heart attack less than a year later. The court affirmed the district court's award of summary judgment for the insurer. It noted that "Arkansas recognizes 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." *Id.* at 829. The court concluded that the insured's representations in the policy application were continuing until the issuance of the policy. Once the insured learned the true nature of his health, his statements in the application became false. He failed to modify that false representation before issuance of the policy. Consequently, the court ruled, the insurer could assert these misrepresentations as its basis for denying the claim for benefits. The insured's duty to act in good faith during the pendency of his application preexisted and survived any alleged misrepresentation regarding the significance of the acceptance form made by the agent at delivery of the policy. *Id.* The dissent argued that the majority's approach used the "duty of utmost good faith" to broaden the explicit policy language.

2. Contractual Duty to Disclose

Similarly, in *Kuehl v. First Colony Life Ins. Co.*, 749 N.W.2d 491 (Ct. App. Neb. 2008), the application signed by the insured required that she "notify the Insurer if any statement or answer given in the application changes prior to policy delivery." *Id.* at 496. The court found that such provision was dispositive and did not address other language in the application regarding an insured being "insurable" at the time the policy is delivered. *Id.* at 497. The court distinguished the case from another where insurer's position was that the insured had breached a condition precedent to coverage related solely to certain continued insurability language of the policy. In that earlier case, the court pointed out, "there was no contractual obligation of the insured to notify the insurer of any change in health status before delivery of the policy." *Id.* at 498. The earlier case referred to the general rule that an applicant for life insurance has no duty to *voluntarily* inform the insurer of new information about his health that arises after a medical examination by the insurer. *Id.* In *Kuehl*, by contrast, "the insured had a contractual duty to inform the insurer of new information concerning statements in the application prior to policy delivery." *Id.* "[T]he requirement in the company's policy that the insured notify the insurer of any changes in statements given in the application for insurance prior to policy delivery was a condition precedent to the formation of the insurance contract. This notification requirement was a condition of the contract which [the insured] acknowledged and signed, and which she failed to satisfy." *Id.* at 499.

C. Misrepresentation

1. Two-Year Contestable Period and Duty to Cooperate

American General Life Ins. Co. v. Broughton, 2008 U.S. Dist. LEXIS 44642 (D. Idaho 2008) involved a challenge to the two-year contestable period and a beneficiary's duty to cooperate in a post-death investigation. The insured died within the two-year limitation period, but the beneficiary made the death claim after the expiration of the 24-month medical authorization in the insured's application. When the insured's estate and surviving wife failed to cooperate in its post-death investigation, the insurer filed suit seeking a declaration that they were required to cooperate. The insured's estate and surviving wife argued that Idaho law allows parties to negotiate a contestability period for less than two years from date of issue and this is what the application's authorization

section did – it was a negotiated period of contestability for 24 months from the date of application, instead of the date of issue. They also argued that prior to the expiration of the 24-month period from the date of application, they must provide or release any medical or financial history that the insurer requests. Once that 24-month period expired, they argued, the policy can still be contested but only on the basis of information found on the face of the application or independently discovered. The court rejected both of these arguments. It found that the authorization contained in the application and the incontestability provision found in the policy were separate and distinct. The authorization to release medical records, and the 24-month time period that went along with it, made no reference to the contestability period provided in the policy. *Id*. at *10. The court also found that the insured's estate and surviving wife must cooperate in good faith with the insurer during its investigation, because Idaho law has recognized that the covenant of good faith and fair dealing is implied in every contract. *Id*. at *13.

2. Materiality of Past Drug Use

In *Cummings v. American General Life Ins. Co*., 2008 U.S. Dist. LEXIS 37157 (E.D. Pa. 2008), the issue was whether the insured's prior use of cocaine was material to the risk. There was no dispute that the insured failed to answer a question about his past drug use on his application. However, the insurer knew that the insured had suffered previous gunshot wounds and, after the policy issued, the insured died of another gunshot wound. The beneficiary argued that the drug use was not a material fact because "it would seem that having been shot twice in the preceding two years would present a greater underwriting risk (especially in light of the fact that that was how he died), than an allegation of cocaine use, where the insured's test results were negative for any drug use in two separate paramedical exams taken months apart" in previous years. *Id*. at *13-14. The court rejected this argument: "However superficially natural such an argument may seem to an understandably grieving mother, [the insured's] prior gunshot wounds and his ultimate death from a gunshot are irrelevant to the analysis of his denial of drug use and the possible materiality of those denials to the issuance of the insurance policy. Under Pennsylvania law, a misrepresentation does not have to be related to the eventual claim for which benefits are sought in order to be 'material' for legal purposes. A statement is material if it is relevant to the risk assumed, even if it is unrelated to the loss actually incurred." *Id*. at 14. The court also observed that any "'misrepresented fact is material if being disclosed to the insurer it would have caused it to refuse the risk altogether or to demand a higher premium' and that 'an insurer is not obligated to investigate beyond the face of an unambiguous insurance application.'" *Id*. at *17-18 (citations omitted).

D. Insured's Capacity to Change Beneficiary Designation

In *American General Life Ins. Co. v. Wilkes*, 290 Fed. Appx. 688 (5th Cir. 2008), there was a dispute over life insurance proceeds between the insured's wife and his daughter from a former marriage. The insured changed the beneficiary on his policies multiple times. The last change was when the insured signed change of beneficiary forms, naming the wife as the sole irrevocable beneficiary, which was witnessed by the

wife. The daughter claimed that the insured lacked the mental capacity to complete those Change of Beneficiary forms. The trial court entered summary judgment for the wife. On appeal, the Fifth Circuit observed that under Louisiana state law, "'A contract made by a noninterdicted person deprived of reason at the time of contracting may be attacked after his death, on the ground of incapacity, only when the contract is gratuitous, or it evidences a lack of understanding, or was made within thirty days of his death, or when application for interdiction was filed before his death.'" *Id.* at 690 (citation omitted). However, exceptions to the presumption of contractual capacity "'must be shown quite convincingly and by the great weight of evidence.'" *Id.* (citation omitted). To attack the validity of the forms, the daughter rested her argument on the basis that the contract itself evidenced a lack of understanding. The husband's caretaker stated that the husband was unable to perform routine tasks and had begun to lose his ability to think during that time period. The court found this evidence to be insufficient. Also, the fact that the wife filled in general information on the forms did not demonstrate a lack of capacity to contract. Thus, like the district court had found, there was insufficient evidence to overcome the presumption that the insured had contractual capacity at the time he executed the change of beneficiary forms. *Id.* at 691. The daughter also attacked the validity of the forms based upon fraud and undue influence. Yet, the court found that the fact that the wife filled in general information on the forms, that the designation of the wife as the sole beneficiary was irrevocable, and that one form was signed a few days before she and the insured married, was not evidence from which a reasonable jury could find fraud or undue influence. Furthermore, the daughter did not set forth any specific facts that the insured was misled or deceived by the wife about the substance or consequences of changing the beneficiary of his policies. *Id.* at 692.

See, also, American General Life Ins. Co. v. Schreiber, 563 F. Supp. 2d 947, 494 (W.D. Wis. 2008) (that fact that the insured had taken psychotropic medication several months before he changed the beneficiary on the policy, that he misstated the number of times he had been married and that at undisclosed times he tried to carry a gun on a bus and could not identify what time of day it was might suggest that the insured had mental health problems, but they did not show that he was legally incapable of forming a binding agreement).

E. Suicide

1. Burden of Proof

Under state law, there typically is a presumption against suicide, which can be quite difficult to rebut in some jurisdictions. For example, in *Green v. William Penn Life Ins. Co. of New York*, 848 N.Y.S.2d 109 (Sup. Ct. N.Y. 2007), the court pointed out that there is no unanimity among jurisdictions as to the degree of the burden placed on an insurer seeking to prove death was due to suicide. *Id.* at 111. In New York, however, the court found that the burden was "exceedingly high" -- "[A] finding of suicide is warranted only if 'no conclusion other than suicide may reasonably be drawn.'" *Id.* (citation omitted). Because the finding of suicide was not the only possible conclusion that could be reasonably drawn from the evidence in *Green*, the appellate court reversed the trial court's judgment in favor of the insurer. *Id.* at 111-12. There was a three-judge

dissent in *Green*, arguing that "the majority's holding would impose a requirement of proof beyond a reasonable doubt rather than a preponderance of the evidence." *Id*. at 121.

2. Two-Year Exclusion Period Upheld

The typical two-year limitation period on suicide found in many policies was challenged in several grounds in *Officer v. Chase Ins. Life and Annuity Co.*, 541 F.3d 713 (7th Cir. 2008). There, the insured killed herself 34 days before the end of the two-year period. The policy had the following suicide exclusion:

> We will limit the proceeds we pay under this policy if the insured commits suicide, while sane or insane:
> 1. within 2 years from the Date of Issue; and
> 2. after 2 years from the Date of Issue, but within 2 years from the effective date of the last reinstatement of this policy.
>
> The limited amount will equal all premiums paid on this policy.

The insurer refunded to the plaintiff the premiums that had been paid, but the plaintiff sought the face amount of the policy based on several arguments. The plaintiff first argued that the exclusion was ambiguous, which argument the court rejected. *Id*. at 716. Second, the plaintiff tried to equate the policy exclusion to a liquidated damage provision, arguing that it was a disproportionate forfeiture or an illegal penalty. *Id*. He argued the exclusion's purpose is to prevent fraud and the insured had fulfilled 95% of the exclusion's time restriction. Therefore, losing the face amount of the policy over 34 days would be illegal. *Id*. The court rejected this argument. It found that fraud prevention was not the only purpose for this exclusion, that insurers have the right to choose not to assume certain risks and premiums are calculated on the avoidance of such liability, and that such an exclusion was not against public policy. *Id*. at 717. It also stated that "forfeiture and liquidated damages are not appropriate concepts to apply to a suicide exclusion in an insurance contract." *Id*. Third, the plaintiff argued that the doctrine of substantial performance should prevent the insurer from discharging its obligation to pay, and that the suicide provision was 95% performed at the time of the breach. *Id*. at 718. However, the court held that "the doctrine of substantial performance is simply inapplicable here; an insured is not 'performing' a life insurance contract by not committing suicide." *Id*. at 718-19. The court confirmed that, pursuant to the terms of the policy, the only payment due as a result of the insured's suicide was a return of the premiums that had been paid.

3. Obtaining Policy Contemplating Suicide

In *Hamilton v. Standard Ins. Co.*, 516 F.3d 1069 (8th Cir. 2008), a case involving an ERISA plan, the insured committed suicide and, as a result, reduced benefits were paid to his beneficiary pursuant to the plan. Seeking full benefits, the beneficiary argued for the application of a Missouri statute, which provided:

> In all suits upon policies of insurance on life hereafter issued by any company doing business in this state, to a citizen of this state, it shall be no defense that the insured committed suicide, unless it shall be shown to the satisfaction of the court or jury trying the cause, that the insured contemplated suicide at the time he made his application for the policy, and any stipulation in the policy to the contrary shall be void.

Id. at 1072. Although the statute by its terms only applied to "policies of insurance . . . issued . . . to a citizen of this state" and the group policy was issued to a non-Missouri citizen in Idaho, the beneficiary argued the statute should still apply because the insured, a Missouri citizen, was issued an individual certificate of insurance. *Id.* However, the court ruled that a certificate holder's residency differed from that of the group policyholder, and that it was the group policyholder's residence which determined whether the statute applied, not the residence of the individual certificate holder. *Id*. at 1073.

F. Slayer – Accomplice to the Insured's Murder Barred from Receiving Life Insurance Proceeds

In *Nationwide Life Ins. Co. v. Richards*, 541 F.3d 903 (9th 2008), the husband had a life insurance policy that named his wife the primary beneficiary. The wife met a man at a nightclub who competed professionally in hand-to-hand mixed martial arts and also was a martial arts instructor. Sometime thereafter, they became lovers. The husband was later murdered by a choke hold known in Brazilian Ju-Jitsu as "Mata Leon," or "To Kill the Lion." After the insured was found dead, the wife sought and received a $50,000 advance from the insurer and, six days later, she purchased a vacation package to Cancun, Mexico, for herself and her paramour. A state court jury subsequently convicted the wife's paramour of the murder. During the litigation involving the insurance benefits, the wife invoked her Fifth Amendment privilege during her deposition by refusing to answer seven questions. At trial, the district court precluded the wife from testifying only as to the subject as to which she asserted the Fifth Amendment privilege. The Ninth Circuit affirmed that ruling, because the trial court's order was narrowly tailored to impose upon the wife only that detriment necessary to prevent unfair prejudice to the contingent beneficiaries. *Id*. at 911. The court also upheld the district court's evidentiary ruling that the paramour's acquaintance could testify as to what he had said about the insured's death. *Id*. at 915. The court affirmed the ruling that the wife was precluded from receiving the life insurance based on the lower court's finding that she had conspired in the insured's death. *See, also, Reliastar Life Ins. Co v. Thompson*, 2008 U.S. Dist. LEXIS 71726 (S.D. Tex. 2008) (applying the Texas "slayer statute").

G. Divorce – Insurance Benefits Payable to Ex-Wife

In *Life Ins. Co. of North America v. Ortiz*, 535 F.3d 990 (9th Cir. 2008), the insured, a police officer, named his wife as beneficiary on his life insurance policies, but they were later divorced. The insured remarried, but did not change his beneficiary

designations before he was killed in the line of duty a short time after his second wedding. A dispute arose between the first wife and the widow as to whom the death benefits should be paid. Applying California law, the court looked to the language of the property settlement agreement to determine whether the agreement extinguished the expectancy interests of the first wife. "'General language in a marital settlement agreement will not be construed to include an assignment or renunciation of the expectancy interest conferred on the named beneficiary of an insurance policy or a will unless it clearly appears that the agreement was intended to deprive either spouse of such a right.'" *Id.* at 993 (citation omitted). A property settlement covering all property and releasing all claims may be found to include a life insurance expectancy interest, "but where the language is not broad enough to encompass such an expectancy the wife may still take as beneficiary if the policy so provides." *Id*. (citation omitted). Turning to the facts of the case, the court found that the language of the divorce judgment did not extinguish the first wife's expectancy interest in the life insurance proceeds. The text of the relevant Judgment on Reserved Issues did not contain a direct reference to life insurance policies. Although there was a provision awarding "[a]ll right, title and interest in any and all of Petitioner's retirement/pension, 457(b) plans, 401(k) plans or other deferred benefits," it was not clearly apparent that the provision encompassed beneficiary status. *Id*. Additionally, the context of the Judgment on Reserved Issues suggests that the parties did not extinguish beneficiary status, because the document contained a pre-printed notice that "[i]t does not automatically cancel the rights of a spouse as beneficiary on the other spouse's life insurance policy." *Id*. On a related issue, the court noted that the insurance companies required written notification of change of beneficiary, that the insured took no steps toward providing such notification, and that this was not a situation when the insured had done all that he could to effect the change but died before the change is actually made. *Id*. at 994.

There was a colorful dissent on *Ortiz*, which complained that the majority had "reache[d] a senseless, unjust and cruel result by awarding half a million dollars to the former wife of a peace officer felled in the line of duty, leaving the officer's widow and children out in the cold." *Id*. at 995. Accusing the majority of "pettifog[ing] its way through the California case law," the dissent complained that "[b]readwinners buy life insurance to provide financial security for their dependents. [The insured] had no reason to provide financial security for a woman who wasn't his dependent and whom, by all accounts, he despised." *Id*. The fact that the insured had not changed the beneficiary designation on his policies by the time he was killed did not compel a finding that he "meant to leave [his ex-wife] a pot of gold and his wife and sons a lump of coal." *Id*. at 996. The insured, "like the rest of mankind, must have believed that he had plenty of time. Imprudent, perhaps, but very human. Who amongst us hasn't put off dealing with wills or other unpleasantries that remind us of our mortality?" *Id*. "I fully expect we'll hear [the insured] yelling from his grave when the majority issues its opinion." *Id*. at 999.

H. Interpleader

1. The Stakeholder is Protected

The Prudential Ins. Co. of America v. Hovis, 2009 U.S. App. LEXIS 1315 (3rd Cir. 2009) involved the issue of how far the protection of the interpleader device extends. The Third Circuit held that bringing a valid interpleader action can shield a stakeholder from further liability to the claimants not only with respect to the amount owed, but also with respect to counterclaims brought by the claimants where the stakeholder bears no blame for the existence of the ownership controversy and the counterclaims are directly related to the stakeholder's failure to resolve the underlying dispute in favor of one of the claimants. An agent sold an insurance policy to the insured, who made her children beneficiaries of the policy. The agent and the insured became romantically involved. The insured was later diagnosed with a terminal illness, and the agent submitted requests to change the ownership and beneficiary to the agent. The insurer did not process that request before the insured died. It had an internal policy prohibiting its sales professionals from having an ownership or beneficiary interest in their clients' policies unless they are members of the "immediate family" of the policyholder. In order to receive an exception to that policy, the agent was required to obtain approval from his managing director and the insurer's compliance division, something that he had not done at the time the changes were initially submitted. After the insured's death, her son found out about the change requests. Both the agent and one of the insured's children submitted competing claims and the insurer filed an interpleader naming the agent and both children as defendants. The agent brought counterclaims against the insurer for breach of contract, negligence, breach of fiduciary duty, bad faith and unfair trade practices, all relating to its alleged failure to process the request to change the ownership and beneficiary of her policy in a timely manner. The agent and the children settled their dispute as to how the insurance proceeds should be disbursed but the agent pressed his counterclaim against the insurer. The district court directed the insurer to pay the proceeds in accordance with the defendants' settlement agreement, and granted summary judgment to the insurer on the agent's counterclaims on the ground that the appropriateness of the insurer's interpleader action shielded it from any liability relating to its failure to resolve the dispute over the interpleaded funds.

On appeal, the Third Circuit affirmed the lower court. It found that the insurer had properly brought the interpleader because it could not be blamed for causing the controversy. The court found that what the agent was arguing was that, by failing to process the request to change the owner and beneficiary of the policy quickly, the insurer created circumstances in which there were competing claims to the proceeds. "But this argument is premised on the strange idea that the controversy over entitlement to the funds was caused by [the insurer's] failure to pay out the proceeds to [the agent] before [the insured's son] found out about [the] request to have the owner and beneficiary of [the] policy changed, rather than the unmistakable appearance of impropriety surrounding that request." *Id*. at *14. As to the agent's second argument – that his counterclaims were not claims *to* the interpleaded funds and thus fell outside the scope of the interpleader action – the court noted that the "normal rule is that interpleader protection

does not extend to counterclaims that are not claims to the interpleaded funds." *Id*. at *17. However, the court found that each of the agent's counterclaims concerned the insurer's failure to resolve its investigation in his favor and pay out the life insurance proceeds to him. As such, none of the counterclaims was truly independent of who was entitled to the life insurance proceeds, which is the issue the interpleader action was brought to settle. *Id*. at *18. "To allow [the insurer] to be exposed to liability under these circumstances would run counter to the very idea behind the interpleader remedy--namely, that a 'stakeholder should not be obliged at his peril to determine which claimant has the better claim.' Put another way, where a stakeholder is allowed to bring an interpleader action, rather than choosing between adverse claimants, its failure to choose between the adverse claimants (rather than bringing an interpleader action) cannot itself be a breach of a legal duty." *Id*. at *18 (citations omitted).

There was a similar result in *National Life Ins. Co. v. Alembik-Eisner*, 582 F. Supp. 2d 1362 (N.D. Ga. 2008). One claimant to the contested life insurance benefits filed a counterclaim against the insurer, which the insurer moved to dismiss. The court found that "an actual claim need not exist but rather only the possibility that more than one person will claim." *Id*. at 1366. "Jurisdiction in interpleader is not dependent upon the merits of the claims of the parties interpleaded, and a plaintiff can maintain the action even though he believes that one of the claims is valid and the other, or others, without merit." *Id*. at 1367. "On the other hand, that which is advanced as an adverse claim may be so wanting in substance that interpleader under the statute may not be justified. While the stakeholder is not obliged at his peril to determine which claimant has the better claim, he must have some real and reasonable fear of exposure to double liability or the vexation of conflicting claims." *Id*. The fact that one claimant eventually disclaimed any right to the proceeds did not make the interpleader action inappropriate but merely expedited its conclusion by obviating the normal second stage of the action to determine who should receive the benefits of the policy. *Id*. at 1368. Having found that the filing of the interpleader was proper, the court turned to the issue of what protection it afforded the insurer: "While the mere filing of the interpleader action does not 'immunize' the insurer from state law counterclaims filed by a claimant, if the interpleader action is properly filed, it is possible that the merits of the state law counterclaims could be rejected. That is to say, the question is whether the counterclaims are independent of the reason for the filing of the interpleader action." *Id*. at 1369-70. As to the allegations of bad faith, the court found that the insurer did not act in bad faith in refusing to pay out the proceeds of the policy and had, in fact, paid out the policy into the registry of the court. *Id*. at 1371. Finally, the court awarded the insurer, as stakeholder, $40,132 in attorney's fees and $8,243.15 in expenses.

2. Cannot Be Brought After Proceeds Paid

Unlike in the previous cases discussed above, in *Lincoln National Life Ins. Co. v. Barton*, 250 F.R.D. 388 (S.D. Ill. 2008), a counterclaim was allowed to proceed against an insured. But in *Barton*, the court found that the insurer could not bring an interpleader because it already had paid the proceeds and thus had no funds to pay into court. "'The purpose of interpleader is to protect a stakeholder from liability when it is forced to

choose between competing claims. In an interpleader action, the stakeholder puts the money in dispute into court, withdraws from the proceeding and leaves the competing claimants to litigate the ownership of the money. That is not what is happening here. The crucial difference between this case and an interpleader action is that in an interpleader action the stakeholder has not yet paid either of the claimants. Here the money has already been paid out.'" *Id*. at 390 (citations omitted).

I. Recovery of Benefits Mistakenly Paid

In *Transamerica Occidental Life Ins. Co. v. Total Systems, Inc*., 2008 U.S. Dist. LEXIS 81579 (D.N.J. 2008), the insurer sought to recover $1,978,418.11 that it allegedly overpaid to the defendants as death benefits under an individual life insurance policy. The insurer contended that it should have applied an aviation exclusion rider to the policy that would have reduced payout in the event that the insured died "as a result of operating, riding in or descending from any kind of aircraft while . . . a crew member of that aircraft," which is how the insured did die. The defendants filed a motion to dismiss, which the court denied. The court found that restitution was an available remedy for an insurance company seeking recovery of payments made under a unilateral mistake of fact in the absence of detrimental reliance, even without an allegation of fraud. *Id*. at *5. Whether the defendants' estoppel argument could prevail would be a matter of fact to be developed, and thus not a grounds for dismissal. Finally, the court rejected the defendants' argument that the insurer waived its right to raise the exclusion because it made payment with full knowledge of the events surrounding the insured's death and waited two months before attempting to recover the overpayment. In the insurance context, the court noted, "'where the policy does not cover the loss, it is inaccurate to speak of waiver since there is nothing to waive.'" *Id*. at *8 (citation omitted).

J. Claim Against Agent for Wrongful Death Dismissed

In *Bovan v. American Family Life Ins. Co*., 897 N.E.2d 288 (Ill. App. 2008), the court upheld the trial court's entry of summary judgment for an insurance agent in a wrongful death suit. The plaintiff alleged that the agent had sold a life insurance policy to a man impersonating as the insured and that the impostor was part of a conspiracy to murder the real insured so that the conspirators could collect the death benefit. She thus contended that the insured's death was a direct result of the agent's negligence in processing the impostor's application and the insurer's negligence in issuing the policy. The Illinois Court of Appeals found that an insurance agent acting on behalf of the insurer has no independent duty of care toward the deceased with whom he had no contact or course of dealing and, consequently, with whom he did not enter into any affirmative undertaking. *Id*. at 295. It went on to state that the insurer was the party that had authority to decide whether to issue the policy that allegedly led to the insured's death, so it is reasonable that the burden of care should be placed on the insurer rather than the agent, who had no ultimate control over the issuance of the policy. *Id*. The court did not reach the issue of whether the agent's acts were the proximate cause of the insured's death.

K. Constructive Trust Not Applicable Where Company Paid Premiums

In *Waldman v. Maini*, 195 P.3d 850 (Nev. 2008), a husband and wife were killed simultaneously. The family business had paid the premiums on the wife's coverage. The Supreme Court of Nevada concluded that although a corporation may acquire an ownership interest in life insurance policies by paying the premiums under constructive trust and resulting trust principles, the facts in this case did not warrant the application of those doctrines. In so concluding, it also noted that under the resulting trust doctrine, a company acquiring equitable ownership of a life insurance policy must show that it has an insurable interest in the life of the insured to recover the proceeds, but in this case the company made no such showing. As to the first issue, the Supreme Court noted that whether a corporation may acquire an ownership interest in life insurance policy proceeds by paying the policy premiums is an issue of first impression for the court. *Id*. at 856. In the present case, the court found that the facts did not warrant the imposition of a constructive trust. No an inequitable act was established that would support such relief. While Nevada may not require fraud, the Supreme Court noted, it had thus far at least required unjust enrichment before imposing a constructive trust. *Id*. at 858. Absent any evidence of an agreement or understanding that the company would receive the policies' proceeds, there is no showing that the insured's estate would be unjustly enriched by retaining the proceeds from the policies. *Id*. No evidence suggested that the company had a greater claim to the proceeds of the life insurance than the insured's estate. *Id.* Moreover, if there were facts sufficient to impose a trust on the insured's estate, making the company the equitable owner of the life insurance policy, to receive the proceeds the company would have to prove that at the time the contract for insurance was entered it had an insurable interest in her life, which it did not. *Id*. at 859. The insured's contribution to the company during her lifetime was to work as bookkeeper and the amount of insurance proceeds far exceeded the value of her services to the company. Thus, the company "would profit more from [the insured's death] than by her life and did not have an insurable interest in her life." *Id*. at 860.

L. STOLI (Stranger-Owned Life Insurance)

This situation has recently been described by the court in *Lincoln National Life Ins. Co. v. Calhoun*, 2009 U.S. Dist. LEXIS 5948 (N.J. 2009):

> This case concerns an aspect of a growing cottage industry in the insurance market, known as stranger-owned life insurance policies or "STOLI" plans, in which an individual, typically an elderly one, procures life insurance on his own life in order to subsequently assign the policy to a third party following the lapse of the two-year contestability period. STOLI transactions are the product of the burgeoning "life settlements" market, in which insureds sell unneeded or unaffordable permanent policies to investors. *See* [J. Alan Jensen & Stephan R. Leimberg, *Stranger-Owned Life Insurance: A Point/Counterpoint Discussion,* 33 ACTEC J. 110, 111 (2007)]. STOLI schemes emerged as investor demand for these policies exceeded supply, leading industry speculators to

solicit insureds to take out additional policies, even if the insureds had no particular need for supplemental insurance coverage. Often, the insureds are persuaded to engage in these STOLI transactions because their bank accounts have run dry and they are forced to spend increasing amounts of money on medical care. As one court put it, "[o]ften pejoratively termed 'stranger-owned life insurance policies' these policies enable the insured to obtain ready cash by selling his policy to a stranger whose only interest in the insured is his early demise." *Life Prod. Clearing LLC v. Angel*, 530 F. Supp. 2d 646, 648 (S.D.N.Y. 2008).

A typical STOLI transaction is structured as follows. An agent attempts to sell a life insurance policy to an elderly insurable candidate, and offers the candidate up-front cash in exchange for promising a future sale of the policy. The agent informs the candidate that the candidate will be able to obtain the policy at virtually no cost to himself, because the agent has secured non-recourse financing to purchase the policy. The candidate then acts as a "nominal grantor" of a life insurance trust that is used to apply for the policy. "At that time, the agent will tell the insured that, in all probability, the policy will be sold to investors for a price that will pay the loan and accrued interest, leaving a profit to split between the agent and the insured. If the insured survives the two-year contestability period on the policy, the owner (the life insurance trustee) typically has two options, in addition to the sale of the policies to investors: (1) have the insured pay the outstanding debt with accrued interest and retain the policy; or (2) transfer the policy to the lender in lieu of foreclosure." Jensen & Leimberg, *supra,* at 111. The insureds are usually able to garner significantly greater sums from the speculators than they would receive by surrendering the policy to the insurance company. *See* Liam Pleven & Rachel Emma Silverman, *Cashing In: An Insurance Man Builds A Lively Business In Death -- As Life Settlements Boom, Banks, Regulators Circle,* Wall St. J., Nov. 27, 2007, at A1.

As the *New York Times* reported several years ago, "trading in life insurance policies held by wealthy seniors has quietly become a big business. Hedge funds, financial institutions, and investors are spending billions to buy life insurance policies from the elderly. Other investors are paying seniors to apply for life insurance, lending the money to buy the policies, and then reselling them to speculators." Charles Duhigg, *Late in Life, Finding a Bonanza in Life Insurance, N.Y. Times*, December 17, 2006, at 1. The secondary market has grown from $ 200 million in transferred death benefits in 1998 to $ 12 million less than a decade later in 2005. Jensen & Leimberg, *supra,* at 111. One study suggested that as many as 89% of life insurance policies did not pay out death benefits. *Id.* at 112.

Though both sides to this controversy agree that consumers should be

> permitted to sell unnecessary policies on a secondary market, some have suggested that the increasing popularity of STOLI transactions, as well as the controversy engendered by them, frustrates the legitimacy of the secondary life settlements market. *See id.* at 123 ("The life settlement community is staggering under poor publicity … and is in great need of distinguishing itself from rogue actors and actions such as STOLI transactions."). Life insurance was typically understood as a means of providing for dependents after the insured has passed on. As some insurance industry advocates have stated, "life insurance is a way for individuals to protect their families. If someone profits from a stranger's death, it stands the whole purpose of life insurance on its head." Duhigg, *supra,* at 1. The insurance industry has further argued that such transactions will inevitably raise the cost of life insurance because insurance companies "count on many customers canceling their policies before they die, usually because their children grow up and no longer need the financial protection, their pensions kick in or premiums become too expensive." *Id.*

Id. at *4-8 (footnotes omitted). Much of the activity involving STOLI is taking place in the legislative arenas in the various states. However, the number of cases involving STOLI is on the rise and there have been some decisions in the last year involving STOLI and insurers' attempts to void policies based on misrepresentations in the applications or a lack of insurable interest.

1. Misrepresentations

(a) Statement as to Insured's Financial Status

In *American General Life Ins. Co. v. Schoenthal Family, LLC*, 2009 U.S. App. LEXIS 2128 (11th Cir. 2009), the issue was whether a Georgia statute allowed an insurer to rescind a life insurance policy because the deceased insured misrepresented his net worth and annual income in his application for the policy. He misrepresented in his application for a policy of $7,000,000 that his net worth was $10,700,000 and his annual income was over $150,000. The insured's net worth, in fact, was $160,000 and his annual income was $7,200. The $7,000,000 policy was applied for in conjunction with the insured's participation in something called the Liberty Premium Finance Program. As the district court explained, the program involved a "maze of related entities" and was "a complicated insurance investment mechanism for which [the insured] technically did not qualify, and in which he ultimately retained very little financial interest in the policy that nominally was intended to insure his life." *Id*. at *3. The various entities that comprised the program worked together to finance a high-value life insurance policy that the insured would have been otherwise unable to afford. In exchange, the entities reserved for themselves the vast majority of the expected payout of the policy. The district court entered summary judgment in favor of the insurer, allowing it to rescind the policy.

On appeal, the beneficiaries argued that determining the materiality of the insured's misrepresentations required that the district court consider the actual conduct of the insurer when it approved the policy. Yet the Eleventh Circuit found that the test for materiality under the relevant state statute was the objective standard of conduct of a prudent insurer, not a subjective standard about the actual conduct of a specific insurer. Second, the beneficiaries argued that there were questions of material fact about the materiality of the misrepresentations. But the court concluded that that record established that they were objectively material. The district court considered (1) underwriting guidelines that are used by numerous insurers and which the beneficiaries described as being a model of reasonable insurance practices, and (2) the uncontroverted testimony of the expert witness of the insurer that no reasonable insurance company would have issued the policy if the insured's true financial condition had been known. *Id*. at *17. Third, the beneficiaries argued that the policy required for rescission actual reliance by the insurer on a material misrepresentation by the insured. The insured's application contained a "Statement by the Proposed Insured," which provided, in relevant part, "I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) it is within its contestable period; and (2) such misrepresentation materially affects the acceptance of the risk." *Id*. at * 18. However, the court found that similar statements of insureds have not been held to limit the right of an insurer to seek rescission under the law of Georgia. *Id*.

The beneficiaries also raised arguments that the insurer waived its right to rescind the policy, was barred by estoppel from rescinding the policy, and denied the claim in bad faith, all of which the court rejected. As to the first argument, although the insurer did not tender the refund of premiums until eighteen months after it received permission from the district court to do so, the complaint filed by the insurer included a count for permission to interplead and the district court correctly ruled that this request for permission to interplead was an offer to restore the consideration received. *Id*. at 20. The beneficiaries failed to identify any evidence that the actions of the insurer were ever inconsistent with an intent to rescind the policy. *Id*. To support their estoppel argument, the beneficiaries tried to point the finger at the actions of the agents in completing the application. The court noted that although insurers are "'estopped to assert the falsity of answers to questions contained in an application for insurance or the policy itself, where such false answers are inserted by the insurer's agent to whom the [applicant] for insurance gave correct answers or information,' the beneficiaries failed to present evidence 'that anyone other than [the insured] provided the financial misrepresentations.'" *Id*. at *21-22 (citation omitted). Finally, the court rejected the argument about bad faith because the objectively material misrepresentations in the application constituted a reasonable ground for the insurer to contest the claim. *Id*. at *22.

(b) Statement as to Other Pending Applications

Often, the insured in STOLI situations applies for and obtains coverage from more than one insurer. In *Jefferson-Pilot Life Ins. Co. v. Marietta Campbell Ins. Group*, slip op., No. 07-1359 (D. Minn. Aug. 12, 2008), the insurer argued that the insured's life

insurance application included material misrepresentations because she failed to disclose other applications she had with other insurers in response to a question about "any applications pending with any other life insurance company now." *Id*. at 15. The parties sparred over what constituted a "pending" application and whether another application was pending when the insured signed the application at issue. The court noted that it was "well settled under the common law doctrine of *uberrimae fidei* 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.'" *Id*. at 17 (citation omitted). Accordingly, the court ruled that the insured was required to update her answer to the question on the application at issue if other applications became pending while the insurer was considering her application. *Id*. The failure to do so, the court found, was a material misrepresentation on which the insurer could assert as the basis for rescinding the policy.

(c) Statement as to Intent to Assign

Calhoun, supra, is a case in which the insurer has sought to rescind a STOLI policy. The insurer alleged as follows: Weinberger, an individual "in the insurance business," approached 75-year old Calhoun, a New Jersey resident, to solicit Calhoun's participation in a premium finance life insurance transaction, whereby Calhoun would "apply for a life insurance policy and sell it for a profit without any cost whatsoever to Calhoun." Weinberger then introduced Calhoun to Gabriel Giordano, a licensed Lincoln National agent in California, in order to prepare an application for a life insurance policy covering Calhoun. Mr. Giordano introduced Calhoun to Chabner, a California resident, and on July 24, 2006, Calhoun established the Walter Calhoun Family Insurance Trust ("the Trust") with Chabner as the designated trustee. An application seeking a $3 million in life insurance policy for Calhoun's life, with the Trust as the proposed owner and beneficiary, was submitted to Lincoln National two days later, on July 26, 2008. In response to Question 4a on the application, which asked whether the applicant had engaged in any discussions regarding possible sale or assignment of the policy to "a life settlement, viatical or other secondary market provider," Calhoun or Chabner answered "No." Both Calhoun and Chabner signed the application and certified that all answers to the application's questions were "complete and true to the best of their knowledge." Lincoln National issued a life insurance policy insuring Calhoun's life, with the Trust as the Policy owner and beneficiary of the $3 million death benefit, but later sought to rescind it on two grounds, one of which was a material misrepresentation in the application. The defendants moved to dismiss the case.

The defendants argued that the insurer's material misrepresentation claim must be dismissed because: (1) the insurer would not have been legally entitled to deny Calhoun's application even if he had answered "Yes" to Question 4a; and (2) a statement of future intent cannot, as a matter of law, form the basis of a material misrepresentation claim. *Id*. at *15-16. The court rejected both arguments. It noted that the insurer's complaint states, and a supporting affidavit confirms, that its underwriters would not have issued the policy had Calhoun answered "Yes" to the question and found that insurance underwriters are entitled to deny coverage based on any number of legal activities that

would increase the risk of the contract, such as smoking, cliff-diving, and other activities that may present a risk to continued life. *Id.* at *16. As to the second argument, the court observed that the defendants' arguments had misread Question 4a, which clearly asks whether, at the time he submitted the application, Calhoun had engaged in any discussions regarding potential sale of the policy to a stranger investor, and not whether he intended in the future to sell the policy. *Id.* The court denied the defendants' motion to dismiss the insurer's misrepresentation count. *Id.*

2. Insurable Interest

In *Sun Life Assurance Co. of Canada v. Paulson*, 2008 U.S. Dist. LEXIS 99633 (D. Minn. 2008), the insurer filed a complaint seeking rescission of seven life insurance policies obtained by defendant Paulson. The insurer had issued a $2 million policy to Paulson on October 11, 2002, and on October 6, 2004, issued six more policies with $15 million in total benefits. Predicting how the Minnesota Supreme Court would rule, the court stated that:

> "'A life insurance policy is void as against public policy if the policy was procured under a scheme, purpose, or agreement to transfer or assign the policy to a person without an insurable interest in order to evade the law against wagering contracts. Moreover, the mutual intent of the insured and the third party to avoid the prohibition on wagering contracts determines the existence of such a scheme, purpose, or agreement. The most important factor in determining the parties' intent is whether or not the assignment from the insured to the third party was done in pursuance of a preconceived agreement.'"

Id. at *3-4 (citation omitted). The insurer argued that Paulson's unilateral intent to transfer the disputed policies at the time of their procurement renders the policies void *ab initio.* However, the court found that evidence of the intent of a third party to buy the policies at the time they were procured was required, which necessarily requires identification of that party. *Id.* at *10. The court wrote that Paulson's intent "'is irrelevant without facts suggesting that a third party lacking an insurable interest intended, at the time Paulson procured the policies, to acquire them upon expiration of the contestability period.'" *Id.* (citation omitted). Because the insurer had alleged no such evidence – and had uncovered none in discovery – the defendants were entitled to judgment on the pleadings. The court also refused to certify the case to the Minnesota Supreme Court.

The insurer made a similar lack of insurable interest claim in *Calhoun, supra.* Reviewing the laws of New Jersey and California, the court observed that both required an insurable interest to exist at the time a life insurance policy is issued. *Id.* at *18. The statutory definitions of "insurable interest" recognized that an individual has an insurable interest in his own life or the life of a close blood relation, and also where there exists "an expectation of pecuniary advantage through the continued life" of the insured. *Id.* "Additionally, under the law of both jurisdictions, an individual who obtains life

insurance on his own life is permitted to transfer ownership of the procured policy to a person or entity that lacks an insurable interest." *Id*. "Insureds begin to run afoul of the insurable interest requirement, however, when they intend at the time of the policy's issuance, to profit by transferring the policy to a stranger with no insurable interest at the expiration of the contestability period." *Id.* The court declined to rule on this issue in the context of a motion to dismiss; "Compelling policy considerations are raised by either position. This Court finds that because issues of intent are crucial to this determination, dismissal at this juncture would be premature." *Id*. at *21. The court allowed the insurer to proceed and attempt to discover whether, and with whom, Calhoun had arranged to sell the policy at the time the application was submitted. *Id*. *See, also, Life Prod. Clearing LLC v. Angel*, 530 F. Supp. 2d 646, 655-56 (S.D.N.Y. 2008) (apparently focusing on the insured's intention, the court found that the counterclaim alleged sufficient facts to support a plausible claim that the insured intended to transfer the policy prior to procuring it and that "[s]uch a scheme surely could amount to an impermissible attempt to circumvent the prohibition on wager policies").

III. Accidental Death & Dismemberment Update

A. "Accidental Death" and "Accidental Means" – *Wickman v. Northwestern*

Courts usually find that a beneficiary must show that an insured died as a result of an accident. *See, e.g., Call v. American International Group, Inc*., 2008 U.S. Dist. LEXIS 45446, *20 (S.D. W.Va. 2008). Historically, there was a distinction between an "accidental death" and "accidental means." Typically, "accidental means" policies require an insured to show that, if the means were intentional, the death resulted from some intervening element of force or violence. On the other hand, "accidental death" policies merely require the insured to show that the death was unforeseen. *See, e.g., Schar v. Hartford Life Ins. Co.*, 242 F. Supp. 2d 708, 715 (N.D. Cal. 2003). "Accidental death" coverage tends to be broader than "accidental means" coverage. "The modern trend is to reject the distinction between accidental means and accidental results when considering whether a particular death or injury is accidental." *Id.* at 751. Yet, there are a number of jurisdictions that continue to adhere to "accidental means" as a category of accidental insurance liability distinct from, and more restrictive than, other categories of accident liability insurance. *See Buce v. Allianz Life Ins. Co*., 247 F.3d 1133, 1144 (11th Cir. 2001).

In some recent cases under state law, courts have focused on the individual insured. In *Smith v. Stonebridge Life Ins. Co*., 582 F. Supp. 2d 1209 (N.D. Cal. 2008), the court found that under California law, "accidental death" occurs where "the death of the insured was objectively unexpected, unintended, and happened out of the usual course of events," and that coverage exists unless the insured "virtually intended his injury or death." *Id.* at 1216 (citation omitted). *See also Donegal Mut. Ins. Co. v. Baumhammers*, 938 A. 2d 286, 292 (P.A. 2007) ("an unexpected and undesirable event occurring unintentionally, and that the key term in the definition of the 'accident' is 'unexpected' which implies a degree of fortuity").

In the context of federal common law as it has been developed under ERISA, perhaps the most cited case is the seminal decision *Wickman v. Northwestern Nat'l Ins. Co*., 908 F.2d 1077 (1st Cir.1990), in which the First Circuit discussed, but chose not to follow, the "accidental means" and "accidental death" approaches in an ERISA case. Rather, the court applied the following analysis that includes both subjective and objective factors:

> [T]he reasonable expectations of the insured when the policy was purchased is the proper starting point for a determination of whether an injury was accidental under its terms.
>
> If the fact-finder determines that the insured did not expect an injury similar in type or kind to that suffered, the fact-finder must then examine whether the suppositions which underlay that expectation were reasonable . . . . If the fact-finder determines that the suppositions were unreasonable, then the injuries shall be deemed not accidental. The determination of what suppositions are unreasonable should be made from the perspective of the insured, allowing the insured a great deal of latitude and taking into account the insured's personal characteristics and experiences . . . .
>
> Finally, if the fact-finder, in attempting to ascertain the insured's actual expectation, finds the evidence insufficient to accurately determine the insured's subjective expectation, the fact-finder should then engage in an objective analysis of the insured's expectations. In this analysis, one must ask whether a reasonable person, with background and characteristics similar to the insured, would have viewed the injury as highly likely to occur as a result of the insured's intentional conduct. An objective analysis, when the background and characteristics of the insured are taken into account, serves as a good proxy for actual expectation. Requiring an analysis from the perspective of the reasonable person in the shoes of the insured fulfills the axiom that accident should be judged from the perspective of the insured.

Id. at 1088. This is sometimes called a subjective/objective analysis. *Wickman* has been followed by a number of federal courts, especially in ERISA cases.

An interesting case demonstrating different approaches to defining an accident is *Tyler v. AIG Life Insurance Company*, 273 Fed Appx. 778 (11th Cir. 2008). The insured "opened the passenger door and jumped from the moving vehicle being driven by her boyfriend with whom she had been having an argument." *Id*. at 780. She suffered a head wound that caused her death two days later. *Id*. Benefits were denied on the basis that her injury was not caused by an "accident." *Id*. at 781. The court ruled in favor of the claimant. The claim was governed by ERISA, but a *de novo* standard of review applied, as did state law on AD&D benefits. *Id*. at 781. The policies did not define "accident" and the court applied Alabama law, finding that it did not conflict with ERISA federal

common law. *Id*. The legal question presented was whether Alabama applies a purely subjective or a combined subjective/objective test to determine whether the insured's conduct was intentional or accidental. *Id*. The court noted that under the former, the beneficiary would prevail because the death is presumed to be accidental and the insurer could not prove the insured intended to take her own life or that she had a basis for believing that by jumping from a slowly moving vehicle serious injury or death would be a virtual certainty. *Id*. On the other hand, if the latter approach applied, then objectively the insured, using the reasonable person approach, would clearly have foreseen that serious injury or death could result from her actions and the insurer would prevail. *Id*. The court concluded, based on state law precedent, "Alabama determines whether a death is 'accidental' for insurance purposes based solely on the subjective intent of the insured." *Id*. at 784. The court acknowledged that *Wickman* calls for a subjective/objective test under ERISA, but concluded that the choice of law provision in the policies controlled and Alabama law provides more coverage and protection to beneficiaries, an express purpose of ERISA, so there was no conflict. *Id*.

B. Time Between an Accident and a Death

Some AD&D policies have provisions which require that a death occur within a specified time period from an accident. In *Craven v. Stonebridge Life Ins. Co*., slip op., No. 8:07-cv-1788-T-23MAP (M.D. Fla. Aug. 13, 2008), the insured was involved in an automobile accident, leaving him in a persistent vegetative state. He died 92 days after the accident. However, the applicable AD&D coverage required that a covered person suffer a loss within 90 days from the date of the accident, which caused such injury. The plaintiff argued the provision was ambiguous and against public policy, and that the insured had lost all independent life function when his vehicle crashed and was kept alive only through artificial means. The court, applying Illinois law, granted summary judgment to the insurer, finding this argument unreasonable. *Id*. at 7. "[I]t is impracticable to suggest that the term 'Loss of Life' means anything other than 'death.'" *Id*. at 7-8. Also, the court noted that insurers are permitted to limit their liability and set forth conditions so long as they do not conflict with statutes or public policy, neither of which was violated. *Id*. at 12-13.

C. Pre-existing Condition or Accident

1. Coverage Language

Cases that involve deaths resulting from the combination of an accident and a pre-existing condition often hinge on the specific language used in the policy. The tests that courts have applied vary, but include: whether the pre-existing condition substantially contributed to the loss; whether an injury took place independent of all other causes; whether the accident was the sole cause of the injury; or whether the accident set in progress a chain of events leading directly to death.

Some courts look at whether a pre-existing condition substantially contributed to the loss. In *Hall v. Met. Life Ins. Co.*, 259 Fed. Appx. 589 (4th Cir. 2007), the insured died of an allergic reaction (anaphylactic shock) in response to a bee sting. The insurer

denied benefits under an exclusion "for losses contributed to or caused by: Disease . . . [p]hysical or mental impairment . . . ." *Id.* at 591. Under ERISA, the court applied a two-prong test: (1) whether there is a pre-existing disease, pre-disposition or susceptibility to injury; and (2) if so, whether this pre-existing disease, pre-disposition or susceptibility substantially contributed to the loss. *Id.* at 595. As to the first prong, the fact that the medical records of the insured failed to reveal any such allergy did not mean that no such condition actually existed. In fact, the medical documentation "compels" the finding that the insured's bee-sting allergy is a "pre-existing disease, pre-disposition, or susceptibility to injury." *Id.* As to the second prong, the court found that the insured's allergy substantially contributed to his death. *Id. But see Crisler v. Unum Ins. Co. of America*, 233 S.W. 2d 658, 663 (Ark. 2006) (where the insured died from anaphylactic shock resulting from an allergic reaction to an injected drug, the court found the death was accidental and did not come within an exclusion for illness, disease or bodily infirmity because an allergic reaction does not qualify as a disease; "If the insurance company wishes to exclude allergic reactions to drugs from coverage under a particular policy, it may do so by the use of specific language, but it cannot accomplish this by the use of the terms 'disease' or 'bodily illness'").

In *York v. Peoples Benefit Life Ins. Co.*, 2008 U.S. Dist. 8585 (W.D. Ky. 2008), the insured, while suffering from multiple sclerosis and quadriplegia, died after choking on scrambled eggs. *Id.* at *1-3. The relevant policy language defined "injury" as "bodily injury caused by an accident, directly and independently of all other causes" and provided that "[b]enefits will not be paid for any loss caused by sickness or other bodily disease or infirmity." *Id.* at *2. Construing state law, the court noted that a pre-existing disease or infirmity will not be considered as a cause unless it "substantially contributed" to the death. *Id.* at *9. The court concluded that there was conflicting evidence which created a jury question whether the MS "substantially contributed" to her death, and thus denied the insurer's motion for summary judgment. *Id.* at *10-11.

Other courts, citing the language of the policy, have looked to whether an injury took place independent of all other causes. In *Chavez v. GHS Property and Casualty Ins. Co.,* 2008 U.S. Dist. LEXIS 48134 (S.D. Tex. 2008), the policy at issue defined an accident as a "sudden and unforeseen event causing loss or injury, which is . . . independent of all other causes." *Id.* at *13. The insured was involved in an automobile accident, but was not injured. Later that same day, he died of an "anterior myocardial infarction." *Id.* at *2-3. The insured's treating doctor, however, stated that in his opinion the accident had a "significant impact" on the insured and precipitated his massive heart attack and subsequent death. *Id.* at *15. The court ruled for the defendants. Even assuming the accident did contribute to the heart attack, the record did not support an inference that death resulted from the accident "independent of all other causes." *Id.*

Similarly, in *Alstork v. AIG Life Insurance Co.*, 2008 WL 2788062 (S.D. Ohio 2008), the insured was killed in a single vehicle accident but the deputy coroner opined that his death was due to "cardiac arrhythmia due to his heart disease." *Id.* at *2. The relevant policy language provided benefits for accidental death which was not "caused by or resulting from disease of any kind" and "injury" was defined as "[b]odily injury

caused by an accident . . . and resulting directly and independently of all other causes . . ." *Id*. at *1. The claimant furnished a report from the treating cardiologist who acknowledged the insured's congenital heart condition but stated that he was totally asymptomatic and did not display any signs to suggest a serious rhythm disorder. *Id*. at *3. The court upheld the insurer's determination that no AD&D benefits were payable, finding that its decision that the insured had a pre-existing medical condition that contributed to his death was not arbitrary and capricious. *Id*. at *9.

Another recent case along these lines is *Young v. Wal-Mart Stores, Inc*., 293 Fed. Appx. 356 (5th Cir. 2008). There, the insured had a long history of hypertension and ten days before his death he stopped taking his medication. *Id*. at 357-58. The doctor listed the cause of death as "[c]hoking resulting in syncope and vomiting and possible aspiration with severe hypertension and anoxic brain injury." *Id*. at 358. The death certificate, also signed by this doctor, listed the cause of death to be "respiratory arrest; choking--Foreign body aspirated into trachea; anoxic brain injury." *Id*. Hypertension was not mentioned and the doctor listed the manner of death to be an "accident." *Id*. However, the insurer's independent forensic pathologist opined that the real cause of death was uncontrolled hypertension. *Id*. The Fifth Circuit, applying a *de novo* standard, upheld the insurer's denial of AD&D benefits finding that it was reasonable to conclude that death was "caused in whole or in part by, or resulted" from sickness or disease because credible evidence conflicted with the treating doctor's final evaluation. *Id*. at 362-63.

Some other plans require that the accident must have been the sole cause of the injury and the injury the sole cause of the covered loss. *See, e.g.*, *Hancock v. Met. Life Ins. Co.,* 2008 U.S. Dist. LEXIS 58259, *22-27 (D. Utah 2008) (where policy required that the accident be the sole cause of the injury, the court upheld the insurer's denial under a discretionary review because there was no evidence that the insured had died of an accidental injury and the plaintiff did not carry her burden of proving that a covered loss occurred); *Honican v. Stonebridge Life Ins. Co*., 455 F. Supp. 2d 662 (E.D. Ky. 2006) (finding that a beneficiary must show that the accident was the "sole cause" of the insured's death); *Pearson v. Metropolitan Life Ins. Co.*, 2009 WL 35339 (N.D. Iowa 2009) (upholding the claims administrator's decision under a discretionary review, the court found that an accident was not "the sole cause of the injury" where an insured likely suffered a heart attack prior to a motor vehicle accident, causing him to lose consciousness).

Still other courts have made reference to a "chain of events," finding that a pre-existing illness does not bar recovery if an accident sets in progress a chain of events leading directly to death. For example, in *Evans v. Mutual of Omaha Insurance Co*., 2008 WL 802709 (Cal. Super Ct. 2008), the court upheld an insurer's decision to deny AD&D benefits when an insured died while at a casino. As he concluded his evening of gambling by standing up to say goodbye to his friends, the insured suddenly died of a heart attack. *Id*. at *1. The relevant policy defined stated that the injury "must result in covered loss independently of sickness and other causes." *Id*. at *4. The court rejected the plaintiff's argument that his death fell within the policy coverage provisions because

under California law a series of events (such as long existing degenerative disease) which finally culminate in a single harm is not considered to be an "accident." *Id*. The court noted that the presence of a pre-existing disease will not relieve an insurer from accident liability if the accident is the proximate cause of death, even though the disease actually contributed to the death, if the accident sets in progress the chain of events leading directly to death, or if it is the prime or moving cause. *Id*. at *6. This is true so long as the accident sets in progress the chain of events, or is the prime or moving cause, leading directly to death. Here, however, the insured simply stood up from his seat and death resulted from longstanding occupational disease -- not from any unusual physical exertion. *Id*.

Similarly, in *Feit v. Great West Life and Annuity Ins. Co.*, 271 Fed. Appx. 246 (3rd Cir. 2008), the insured was covered under a $1,000,000 life insurance policy with a double indemnity for accidental death. *Id*. at 248. The policy required that the insured's death result from bodily injury caused solely by accidental means and be the direct result of the accident and unrelated to any other cause. One morning, the insured's car drove off a highway, crashed through a guardrail, traveled down a grassy slope and finally struck a chain-link fence. *Id*. He was found dead at the accident scene, clutching his chest and biting his shirt. *Id*. The police and medical examiner's investigator stated that they did not see any cuts, lacerations, abrasions or bruises on his body. *Id*. The investigator also commented that the insured's widow later told him that her husband recently experienced chest and back pain, which she denied. *Id*. The medical examiner performed an autopsy and ruled the cause of death to be myocardial infarction. *Id*. at 249. No signs of trauma were found, however, no internal examination of the head and neck was performed. *Id*. at 249 n.3 The widow presented two medical experts who reviewed the autopsy findings and stated there were no findings of clots or thrombus and the amount of artery blockage found generally would not cause a heart attack. *Id*. They could not, however, rule out the possibility of a fatal arrhythmia. *Id*. at 250. A jury verdict was entered for the widow on the basis that the accident set in motion a chain of events that activated or excited a pre-existing condition which before the accident was only passive or dormant and not alone sufficient to cause death. *Id*. at 251. The district court granted the insurer's motion for judgment as a matter of law. The Third Circuit affirmed, finding that the widow failed, as a matter of law, to show that some unspecified bodily injury triggered or activated an underlying heart condition, which in conjunction with the injury, killed the insured. *Id*. at 252. Her argument that "it is common knowledge that a stressful event like a violent car accident can cause bodily injury that triggers a cardiac event" was found to be "far too speculative." *Id*.

2. Exclusions

In these cases, there often is an exclusion that precludes coverage for a death caused by an illness, sickness and/or disease. Courts' analyses of this type of exclusion have varied. In *Kellogg v. Metropolitan Life Ins. Co.*, 549 F.3d 818 (10th Cir 2008), the insured, covered under an ERISA plan, died from injuries sustained in a single vehicle crash. *Id*. at 820. A witness told police that the driver appeared to suffer a seizure and did not apply his brakes before hitting a tree. *Id*. The coroner ruled that death resulted

from traumatic injuries sustained in the car crash, but the insurer determined that a reaction to the prescription drugs that the insured had been taking was seizures, and denied the claim under a plan exclusion "for any loss caused or contributed to by: 1. physical . . . illness or infirmity." *Id*. at 821-23. Applying a *de novo* standard of review, the court held the physical illness exclusion was inapplicable. *Id*. at 828-33. "[C]ourts have long rejected attempts to preclude recovery on the basis that the accident would not have happened but for the insured's illness." *Id*. at 831. "While the seizure may have been the cause of the crash, it was not the cause of [the insured's] death. The Plan does not contain an exclusion for losses due to accidents caused by physical illness, but rather excludes only losses caused by physical illness. Because there was no evidence that the seizure caused [the insured's] death, [the insurer's] argument fails." *Id*. at 832.

In a case arising under state law, *Inglis v. Life Ins. Co. of North America*, 2008 U.S. Dist. LEXIS 39422 (S.D. Ind. 2008) involved an exclusion "contributed to by disease, Sickness, mental or bodily infirmity." The insured was injured in a fall and died two and one-half weeks later of a pulmonary embolism. *Id*. at *4-9. The coroner ruled his death as being caused by arterioschlerotic cardiovascular disease. In court, plaintiff's experts testified the insured's signs were "classic" of a massive pulmonary embolism, which formed when the insured, having severely injured his back, barely could move out of his bed. *Id*. at *27-8. The insured had no pre-existing clinical symptoms of coronary artery or heart disease. *Id*. at *13. The court accepted the plaintiff's testimony, finding the coroner to be a chiropractor and unqualified to render a "meaningful" opinion as to the insured's cause of death." *Id*. at *10. There was no evidence that the insured's fall or embolism was caused or contributed to by disease or sickness and, as an exclusion, the insurer had the burden of proof on this issue, which it failed to meet by a preponderance of the evidence. *Id*. at *23, 26-27.

On the other hand, in *Roznowski v. Liberty Life Ins. Co.*, 2008 U.S. Dist. LEXIS 72745 (E.D. Mich. 2008), the court upheld an insurer's reliance on a similar exclusion for a death that "results directly or indirectly from disease, illness or infirmity of the body or mind." *Id*. at *5. The insured died while sleeping. *Id*. at *2. He had a long history of COPD and severe obstructive sleep apnea. *Id*. at *2-4. Due to the apnea, his doctors prescribed a continuous positive airway pressure device which produces a constant flow of airway pressure and the insured used this device for six years. *Id*. A renewal prescription was not filled properly and the insured notified the manufacturer. *Id*. He was told to use the new device until an exchange could be made. *Id*. He died that night and a pathologist ruled his death to be cardiomyopathy along with pulmonary edema. *Id*. at *4-5. The claimant argued the improper device furnished caused the Insured's death. The court, applying Michigan law, disagreed. The court said that the beneficiary must establish that death was not related to an illness or disease, which she failed to do. *Id*. at *10. The reason the insured needed the medical device was his breathing difficulties associated with pulmonary disease, and this disease played an indirect role in his death. *Id*.

D. Medical Malpractice and Medical Procedures

Nationally, the cases are across the board on whether and when a death resulting from medical malpractice or a medical procedure is an accident. *See Couch on Insurance 3d*, "Coverage for Harm Related to Medical Procedures; Surgery," §§ 141:79-141:89; "Death During or Allegedly Resulting From Surgery as Accidental or From Accidental Means within Coverage of Health or Accident Insurance Policy," 91 ALR 3d 1042. The cases generally seem to fall into several basic categories: (1) Cases holding that death or injury resulting from medical malpractice does not constitute an accidental injury; (2) Cases finding that, in the absence of a mishap, death resulting from surgical procedures are not accidents; (3) Cases holding that a death from medical malpractice is accidental; (4) Cases holding that death from a medical procedure is accidental if it were not reasonably expected; and (5) Cases where the policy contains an exclusion for medical treatment.

1. Medical Malpractice Not An Accident

There are cases in which courts, mostly deciding appeals under ERISA, have held that deaths or injuries resulting from medical procedures and/or malpractice do not constitute accidents. *See*, *Senkier v. Hartford Life & Accident Ins. Co.*, 948 F.2d 1050 (7th Cir. 1991) ("Medical treatment is often risky and when the risk materializes and the patient dies we do not call it dying in or because of an accident; it is death from sickness. [T]he presence of negligence or other fault does not convert a medical or any other mishap into an accident. . . . A medical mishap, whether or not caused by negligence, is . . . not an accident . . . .").

In *Corum v. Hartford Life and Accident Ins. Co.*, 553 F. Supp. 2d 800 (E.D. Ky. 2008), the insured had coronary artery disease and was hospitalized for a procedure but complications arose, especially from the use of a certain device. *Id*. at 802. Remedial surgery was tried, without success, and the insured died. *Id*. The beneficiary argued that death resulted from medical negligence or product failure due to the malfunctioning device used during the procedure. *Id*. at 803. Applying an arbitrary and capricious standard of review in this ERISA case, the court affirmed the denial of benefits. As to whether the accident was caused directly and "independently of all other causes," the court found that this language meant that a pre-existing condition will bar recovery if it was "a contributing cause or substantial contributing cause of death." *Id*. at 806. Here, the administrative record was not totally clear on whether the coronary artery disease contributed to the death. *Id*. at 807. However, there was some evidentiary support for this conclusion and under ERISA's deferential standard; the administrator's decision will be affirmed if there is some reasoned explanation, based on the evidence, for a particular outcome. *Id*.

2. If No Mishap, Death Is Not An Accident

Another line of cases appears to hold that, unless there was a mishap during a medical procedure, a death resulting to an insured is not an accident for the purpose of

AD&D benefits. For example, in *Beneficial Standard Life Ins. Co. v. Forsyth*, 447 So.2d 459 (Fla. App. 2 Dist. 1984), the insured died following an elective jaw-wiring surgical procedure. The court concluded that, "There was no misstep or miscue during the operation to Mr. Forsyth. The embolism and death were foreseeable, albeit unanticipated results of this surgical procedure." *Id*. at 462. *See also Pennsylvania Life Ins. Co. v. Aron*, 739 So.2d 1171, 1173 (Fla. App. 3 Dist. 1999).

3. Medical Malpractice Is An Accident

Other cases have held that if an insured dies as a result of medical malpractice, it is accidental for the purposes of AD&D coverage. In *Smith v. Continental Casualty Co*., 2007 U.S. Dist. LEXIS 51125 (N.D. Ga. 2007), the insured suffered a disability as a result of a screw being placed on the wrong place during spine fusion surgery. The policy at issue provided benefits if a loss were the result of an accident. Although the misplacement of the screw during surgery was a known risk of the procedure, and thus was foreseeable, the court concluded that it still constituted an accident. Applying a *de novo* review under ERISA, it found that the terms "accident" in the policy was subject to multiple reasonable constructions, was therefore ambiguous and must be construed against the drafter. The court construed "accident" to mean "an injurious event that may be foreseeable, but is unintended and not reasonably expected to occur." *Id*. at *25. *See, also*, *Swisher-Sherman v. Provident Life & Accident Ins. Co.*, 1994 U.S. App. LEXIS 28768, *5 (6th Cir. 1994); *Whetsell v. Mut. Life Ins. Co. of N.Y.*, 669 F.2d 955, 957 (4th Cir. 1982); *The Michael J. Borrelli Family Trust v. UnumProvident Corp.*, 2002 U.S. Dist. LEXIS 722 (N.D. Ill. 2002); *cf. Fegan v. State Mut. Life Assurance Co. of America*, 945 F. Supp 396 (D. N.H. 1996).

4. Death From Medical Procedure Not An Accident If Not Reasonably Foreseeable

Another line of cases has found that if an insured dies from a medical procedure and his death could not have been reasonably expected, it is accidental for the purposes of AD&D benefits. For example, in *INA Life Ins. Co. v. Brundin*, 533 P.2d 236 (Alaska 1975), the court found that the accidental death policy at issue covered "results and conditions which are unexpected and unforeseen and hence 'accidental' in common usage." *Id*. at 242-43. It also noted that the insured's death occurred during a routine hemorrhoid procedure, "in which the risk is ordinarily not substantial, so the insured cannot be said to have foreseen the result." *Id*. at 243 n.24. *See also Bornstein v. J. C. Penney Life Ins. Co.,* 946 F. Supp. 814 (C.D. Cal. 1996).

5. Exclusions For Medical Treatment

A number of decisions have turned on whether or not the policy in question contained an exclusion for medical treatment. *See generally* "What Constitutes Medical or Surgical Treatment, or the Like, Within Exclusionary Clause of Accident Policy or Accidental Death Feature of Life Policy," 56 ALR 5th 471.

In *Brown v. Stonebridge Life Ins. Co.*, 2008 WL 4610294 (N.D. Ill. 2008), the policy had an exclusion from coverage for an injury that "is due to disease, bodily or mental infirmity, or medical or surgical treatment of these." *Id*. at *1. The insured, suffering from rectal bleeding, with a history of diverticular disease and other gastrointestinal problems, underwent a colonoscopy, resulting in the perforation of the colon and subsequent death. *Id*. Benefits were denied under the exclusion for medical or surgical treatment. *Id*. The plaintiff argued a colonoscopy is simply a diagnostic procedure and not performed as part of "medical or surgical treatment." *Id*. at *2. Under state law, the court found for the insurer. A colonoscopy, as part of a routine cancer screening, when no symptoms are exhibited may not fall into the category of medical treatment. However, in the present case, even though the colonoscopy was diagnostic in the sense of trying to determine the cause of the rectal bleeding, the court found that it fell within a definition of "treatment" as taking steps to "'remedy or improve a malady.'" *Id*. at *4 (citation omitted). The court also found that the word "treatment" in the exclusion was not ambiguous. *Id*. at *6. *See also Brooks v. J. C. Penney Life Ins. Co.*, 231 F. Supp. 2d 1136 (N.D. Ala. 2002) (an exclusion for "medical or surgical treatment" included diagnostic procedures). *Contra*, *Franceschi v. American Motorists Ins. Co*., 852 F.2d 1217, 1220 (9th Cir. 1988) (finding that the term "medical treatment" contained in a pre-existing condition exclusion to be ambiguous as it related to a colonoscopy).

Similarly, in *Corum, supra,* the ERISA plan had exclusions for losses resulting from a sickness or disease, or medical or surgical treatment of a sickness or disease. *Id*. at 802. The insured was hospitalized for a procedure but complications arose. *Id*. Remedial surgery was tried, without success, and the insured died. *Id*. The beneficiary argued that death resulted from medical negligence or product failure due to the malfunctioning device used during the procedure. *Id*. at 803. The court, applying an arbitrary and capricious standard of review, upheld the administrator's decision to deny benefits under the "medical or surgical" exclusion. *Id*. at 808. The court found that it was rational that a death caused by a malfunctioning medical product used in treatment is excluded under the medical or surgical treatment exclusion. *Id*.

E. Overdose of Prescription Medicine

1. Whether the Overdose is an Accident

There is a split of authority as to whether a death from an overdose of prescription medication is an accidental death, and thus compensable. *See, generally,* Delano, Robert B. "Chip," "Overdose of Oxycontin and Other Painkillers," *DRI Life, Health and Disability News*, Winter 2008, at 11-16.

Some courts have found that an overdose death is an accident. In *Gower v. AIG Claim Services, Inc*., 501 F. Supp. 2d 762, 773-74 (N.D. W.Va. 2007), the court applied a *de novo* standard of review and *Wickman*, finding that the common meaning of "accident" is an "unexpected" event, and that the totality of the evidence in the record weighed in favor of the conclusion that the insured did not expect his actions to result in death. *See, also, Santaella v. Metro. Life Ins. Co.*, 123 F.3d 456 (7th Cir. 1997); *Andrus v. AIG Life Ins. Co.*, 2005 U.S. Dist. LEXIS 8525 (N.D. Ohio 2005).

Other courts have found the issue to be one of fact for a jury to decide. In *Smith v. Stonebridge Life Ins. Co.*, 582 F. Supp. 2d 1209 (N.D. Cal. 2008), the insured was found dead in her home with a bottle of oxycodone containing only one pill (another pill was found on the floor). *Id*. at 1213. Two weeks before, the prescription had been filled for 180 tablets. *Id*. Her doctor had warned the insured about the risk of taking the medication, including the risk of an overdose, and told her not to take more than what was prescribed. *Id*. The insurer denied AD&D benefits as non-accidental because the insured knew the risks of taking an overdose. At trial, the court denied the beneficiaries' motion for summary judgment on that issue. *Id*. at 1216. The judge noted that under California law "accidental death" occurs where "'the death of the insured was objectively unexpected, unintended, and happened out of the usual course of events.'" *Id*. (citation omitted). Coverage exists unless the insured "'virtually intended his injury or death.'" *Id*. (citation omitted). The fact that the insured took more oxycodone than prescribed was insufficient to bar recovery. The relevant question was whether the insured, when she took an excess of this drug, she had "'designed, anticipated' or 'virtually intended' her death." *Id*. (citation omitted). This was a question of fact for the jury. *Id*. at 1217.

However, AD&D benefits have been denied when a beneficiary had failed to prove that a death from an overdose of prescription medications was an accidental bodily injury. In *American General Life and Accident Ins. Co. v. Birchum*, 2008 U.S. Dist. LEXIS 90859 (E.D. Ky. 2008), the insured was found dead at home and the coroner stated he suspected death was due to "acute combined effects of oxycodone & trazodone." *Id*. at *3. The suspected cause of death was accidental. *Id*. The court granted summary judgment to the insurer under state law, finding that the beneficiary failed to meet her burden of proof to establish the insured died as the result of an accidental death. *Id*. at *10-11. The court noted that the death certificate was not admissible for determining whether the insured's death was accidental. *Id*. at *10. Other doctor opinions offered no support for the position that death was accidental. *Id*. at *10-11. The claimant acknowledged that the insured had a number of serious medical conditions including diabetes, hypertension, morbid obesity and depression. *Id*. "The fact is, somewhere between suicide and accidental death lie a number of other possible reasons for the decedent's death." *Id*. at *11.

2. Prescription Drug Exclusions

The wording of the exclusions can be important. *See, e.g., Hummel v. Continental Cas. Ins. Co.*, 254 F. Supp. 2d 1183, 1190 (D. Nev. 2003). For example, one type of exclusion uses the phrase "taken as prescribed by a physician" while another type uses the phrase "administered on the advice of a physician." "'Taken as prescribed by' [a physician] is a much stricter standard than 'administered on the advice of' [a physician] it requires exact adherence to the instructed dosages, whereas 'administered on the advice of' does not." *Id*. at 1190. More recent cases have made similar observations.

In *Smith v. Liberty Life Ins. Co.*, 535 F.3d 308 (5th Cir. 2008), the policy excluded deaths resulting "directly or indirectly, in whole or in part, from injury occurring while

under the influence of alcohol or . . . drugs (including but not limited to narcotics, hypnotics, and amphetamines) unless administered on the advice of a physician." *Id*. at 310. The insured was killed when his truck went off the road and struck two trees. *Id*. at 311. A subsequent autopsy determined that the primary cause of death was trauma, but acute ethanol and multi-drug intoxication were also listed as contributing causes. *Id*. The insured's system contained a potentially lethal amount of hydrocodone, as well as diazepam. *Id*. A doctor stated that these drugs would have impaired his mental and physical faculties, including his ability to drive, and opined that the drugs in the insured's system caused the accident which led to his death. *Id*. Applying Louisiana law, the court found the exclusion was more restrictive than the state's statutory language and thus applied the latter; *i.e.*, "The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of narcotics unless administered on the advice of a physician." *Id*. at 315. Nevertheless, the insurer prevailed. The court rejected the argument that the insurer had to show that intoxication was *the* cause of the accident. *Id*. The court found that the intoxication exclusion applied when an insurer can establish by a preponderance of the evidence that the insured was intoxicated to the point that he lost normal control of his mental and physical faculties and the intoxication was a contributing (not necessarily the sole) cause of the accident. *Id*. at 315-16.

In *Smith v. Stonebridge Life Ins. Co*., *supra*, the insured was prescribed oxycodone and was later found dead with a level of oxycodone in her system that was on the "low-end of potentially toxic." *Id*. at 1213-14. That amount exceeded the amount that had been prescribed. *Id*. The insurer relied on a policy exclusion for losses caused by or resulting from the insured's taking or using any narcotic, barbiturate or any other drug unless "taken or used as prescribed by a Physician" to deny AD&D benefits. *Id*. at 1214. However, the court found that this exclusion was less favorable than the state mandated provision; *i.e.*, "unless administered on the advice of a physician." *Id*. at 1220. The former would deny coverage for an overdose because the dosage exceeded that prescribed. *Id*. The latter would allow coverage as long as the drug causing death was prescribed to the insured, regardless of whether the prescribed dosage was taken. *Id*. at 1221. The court found the purpose of the statutory limitation is to exclude losses resulting from the illegal use of drugs, as opposed to the legitimate use of these drugs pursuant to a physician's advice. *Id*. at 1222-23.

3. Self-Inflicted Injury Exclusion

In *Gower, supra*, the policy excluded "any loss caused in whole or in part by, or resulting in whole or in part from . . . intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury" from coverage. The court observed that a "person's 'general cognizance' that an injury could result from his actions does not lead to the conclusion that he intended to inflict an injury." *Id*. at 775. It went on to state:

> AIG argues that a person need only have a general cognizance that an injury might result from his actions to trigger the Policy's exclusion. This Court, however, cannot conceive of a scenario in which a person who acts

> intentionally does not face unexpected and potentially injurious consequences. Because AIG's rationale defeats the purpose of life insurance coverage, the Court rejects it. Accordingly, in assessing whether the exclusion applies here, the relevant inquiry is whether [the insured] ingested a lethal dose of medications to purposefully injure himself.

Id. at 776. It concluded that he had not. *Id*.

F. Illegal Drugs or Non-prescribed Controlled Substances

Death from an overdose of drugs is more likely to be found not accidental if the policy is deemed to be an "accidental means" policy. *See, e.g., Weil v. Federal Kemper Life Ass. Co.,* 866 P.2d 774 (Cal.1994). On the other hand, if the analysis is based on an insured's intentions, such a death is more likely to be found accidental. *See, e.g., Marsh v. Metro. Life Ins. Co., Inc.*, 388 N.E.2d 1121 (Ill. Ct. App. 1979). Similarly, the application of an expectation analysis has resulted in the conclusion that an overdose was accidental. *See, e.g., Hardy v. Beneficial Life Ins. Co*., 787 P.2d 1 (Utah Ct. App. 1990). *Andrus v. AIG Life Ins. Co.*, 368 F. Supp. 2d 829 (N.D. Ohio 2005) (applying an expectation/intent analysis to find that an overdose was accidental in an ERISA case under a *de novo* review). Recently, the court in *Catledge v. Aetna Life Ins. Co*., 2009 U.S. Dist. LEXIS 4441 (D.S.C. 2009) remanded the claim so that evidence of intention could be developed. In that case, the insured died as the result of ingesting ethylene glycol (a chemical found in anti-freeze). *Id*. at *1. The insurer denied coverage, contending that the death was not accidental and that it fell within one of two plan exclusions for self-inflicted injury and/or death resulting from the intentional use of alcohol or intoxicants. *Id*. at *1-2. The court reviewed the decision under the abuse of discretion standard. *Id*. at *2. "Whether the death was accidental and whether one of the two cited exclusions applies turns on a single underlying determination: whether Decedent *intentionally* consumed antifreeze or some other substance containing ethylene glycol." *Id*. at *35 (original emphasis). It noted three possibilities: that the toxic substance was consumed accidentally, that it was consumed for the purpose of self-harm, or that it was consumed as an intoxicant. *Id*. at *39-40. After reviewing the facts know to the insurer, the court concluded that the insurer had improperly denied the claim. *Id*. at *52. Yet, it did not find the record adequate to support payment of benefits. *Id*. "This is because *any* decision as to Decedent's intent would be speculative based on the present record. The court, therefore, remands the matter to Aetna for further review by an individual not involved in the earlier review process." *Id*. (original emphasis).

On the other hand, applying the *Wickman* analysis, the court in *Ablow v. Canada Life Assurance Co.*, 2003 U.S. Dist. LEXIS 24873 (D. Conn. 2003) found that an insured's death by Ephedrine toxicity was not an accident. And, even where a death is deemed or assumed to be accidental, coverage can still be precluded by an exclusion. *See, e.g., Ablow, supra; Holsinger v. New England Mut. Life Ins. Co*., 765 F. Supp. 1279 (S.D. Mich. 1991); *Gerdes v. John Hancock Mut. Life Ins. Co.*, 199 F. Supp. 2d 861 (C.D. Ill. 2001) (the insured's cause of death was due to opiate and cocaine intoxication);

Landis v. Healthcare Resources Group, LLC, 2003 U.S. Dist. LEXIS 12025 (W.D. Mich. 2003) (finding that an intentional self-inflicted injury exclusion applied even if the insured did not intend to injure himself).

In addition to cases where the insured died directly from the effects of illegal drug use, there have been instances where AD&D benefits have been denied where the insured's use of such substances has contributed to his or her death. In *Heiple v. Jefferson Pilot Financial Ins. Co.*, 2008 U.S. Dist. LEXIS 1131 (E.D. Mich. 2008), the plan had an exclusion for any loss to which "a contributing cause" was "the voluntary use of drugs; except when prescribed by a physician." *Id*. at *3. The insured was killed in a two vehicle accident for which she was found to be at fault. *Id*. at *2. She failed to yield at a stop sign and pulled into the path of an oncoming vehicle. *Id*. at *11. There was no evidence of any highway obstruction or adverse weather conditions. *Id*. A toxicology screen determined the insured was under the influence of cannabis and cocaine. *Id*. The claimant argued that the insured had recently undergone surgery which resulted in her use of sedatives and she was taking medications which could result in false positives for these substances. *Id*. at *3-4. Additionally, he provided affidavits from seven co-workers, all of whom interacted with the insured the day of the accident and none of whom noticed any condition that suggested she was under the influence of drugs. *Id*. at *6. However, a review by a medical consultant concluded that these drugs would have been "significant and contributory" to the insured's motor vehicle accident. *Id*. at * 7. This medical opinion was unsuccessfully challenged by the claimant, who argued that this doctor had no qualifications in the fields of toxicology or pharmacology. *Id*. at *12. The court held in favor of the insurer, applying the arbitrary and capricious standard, finding that there was sufficient evidence in the administrative record to determine that the insurer's decision was reasonable. *Id*. at *11.

G. Alcohol Abuse/Poisoning

Some courts have concluded that deaths from acute alcoholism are not foreseeable and, thus, were accidental. In *Stischok v. Hartford Life Group Ins. Co.*, 2008 U.S. Dist. LEXIS 25424 (S.D. Ohio 2008), the insured, after imbibing at a New Year's Eve party, died. *Id*. at *3-4. An autopsy determined his blood-alcohol level was 0.34% and the coroner ruled his death to be caused by "acute ethanol drug effects." *Id*. at *4. The relevant plan provided that benefits would be paid for a bodily injury caused by an accident, which was defined as a "sudden, unexpected, unusual, specific and abrupt event." *Id*. at *5. The insurer denied the claim based, in part, on its conclusion that the death was not an accident. *Id*. at *8. Even though the insurer had discretion under the plan, the court found its decision to be arbitrary and capricious. Applying *Wickman*, the court found that the insurer's approach was wrong, in that it had focused on the insured's intentional conduct as being determinative of whether the injury was intentional. *Id*. at *24-25. The court found that there was no evidence of the insured's subjective intent. *Id*. at *25. As a result, it focused on the objective inquiry and concluded that a reasonable person, with the insured's background and characteristics, would not have viewed the injury as highly likely to occur as the result of his intentional conduct. *Id*. at *25-29. "Heavy drinking and driving greatly increase the risk of death, to the point that an

accident may be reasonably expected or even intended. The same conclusion does not arise from one who, in a friend's home with his family, drinks to an excess on New Year's Eve." *Id*. at *25.

On the other hand, finding that a death from acute alcoholism was foreseeable, some courts have upheld a determination that no accidental death benefits were payable. *See, e.g., Anderson v. Minnesota Life Ins. Co.* 2004 U.S. Dist. LEXIS 19803 (W.D. Va. 2004).

There have been some recent cases on alcohol exclusions. In *Loan v. Prudential Ins. Co.*, 2008 U.S. Dist. LEXIS 98249 (E.D. Ky. 2008), there was an exclusion for a loss if it resulted from "[b]eing legally intoxicated." *Id*. at *2. The insured died after falling down some steps. *Id*. He suffered blunt force head trauma. *Id*. Blood tests taken two hours after the fall indicated his plasma alcohol level was .178 mg. *Id*. Benefits were denied based on the exclusion. *Id*. at *3. Applying an arbitrary and capricious standard of review in this ERISA case, the court entered judgment for the insurer. The beneficiary challenged the insurer's reliance on blood plasma readings as opposed to whole blood levels. *Id*. at *7-8. However, the insurer had converted the plasma readings into whole blood readings and the result was that the insured's BAC was still almost two times the legal limit in the state. *Id*. at *8. The beneficiary also argued that under Kentucky law, the term "legally intoxicated" was ambiguous because he was at home when the accident took place, not driving. The court rejected a Kentucky Supreme Court decision holding that such exclusionary provisions were ambiguous due to various statutory definitions of "legal intoxication." It concluded that the insurer's interpretation was rational. "An ordinary person in Kentucky would likely agree . . . that 'legally intoxicated' refers to the 0.08% BAC limit" for DUI violations and is "probably unaware of any conflicting definitions under Kentucky law." *Id*. at *10.

Similarly, in *Hanna v. United of Omaha Life Ins. Co.*, 553 F. Supp. 2d 1064 (S.D. Iowa 2008), the exclusion was "for any loss which: (1) is caused by you, and is the result of injuries You receive, while intoxicated." *Id*. at 1066. "Intoxicated" was defined as a blood-alcohol level that is equal to or exceeds the legal limit for operating a motor vehicle in the state where the death occurs. *Id*. The insured was struck and killed by a truck while trying to flag down traffic late at night. *Id*. A toxicology analysis determined that his blood-alcohol level was 0.14%. *Id*. The court looked at the meaning of the word "caused." *Id*. at 1069. The beneficiary argued that "caused" meant "proximate cause," whereas the insurer contended it meant only that there be a causal relationship between the insured's conduct and his death. *Id*. The insurer argued that, by this definition, so long as the insured's conduct was a substantial factor in producing the loss, which would not have occurred except for his intoxication, the exclusion would apply. *Id*. at 1071. The court, applying an abuse of discretion standard, agreed with the insurer. *Id*. at 1072. It noted that the insured was intoxicated, dressed in dark clothes, and standing in a poorly lighted section of an interstate highway at 2:11 a.m. *Id*. at 1073. The court found that the insurer's interpretation was reasonable, supported by substantial evidence and it would not second guess the administrator's decision. *Id*. at 1074.

Some insurers have also invoked intentional self-inflicted injuries exclusions. In *Stischok, supra,* another ground for the insurer's denial in the case of an insured who died of alcohol poisoning was an exclusion for intentionally self-inflicted injury. *Id.* at *29. The policy did not have an alcohol exclusion, although a separate seatbelt and air bag benefit did contain such an exclusion. *Id.* at *5-6. The court rejected the insurer's argument that the death was intentionally self-inflicted. "Inherently risky activities . . . do not necessarily fall within the self-inflicted injury exclusions under ERISA plans." *Id.* at *35. Rather, an insured must have known that the risky behavior is likely to cause his or injury. *Id.*

H. Drinking And Driving

For a thorough article on this topic, *see* Schuman, Gary, "Driving Under the Influence: Drunk Driving and Accidental Death Insurance," *Tort Trial & Insurance Practice Journal*, Summer/Fall (2008).

1. Whether Drinking and Driving Constitutes An Accidental Death

Some courts and commentators have suggested that state courts typically find that deaths from drunk driving are accidental whereas federal courts often conclude otherwise, especially under a deferential review in ERISA cases. *See, e.g., Cranfill v. Aetna Life Ins. Co.*, 49 P.3d 703, 707 (Okla. 2002) ("The split is between the federal courts on the one hand and state courts on the other."); Gardner, Michael E., "Accidental Death Insurance Coverage of Drunk Drivers," 69 Mo. L. Rev. 235 (2004).

As recent cases have demonstrated, courts are less likely to find a *per se* rule of non-coverage should not apply, but rather that the fiduciary must "assess all the facts and circumstances attending a claim, afford the insured adequate opportunity to address the causes and circumstances surrounding any occurrence, and make a reasoned, principled assessment supported by substantial evidence." *Eckelberry v. Reliastar Life Ins. Co.*, 469 F.3d 340,347 (4th Cir. 2006). As a result, in most instances, the totality of the circumstances should be considered.

In *Stamp v. Metropolitan Life Ins. Co.*, 531 F.3d 84 (1st Cir. 2008), the First Circuit had an opportunity to apply its *Wickman* decision in the context of a DUI. The road conditions were dry, traffic was light and there were no adverse weather or driving conditions at the time of the insured's crash. *Id.* at 86. Nevertheless, the insured's vehicle left the road and struck a tree. *Id.* His blood-alcohol level was 0.265%, more than three times the state limit. *Id.* The First Circuit, applying an abuse of discretion standard, found that the administrator's decision to deny AD&D benefits was reasoned and supported by substantial evidence. *Id.* at 88. Following its own *Wickman* decision, the court noted that other courts in drunk driving cases had emphasized the decedent's level of intoxication when determining whether a plan administrator's denial of benefits was reasonable. *Id.* at 90. "We endorse this approach. The *Wickman* analysis does not require a categorical determination that all alcohol-related deaths are per se accidental or

nonaccidental. Rather, it leads us to consider the circumstances of the fatal event in question." *Id*. at 90-91. The court then reviewed the facts that the insured was "severely intoxicated;" the effects that such level of intoxication would have had on the insured; and that no other vehicle, object, mechanical failure, adverse weather or adverse road conditions were involved. *Id*. at 91. "In *Wickman* terms, it is not arbitrary and capricious to conclude that a reasonable person would view death or serious injury as a highly likely outcome of driving while so drunk that one may need help to stand or walk and is likely to black out." *Id*. The court found that statistics that many more people drive drunk than are injured or killed were "meaningless in this context" because they did not consider the individual's level of intoxication. *Id*. at 92. "Statistical analysis is simply not at the core of the Wickman analysis." *Id*. at 93.

A similar result was reached in *Lennon v. Metropolitan Life Insurance Co.*, 504 F.3d 617 (6th Cir. 2007). Driving his car "for the last time" at about 2:30 a.m., the insured "flew down a dry and well-lit divided boulevard . . . and into a wall." *Id*. at 618-19. His blood-alcohol level was 0.321%, more than three times the state's legal limit. *Id*. at 619. MetLife denied the AD&D claim on the grounds that the death was not an accident and that an exclusion for self-directed injuries applied. *Id*. at 620. Reversing the district court's holding in favor of the claimant, the Sixth Circuit found that the insurer did not act arbitrarily and capriciously when it found that the insured did not die as a result of the accident under the plan. *Id*. at 620. The insured's driving while legally intoxicated, with impaired mental and physical driving skills, created a significant risk of death to others and himself. *Id*. at 621. The court noted that "the very number of cases holding [that drunk driving is not an accidental bodily injury] supports the conclusion that MetLife's determination was not arbitrary and capricious." *Id*. at 622-23. Acknowledging that statistics showing relatively few deaths from DUIs in comparison to the number of incidents of DUIs, which the district court had cited, had some "logical force," the court questioned their relevance where the insured was significantly impaired – "extremely drunk" – because they do not account for the degree of intoxication. *Id*. at 623. The court did not reach the question of whether a fiduciary can reasonably deny AD&D benefits for an injury that results "from driving while only somewhat impaired." *Id*. at 624. There was both a concurring opinion and a dissent from the three-judge panel.

In *Grose v. Sun Life Assurance Co. of Canada*, 568 F. Supp. 2d 652, 656 (W.D. Va. 2008), the court, applying an abuse of discretion standard, stated, "The dangers of drunk driving are pellucid and any reasonable person knows or should know that drunk driving can result in serious bodily injury and death. And, when such death occurs, as it did here, it is not an accident within the meaning of ERISA." The court noted that the claimant argued that the insured "became intoxicated by unknown means sometime after his motorcycle crash, presumably while in the ambulance, in the hospital, or in the morgue. In support of these fantastical, though not impossible, scenarios, the plaintiffs have offered nothing." *Id*. at 655. *See also Arnold v. Hartford Life Ins. Co*., 542 F. Supp. 2d 471, 481 (W.D. Va. 2008) (the decedent's "death was reasonably foreseeable given that his alcohol consumption placed him well above the legal limit at the time of the crash that ultimately led to his death"); *Kovach v. Zurich American Ins. Co.*, 2008 U.S. Dist. LEXIS 104605, *14 (N.D. Ohio 2008) (the court observed that there is a "'near universal

accord that alcohol-related injuries and deaths are not accidental under insurance contracts governed by ERISA.'" (citation omitted)).

There is an interesting discussion of the *Wickman* factors in *McGillivray v. Life Ins. Co. of North America*, 519 F. Supp. 2d 157 (D. Mass. 2007). The insured crossed over the center line of a street and collided with a box truck. *Id*. at 159. His blood-alcohol level was 0.242%, well above the state's legal limit. *Id*. The court first found that an arbitrary and capricious standard of review in this ERISA was proper. *Id*. at 162. Turning to the merits, the court noted that there were difficulties in applying *Wickman* to a situation where the insured is impaired, including how the insured's impairment factors into this test. *Id*. at 164. It then reviewed existing case law on AD&D drunk driving cases. *Id*. at 164-66. Unlike in other cases, the claimant had not proffered any statistical evidence about the risks of injury or death from drunk driving; even if she had, the court observed such statistics would not be conclusive. *Id*. at 167. Finding that there was no evidence of the insured's subjective expectations, the court moved to an objective analysis of his expectations, asking whether a reasonable person, with the background and characteristics similar to the insured, would have viewed the injury as highly likely to occur as a result of his intentional conduct. *Id*. The court reviewed the events leading up to the insured's death, including his previous arrest for DUI and subsequent release, at which time the court assumed his judgment was no longer impaired. *Id*. at 168. The court looked at whether a reasonable person with the background and characteristics similar to the insured (an alcoholic for over 25 years, in and out of detox and at high risk for seizure, DTs and relapse) would have viewed the collision as highly likely to occur due to his intentional conduct. *Id*. at 169. The court found this insured would have seen injury or death as highly likely to occur due to this intentional conduct. *Id*.

However, in *Carter v. Sun Life Assurance Co*., 2006 U.S. Dist. LEXIS 28622 (E.D. La. 2006), the court found that the insurer had applied the wrong test under *Wickman* analysis. The insurer based its determination on a plan interpretation that would exclude coverage if the insured's death was "reasonably foreseeable and the natural and probable result" of his conduct. This interpretation used two standards, "reasonably foreseeable" and "natural and probable result," which the court noted have been treated as synonymous. This standard, the court found, was inconsistent with the standard laid out in *Wickman,* which requires that the fact-finder ask whether a reasonable person, similarly situated, would view death as highly likely to occur from the insured's conduct. The difference between the two standards was material, the court found, and the insurer's interpretation of the plan term was unreasonable and legally incorrect under a "sliding scale" deferential review. *Id*. at *19.

A recent decision under state law, *Sarac v. Minnesota Life Ins. Co*., 529 F. Supp. 2d 924 (N.D. Ill. 2007), involved an insured who attempted to pass a truck, lost control and collided with the rear of the truck's trailer. *Id*. at 925. His blood-alcohol level was 0.203%, more than twice the legal limit in Illinois. *Id*. at 926. Following state law, the court found that death can be considered to be accidental for such insurance purposes even when the insured "embarked upon voluntary and reckless criminal conduct which caused his death; as long as he did not intend to cause himself injury or death." *Id*. at

927. The court focused on the intent of the insured to cause his own death or serious injury as a determining factor of whether the cause of death was an accident. *Id*. at 929. It found that Illinois law does not follow tort or criminal principles regarding foresee ability. *Id*. Thus, the insurer must establish that the insured "both expected death or serious bodily injury to occur and that a reasonable person would regard death or serious bodily injury to be the natural and probable consequence from driving drunk." *Id*, at 929-30. *See, also, Collins v. Minnesota Life Ins. Co.*, 2006 U.S. Dist. LEXIS 2134, *6 (W.D. Mo. 2006) (the court in a diversity case found "unpersuasive defendant's argument that an automobile collision [was] not an accident if the driver [was] legally drunk. The submitted statistics are too low to prove that deaths and serious accidents are the natural and probable consequence of individuals who drive with blood alcohol levels above the legal limit"); *contra*, *Minnesota Life Ins. Co. v. Scott*, 330 F. Supp. 2d 661 (E.D. Va. 2004) (finding a DUI death not an accident under Virginia law).

Some courts have found policies to be ambiguous as to whether a DUI death is an accidental death. In *Gardner v. Hartford Life and Accident Ins. Co.*, 2008 U.S. Dist. LEXIS 69416 (W.D. Mo. 2008), the term "accident" was not defined. *Id*. at *2. The insurer moved for summary judgment that as a matter of law the insured's DUI death was not an "accident." The court found there is conflicting case law in Missouri regarding the issue of whether all deaths occurring while the insured is intoxicated are not "accidents," so the term is subject to various interpretations and thus was ambiguous. *Id*. at *4-10. The court noted that the case law (including a case involving Hartford) predated the issuance of the policy at issue, so that the insurer could have defined the term. *Id*. at *10. The court denied the motion for summary judgment. *Id*. Similarly, in *Blumer v. Globe Life and Accident Ins. Co.*, 2008 WL 5110570 (E.D. Mo. 2008), the policy defined "accident" as a "fortuitous event, unforeseen and unintended." *Id*. at *1. Citing *Gardner*, the court found that the term "accident" was broad and ambiguous. *Id*. at *9-10. The court interpreted the term in a manner ordinarily understood by the insured when purchasing the policy. *Id*. at 10. The court noted that, "A general rule that an alcohol-related collision is no longer an accident appears unwarranted absent substantially different scientific and statistical evidence." *Id*. at *11.

2. Whether Crime Exclusions Apply

Some of the exclusions refer to only felonies. For example, in *Steele v. Life Ins. Co. of North America*, 507 F.3d 593 (7th Cir. 2007), the insured drove with a BAC of 0.255% and was speeding to elude police when he crashed his vehicle. *Id*. at 594-95. The insured had two prior DUIs, and the insurer denied coverage based on a felony exclusion because a third DUI was a felony. Applying Illinois state law under a *de novo* review, the court found for the insurer. The beneficiary argued that because her husband was not actually convicted of a third DUI, the exclusion is not applicable. *Id*. at 596-97. She submitted an affidavit from the county prosecutor stating that had the insured survived, he would not have been charged with a felony. These arguments were rejected. The policy exclusion refers only to the "commission" of a felony, not a conviction. *Id*. at 597. "If the insured's conduct is punishable as a felony, the insured's commission of that conduct is enough to come within the language of the policy's felony exclusion

regardless of whether a felony *conviction* is actually sought or obtained." *Id*. (original emphasis).

Other exclusions refer to crimes and/or felonies. For instance, in *Carter v. Sun Life Assurance Co., supra*, an ERISA case, the policy stated that no accidental death benefits would be paid if the death results from intentionally self-inflicted injuries or the commission or attempted commission of an assault, felony or other criminal act. The insured died in a motor vehicle accident and was found to have blood alcohol concentration after the crash to be between 0.16% and 0.13%. The court found that the insured was engaged in the crime of committing a DUI, even though no charges were filed by any law enforcement authority. *Id*. at *25-26. The court found that it was thus reasonable for the insurer to infer that the insured's intoxication was the but-for cause of his death. *Id*. at *26. It also found that there was sufficient evidence in the administrative record to support a determination that the insured died in the commission of a vehicular homicide. *Id*. at *30. *Accord, Read v. Sun Life Assurance Co. of Canada*, 2008 U.S. App. LEXIS 4974 (5th Cir. 2008).

On the other hand, in *Lankford v. Webco, Inc.*, 545 F. Supp. 2d 961 (W.D. Mo. 2008), there was an exclusion in a medical coverage that denied benefits for "any loss associated with the Plan Member's commission or attempt to commit a felony or engaging in an illegal activity" and went to state that "[s]hould an individual accused of an aforementioned act(s) and who subsequently has the criminal charge dismissed or is acquitted of any criminal act, this exclusion shall no longer be applied." The insured was injured in a motor vehicle accident and was later found to have a BAC of 0.148%. Yet, she was not charged with any crime. In apparent dicta, the court noted that it would not be reasonable to exclude from this provision someone actually acquitted or where the charges dismissed, but to apply the exclusion to someone not actually charged at all with a crime. "It would be nonsensical for someone who had all charges dismissed against them [to] receive benefits under the Plan, but then deny benefits to someone never charged or convicted of any crime." *Id*. at 970.

A case outside of the context of ERISA, in *Minnesota Life Ins. Co. v. Scott*, 330 F. Supp. 2d 661 (E.D. Va. 2004), the insurer's alternative ground for not paying the AD&D benefits was that, even if there had been an "accidental death," coverage would be excluded because the death resulted from or was caused directly or indirectly by "the insured's participation in or attempt to commit a crime or a felony." The court agreed that this exclusion applied. *Id.* at 666. It found that the exclusion was not ambiguous. "When Decedent voluntarily drove while under the influence of alcohol, he participated in a crime." *Id*.

There are also exclusions that specifically address DUIs. For example, in *Fitts v. Life Ins. Co. of North America*, 2008 WL 3925319 (N.D. Ind. 2008), the policy contained an exclusion for any "[l]oss which, directly or indirectly, in whole or in part, is caused by or results from operating any type of vehicle while under the influence of alcohol." *Id*. at *2. "Under the influence of alcohol means intoxicated, as defined by the law of the state in which the Covered Accident occurred." *Id*. Applying a *de novo* standard of review, the court upheld the insurer's denial. *Id*. The court found that, under the policy language,

the insurer need not prove that intoxication was the sole or even the primary cause of the accident. *Id*. at *5. All that is necessary is the loss be "directly or indirectly, in whole or in part" attributable to driving while intoxicated. *Id*. The fact the insured was never criminally charged is irrelevant because a failure to be charged does not mean that the insured did not, in fact, commit a traffic violation. *Id*. *See, also, Pando v. Prudential Ins. Co. of America*, 524 F. Supp. 2d 848, 853-56 (W.D. Tex. 2007) (finding that an exclusion for "[a] loss is not covered if it results from while operating a motor vehicle, the person's illegal use of: (1) alcohol" was ambiguous (the beneficiary contended the exclusion applies only when the insured's actual drinking of alcohol is illegal such as if he had been underage), but still upheld the insurer's denial under an ERISA the abuse of discretion standard because its interpretation was reasonable).

3. Whether Alcohol Exclusions Apply

Generally speaking, there are two types of intoxication exclusions in accidental death policies: a "status" exclusion and a "causation" exclusion. A status exclusion in an accidental death policy precludes coverage to an insured if he is intoxicated, regardless of whether that intoxication had anything to do with the cause of his accidental death. A causation exclusion is one that applies in a situation where there is some causal link or connection between an insured's intoxication and his death. Of the two, causation exclusions are more common today and, indeed, are sometimes required by state statutes and regulations if an insurer desires to include an intoxication exclusion as part of its coverage.

(a) Status Exclusions

In *Empire Fire & Marine Ins. Co. v. Bennett*, 2008 WL 110388 (N.J. Super. A.D. 2008), the policy included an exclusion for any "[l]oss arising out of an 'accident' which occurs while the 'insured' is under the influence of alcohol or drugs, or other substances unless prescribed by a physician." *Id*. at *1 n.1. An insured became involved in an accident, injuring his passenger. *Id*. at *1. The insured pled guilty to the charge of DUI. *Id*. The passenger sued the insured and the insurer denied coverage based on the alcohol exclusion. *Id*. The passenger argued this exclusion was ambiguous and violated public policy and, as such, was unenforceable. The court disagreed, holding that such an exclusion does not violate public policy. *Id*. at *2.

(b) Causation Exclusions

Most cases have focused on causation exclusions. For example, in *Stevens v. Union Security Ins. Co.*, 2008 U.S. Dist. LEXIS 66497 (W.D. Va. 2008), the exclusion was for "loss result[ing] directly or indirectly from your intoxication, unless administered on the advice of a doctor; this includes but is not limited to operating a motor vehicle while you are intoxicated." *Id*. at *10. Further, "intoxication" was defined as "your blood alcohol level at death . . . exceeds the legal limit for operating a motor vehicle in the jurisdiction in which the loss occurs." The insured ran off the road to the right, struck a tree and then ran off the road to the left, resulting in the vehicle overturning and the driver being partially ejected. *Id*. at *5. There were no defects found with the car or

roadway. *Id*. A subsequent blood-alcohol test determined the driver had a level of 0.227% and the legal limit for driving in Virginia was 0.08%. *Id*. at *6. The insurer requested the opinion of a physician who concluded that with such a high blood-alcohol level, the driver would have been severely impaired in cognition and reaction, and would have been unable to properly and safely operate a motor vehicle. *Id*. at *7. The insurer's denial was upheld by the court applying a discretionary review under ERISA. *Id*. at *15.

In *Benoit v. Prudential Ins. Co. of America*, 2008 WL 2917492 (W.D.N.Y. 2008), the policy provided certain medical coverage, but had an alcohol exclusion if the loss resulted from the insured being legally intoxicated. *Id*. at *2. The blood tests were taken three hours after the accident, and the results were that the insured's blood-alcohol level was 0.15%. *Id*. at *3-4. Plaintiff was charged with DUI but in a plea bargain agreement pled guilty to the lesser offense of driving while impaired. The plaintiff argued that the accident really occurred because his cell phone dropped to the vehicle's floor and he lost control when reaching to pick it up. *Id*. at *4. He also argued that waiting three hours to administer the blood test affected the result. *Id*. The insurer's medical consultant determined that a blood-alcohol level three hours after the accident strongly suggested that the level was even higher at the time of the accident, and that such a level of blood alcohol was not caused by any post-accident medical treatment. *Id*. at *4. He also found that an individual with such a high level would, with a reasonable degree of medical certainty, unavoidably be considered functionally impaired and a significant risk of accident and contributor to the motor vehicle accident. *Id*. at *5. The court, applying the deferential arbitrary and capricious standard, upheld the insurer's decision under ERISA. *Id*. at *8-9.

There have been challenges to alcohol exclusions on the basis that they are ambiguous. In *Hill v. Aetna Life Ins. Co.*, 546 F. Supp. 2d 343 (S.D. Miss. 2008), the plan and the summary plan description had differing alcohol exclusion language. The plan excluded benefits where alcohol is a contributing factor in the employee's death, whereas the SPD stated that losses will not be covered "resulting from voluntary self-administration of any drug or chemical substance not prescribed by and taken according to the directions of a doctor." *Id*. at 446. The beneficiary argued these provisions are inconsistent and when the SPD conflicts with the complete plan document, a plan participant may seek relief based on the language contained in the SPD. *Id*. at 349. The court disagreed and, applying an arbitrary and capricious standard of review, granted summary judgment to the defendants, finding that there is no inconsistency because "[b]oth documents address alcohol, which is both a drug and a chemical substance." *Id*. at 350. It found that the SPD placed participants on notice that all losses incurred as the result of the voluntary self-administration of a chemical substance, such as alcohol, are not covered. *Id*. at 350-51.

On the other hand, in *Blumer v. Globe Life and Accident Ins. Co., supra*, the policy had an exclusion for death caused by the "Insured's intoxication (blood alcohol level of .10 percent weight by volume or higher)." *Id*. at *2. The medical examiner's investigation determined that he died from blunt trauma and a significant condition was the insured's acute ethanol intoxication (0.169% blood alcohol and 0.0248% vitreous

alcohol), which exceeded the state's legal driving limit of 0.08% BAC. *Id.* at *3. The insurer denied AD&D benefits on two grounds, including that the death was caused by the insured's intoxication (blood alcohol level of .10 percent weight by volume or higher). In denying the insurer's motion for summary judgment on that ground, the court found that the wording of the exclusion meant that the intoxication must be the cause of death, not a cause of death. *Id.* at *14-15. Although the medical examiner's report stated the death resulted from trauma, and probable contributing factors were intoxication, the court said that these facts do not support the argument that intoxication was <u>the</u> cause of death, so there is a genuine issue of material fact as to whether the death was "caused by" intoxication. *Id.* at 15. The court also noted the policy did not contain an exclusion for driving while intoxicated or having a BAC over the state legal limit. *Id.* at *15-16 n. 6.

Gardner v. Hartford Life and Accident Ins. Co., *supra*, is class action that alleging an exclusion – for "injury sustained as a result of being legally intoxicated from the use of alcohol" – is ambiguous as applied by the insurer to deny coverage in all cases seeking benefits for injury or death when the insured is intoxicated. This may be a case to watch as it moves forward.

4. Whether Self-Inflicted Injury Exclusions Apply

In *Lankford v. Webco, Inc., supra*, the group health plan had a "Self-Inflicted and/or Intentional Injury" exclusion that stated, in part, that any injury which is "incurred as a result of the Plan Member's use of alcohol or drugs, in excess of the state or federal statute." *Id.*, at 964. The dependant of a covered employee was involved in a single car accident and her blood-alcohol level was 0.148%, which exceeded the .08% limit set by state law. *Id.* The plan administrator argued that the exclusion was meant to exclude expenses incurred as the result of injuries or illnesses which are either self-inflicted or intentional, and that wrecking a car driving late at night at an excessive speed and legally intoxicated constituted a self-inflicted injury regardless of whether the consequences were intentional. *Id.* at 971. Applying an abuse of discretion standard of review, the court found that the plan administrator's interpretation of the exclusion to be reasonable. *Id.* The court found that the plan drafters intended to exclude losses where the alcohol level of the plan member violates state criminal laws. *Id.* The plan administrator also reached a rational conclusion that illegal alcohol consumption contributed to the accident by reviewing the police and hospital laboratory reports. *Id.* at 972.

On the other hand, in *Carter v. Sun Life Assurance Co., supra*, the court noted that the insurer could not deny AD&D benefits based on a self-inflicted injury exclusion. "Here, while the record supported the inference that [the insured] intended to drink and drive, there was no evidence that he subjectively intended to harm himself. Drinking and driving, like the use of illicit drugs, is risky behavior frequently engaged in by people who do not seek to injure themselves. Because the decision to drink and drive without the intent to cause injury is insufficient to support a denial of benefits, [the insurer's] decision can not be upheld on this basis." *Id.* at *32.

I. Suicide and Certain Intentional Acts

The determination of whether accidental death benefits are payable when an insured takes his own life often hinges on the intent of the insured and the application of certain exclusions, including those concerning intentional self-inflicted injuries.

In *Thomas v. Reliance Standard Life Ins. Co*., 487 F. Supp. 2d 697 (D.S.C. 2007), the insured died in his car while parked in front of the graveyard where his father was buried. *Id*. at 699. On the day before he died, the insured told his mother that he was going to kill himself at his father's grave. *Id*. The insured had been going through a divorce and had been depressed and abusing his prescription drugs. *Id*. According to the coroner's certificate of death, the cause of death was "asphyxia by vomitus" which occurred due to "self drug administration." *Id*. The coroner noted that the manner of death was "accident." *Id*. A forensic laboratory report indicates that the insured had various prescription medications in his system. *Id*. The insurer denied AD&D benefits, in part because it concluded that the insured's death was not an accident and based on a self-inflicted injury exclusion. *Id*. at 699-700. The court considered whether the insurer's decision to deny benefits constituted an abuse of discretion under ERISA. *Id*. at 701. The court noted that the coroner's determination that death was an "accident" is not determinative. "As several courts have noted, 'the cause of death as certified by the Medical Examiner does not determine whether the death was an accident for purposes of the Policy.'" *Id*. at 702 n.3 (citation omitted). The claimant argued in her appeals that because the insured did not ingest a lethal dose of drugs, his death by asphyxiation was accidental. *Id*. at 702. She also pointed to the insurer's internal report that noted the weaknesses of a suicide theory. *Id*. However, the court found that the fact that the insurer recognized and considered the weaknesses of a finding of suicide prior to issuing its final decision did not make this decision unreasonable. *Id*. at 703. The court noted that the evidence available at the time of denial supported the insurer's finding that the insured intended to commit suicide, ingested dangerous narcotic medications, and died as a result. *Id*. "Although [the insured's] suicide attempt may have been unsuccessful absent an intervening occurrence, *i.e.*, his vomiting, [the insurer] reasonably found that [the insured] intended the ultimate result, although he may not have anticipated the exact means." *Id*. *See, also, Phillips-Foster v. Unum Life Ins. Co. of America*, 302 F.3d 785, 788 (8th Cir. 2002); *Racknor v. First Allmerica Financial Life Ins. Co*., 71 F. Supp. 2d 723 (S.D. Mich. 1999).

Recently, several courts have rejected arguments that an insured was so impaired by drug use that his actions could not have been intentional, or he could not have foreseen his own death. *See, e.g., Life Ins. Co. of North America v. Valtier*, 116 F.3d 279 (7th Cir. 1997); *Miles v. AIG Life Ins. Co.,* 2005 U.S.Dist. LEXIS 8024 (E.D. La. 2005).

Some courts have refused to enter summary judgment when they have concluded that evidence as to an insured's intention was incomplete or disputed. *See, e.g., Baldwin v. Stonebridge Life Ins. Co.*, 283 F. Supp. 2d 1148 (D. Colo. 2003); *Schrek v. Reliance Standard Life Ins*., 104 F. Supp. 2d 1373 (S.D. Fla. 2000); *Brust v. Mut. of Omaha Ins. Co*., 724 N.Y.S.2d 254 (N.Y. App. Div. 2000).

In *Parker v. Fidelity Security Life Ins. Co*., 2007 U.S. Dist. LEXIS 69424 (E.D. Ca. 2007), the court found that even though the policy had an exclusion for suicide while an insured was sane and insurers typically have the burden to prove that a suicide exclusion in a life insurance policy applies, the plaintiff still was required to show initially that decedent's death fits within the coverage, meaning she must show an accidental death either by disproving suicide or proving decedent committed suicide while insane. *Id*. at *30-31. Under applicable state law, "suicide exclusions in such accidental death policies essentially operate to further define the risks covered; they do not act as conditions subsequent and thus, do not shift the burden of proof to the insurer." *Id*. at *29.

Where an insured may not have had the intention to kill himself, courts have considered the application of certain exclusions. For instance, in *Martin v. UNUM Life Ins. Co. of America*, 2008 U.S. Dist. LEXIS 25680 (S.D. Ill. 2008), benefits were excluded under a group policy if death was caused by, contributed to by, or resulting from, a self-inflicted injury. *Id*. at *8. The insured, after arguing with his wife, was found in the backyard dead with a piece of electrical cord tied around his neck and a blood alcohol content that exceeded 0.10 %. *Id*. at *3-4. Benefits were excluded based on the exclusion. *Id*. at *4. Applying an arbitrary and capricious standard of review under ERISA, the court upheld the insurer's determination. *Id*. at *7-10. Although there was a question whether the insured intended to kill himself, the court had "its hands tied, so to speak, by the provisions in this policy that excludes all self-inflicted injuries." *Id*. at *10. "[The insured] put the electrical cord around his own neck, while heavily intoxicated, and somehow or another ended up hanging himself." *Id*. The court, however, seemed troubled by the exclusion. "There are few 'accidents' that do not have some element of self-infliction, even if the result is totally unintended. Defendants seem to have crafted a provision that makes the policy nearly claim-proof. As a matter of policy, the Court finds such a provision rather distasteful, but feels bound to its terms by the law." *Id*. at *10.

J. Violent Behavior

1. Altercations With Police

Some accidental death cases involve an insured who acts in a violent or aggressive manner, for example, when interacting with police. In *Reinhardt v. Metropolitan Property & Casualty Ins. Co.*, 2009 Neb. App. LEXIS 7 (Neb. App. 2009), the insured tried to escape being arrested by hitting one police officer with his car and pinning the other between his car and the police cruiser. *Id*. at *1-2. The pinned officer shot and killed the insured. *Id*. The court found that "[a]n accident within the meaning of contracts of insurance against accidents includes any event which takes place without the foresight or expectation of the person acted upon or affected thereby." *Id*. at *4-5. [The beneficiary] contends that the incident was an "accident" because [the insured] did not intend to be shot and killed. We disagree because [the insured's] injuries and death were the foreseeable result of his actions. Where the party acted upon was the aggressor and provoked the foreseeable use of deadly force, there is no accident." *Id*. at *5-6.

Similarly, in *King v. CIGNA Corp.*, 2008 U.S. Dist. LEXIS 22992 (W.D.N.Y. 2008), the insured had told his wife and a friend that he intended to provoke the police into killing him. *Id*. at *3-4. He also told his wife that he wanted to be killed so that she could receive insurance money. *Id*. The insured later engaged in a stand-off with police officers, telling them that, "I've got a gun, it's a .22 and I'm shooting." *Id*. at *4. He finally came out from his apartment with a rifle, pointed the weapon at one of the officers and charged toward him. *Id*. at *5. Fearing for his life, the officer fatally shot the insured. *Id*. The court, applying a *de novo* standard in this ERISA case, upheld the insurer's denial of AD&D benefits. *Id*. at *7. The court stated that where "the insured is an aggressor in an altercation, and where the injuries received as a result of his actions are both subjectively and objectively foreseeable, the injuries sustained by the insured are not accidental, but indeed, are intentional, and therefore excluded from coverage under a policy insuring accidental injuries." *Id*. at *9. The court found that "it is not only objectively reasonable to conclude that deadly force would be used against [the insured], but it is also clear beyond doubt that [the insured] both subjectively believed that deadly force would be used against him, and indeed *intended* that such force would be used against him." *Id*. at *12 (original emphasis). The insured's death was not accidental. *Id. But see Harrington v. New England Mut. Life Ins. Co.*, 873 F.2d 166 (7th Cir. 1989) (where the court determined that the insured's death, which resulted from a crash that occurred while the insured was fleeing from the police, was an accident).

2. Fights

Some courts have looked to an insured's expectations in getting into an altercation to determine whether his subsequent death was an accident. *Compare McElyea v. AIG Life Ins. Co.*, 326 F. Supp. 2d 960 (N.D. Ark. 2004) (where the insured was killed by multiple gun shot wounds during an altercation with his wife's former lover was found to have been an accident) *with Komperda v. Hartford Life and Accident Ins. Co.*, 2003 U.S. Dist. LEXIS 8433 (N.D. Ill. 2003) (where an insured's death when he was making a bomb was not accidental).

3. Russian Roulette

Courts do not seem hesitant to find that death as a result of an insured's engaging in "Russian Roulette" is not an accident. *See, generally,* Schuman, Gary, "Bang! You're Dead: Russian Roulette and Accidental Death Insurance," *DRI Life, Health and Disability News*, Summer 2007, at 10-14; *Moats v. Life Ins. Co. of North America*, 1998 U.S. App. LEXIS 20789 (6th Cir. 1998); *Arnold v. Metro. Life Ins. Co.*, 970 F.2d 360 (7th Cir. 1992).

4. Murder

Courts typically have found that the murder of an insured is an accidental death. For instance, in *Cole v. State Farm Mut. Ins. Co.*, 753 A.2d 533 (Md. App. 2000), an insured was killed while sitting in a parked van. The Maryland Court of Appeals noted

that it was a critical distinction as to whether this event was deemed to be an accident from the standpoint of the murderer of the insured, or an accident from the standpoint of the insured who was the victim of the violent attack. *Id*. at 538. Choosing the latter, the court applied the *Wickman* test and found that the insured's death was the result of an accident because there was no evidence suggesting that the insured expected that the murderer was going to kill her, and that "[v]iewing the undisputed facts of the case objectively, there [was] no evidence from which a reasonable trier of fact could determine that a reasonable person in the same situation as [the insured] would have expected to be shot and killed . . . . From [the insured's perspective], as the insured victim, the events which caused her death were 'unforeseen, unusual, and unexpected' and therefore 'an accident.'" *Id*.

K. Autoerotic Asphyxiation

Autoerotic asphyxiation is the "practice of limiting the flow of oxygen to the brain during masturbation in an attempt to heighten sexual pleasure." *Todd v. AIG Life Ins. Co*., 47 F.3d 1448, 1450 (5th Cir. 1995). *See, also, MAMSI Life & Health Ins. Co. v. Callaway*, 825 A.2d 995, 996 (Md. 2003). Courts have not been uniform in their handling of autoerotic asphyxiation cases. There are decisions going each way on issues such as whether such a death is an accident and, if so, whether exclusions such as those dealing with intentional self-inflicted injuries would apply to it.

In *Bucher v. Reliance Standard Life Ins. Co*., 2006 U.S. Dist. LEXIS 83446 (D. Neb. 2006), the court upheld an insurer's claim determination under a discretionary review in this ERISA case that where an insured engaged in autoerotic asphyxia dies, the result is not an accident under Iowa law, "since a reasonable person would have recognized that his actions could result in his death." *Id*. at *7 (citation omitted). Because of existing case law that supported the insurer's decision, the court noted that it was "sufficient to support a finding that a reasonable person could reach the same conclusion." *Id*. at *9.

In *Estate of Captain Bradley James Thompson v. Sun Life Ass. Co. of Canada*, slip op. No. 4:07-CV-594-Y (N.D. Tex. Dec. 10, 2008), an ERISA case decided under an abuse of discretion standard, the insured was found dead in his bedroom "hanging, nude, from a black strap tied to a metal framing of his ceiling." *Id*. at 1. In affirming the claims administrator's denial of AD&D benefits, the court decided that the death was not an accidental bodily injury as defined in the policy and that it was excluded by the self-inflicted injury exclusion. The court distinguished the case from *Todd, supra*, in which the Fifth Circuit found that an autoerotic death was not an intended death. The court noted that, unlike in *Todd*, the policy before it included a definition of accidental bodily injury as "bodily harm cause solely by external, violent and accidental means which is sustained directly and independently of all other causes." *Id*. at 19-20. It found that, "While the injuries that ultimately took [the insured's] life – the prolonged oxygen deprivation and attendant failure of essential bodily functions – were accidental, his initial injuries – the partial strangulation and temporary deprivation of blood and oxygen were not. Thus, his death was not solely caused by independent accidental means as

required by the policy in order to be covered in the first instance." *Id*. at 20. In addition, the court also concluded that it was reasonable for the claims administrator to determine that the insured's death was due to or resulted from a self-inflicted injury. *Id*. at 21. It expressly declined to follow other courts that had concluded the insured's act does not involve an injury – "'Partial strangulation is an injury in and of itself.'" *Id*. (citation omitted).

Other cases have focused on the self-inflicted exclusion. For instance, in *Bond v. Ecolab, Inc.,* 2007 WL 551595 (E.D. Mich. 2007), the insured was found hanging from a black and orange nylon rope which he had connected to a hook attached to a floor joist in the ceiling of his basement. *Id*. at *1. The police and medical examiners ruled his death to be "accidental" and resulted during the practice of self-inflicted autoerotic asphyxiation. *Id*. The policy specifically excluded any loss "[i]f it in any way results from, or is caused or contributed by injuring oneself on purpose." *Id*. at *2. Under an arbitrary and capricious standard of review in this ERISA case, the court noted that other court decisions have been divided over whether this conduct constituted an intentionally self-inflicted injury, but concluded that death resulting from autoerotic asphyxia falls within the scope of the exclusion. *Id*. at *4-6. The court found persuasive the decision in *Fawcett v. Metropolitan Life Ins. Co.*, 2000 U.S. Dist. LEXIS 10061 (S.D. Ohio 2000). *Id*. at *5. The insured's restriction of oxygen to his brain was an intentional act, and the fact that other courts reached similar conclusions supported a finding that the decision was not arbitrary. *Id*. at *6-7. *See, also, Callaway*, *supra; Sims v. Monumental General Ins. Co.*, 960 F.2d 478, 479 (5th Cir. 1992); *Cronin v. Zurich Am. Ins.,* 189 F. Supp. 2d 29, 39 (S.D.N.Y. 2002); *Bryant v. AIG Life Ins. Co.*, 2002 U.S. Dist. LEXIS 23289, *16 (S.D. Mich. 2002): *Hamilton v. AIG Life Ins. Co.*, 182 F. Supp. 2d 39, 50 (D. D.C. 2002).

For two recent federal circuit courts that have reached the opposite result, both with dissenting opinions, compare *Padfield v. AIG Life Ins. Co.,* 290 F.3d 1121 (9th Cir. 2002) with *Critchlow v. First Unum Life Ins. Co. of America,* 378 F.3d 246 (2d Cir. 2004).

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