THE CONTRACT OF PERSONAL ACCIDENT AND HEALTH INSURANCE

BY

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I. The Evolution of the Contract

Accident and health insurance in practice comprises two separate forms of insurance and hence there are two separate contracts, (a) the accident contract, which insures against the effects of injuries caused by all or certain specified accidents, and (b) the health contract which insures against the effects of all or certain specified diseases or sicknesses. These may be issued as separate and independent contracts and often are. In fact, policies of accident insurance only are issued far more commonly than are policies of either health insurance or accident and health insurance combined. Formerly health policies were issued as independent contracts rather freely, but of late years health insurance is not generally granted except in combination with accident insurance.

In common practice, therefore, we find the accident policy and the accident and health policy—the latter being formed by merely inserting in the accident policy the additional clauses necessary to express the benefits payable on account of sickness from disease, thus practically incorporating two contracts in a single document.

The study of these two contracts is best approached with some knowledge of the history and development, or perhaps we may say the evolution, of policy drafting.

Formative Stage of the Accident Policy

In this country, accident insurance antedated health insurance by many years, so far as active prosecution as a commercial busi-

ness is concerned, and the earliest efforts at policy drafting were by men with no experience in the practical operation of the business, no data to guide them, no real knowledge of probable costs nor adequate appreciation of relative risks. They often worked under a great fear of unknown hazards and usually had limited financial resources with which to face untoward results. Moreover, while a few old-line companies, managed by trained insurance men, engaged in the business, the bulk of pioneering was done by many newly organized companies, associations, and so-called fraternal organizations, managed by men with little or no insurance training or background and drawn fresh from other businesses. Policy drafting, therefore, began as a process of experimentation by inexperienced men whose aim was to make attractive offerings to the public while safeguarding their companies against disaster from the uncertainties of a venture into an uncharted field. Above all, they saw dimly the fearsome elements of adverse selection, moral hazard and the machinations of the unscrupulous or predatory.

Early Exclusions of Coverage

The early fear of the unknown revealed itself in the many limitations put upon the scope of the insurance. A policy would purport to insure basically against accidental injuries but would contain a limiting provision excluding, for example, injuries due to voluntary exposure to danger; contributory negligence; violation of law, or of the rules of any corporation; walking or being on a railroad bridge or roadbed; inhaling gas; poison or anything accidentally or otherwise taken, administered, absorbed or inhaled; lifting; over-exertion; fighting; wrestling; playing football or polo; bicycling; sunstroke or freezing; getting on or off of conveyances; riding on the platform of a car; or injuries intentionally inflicted by another, or sustained while under the influence of intoxicants, or while failing to exercise due care and diligence; or injuries of which there should be no external mark, the body itself not to be deemed such mark; or injuries due partly or wholly to fits, vertigo, somnambulism, or disease or infirmity of any kind.

All policies did not contain all of these protective conditions though in early days they were pretty generously employed upon the theory that the insurance should be confined to those accidents that might be classed practically as acts of God, uninfluenced by human fault, responsibility or cooperation. And from time to time, as losses were incurred from unanticipated causes, or when companies were confronted with doubtful or unfair claims, new conditions would be devised for protection against possible repetition.

In those days business of all kinds was commonly conducted with strict regard for technical rights and contract obligations. It was not out of line with prevailing business practice that these conditions should be enforced to the fullest extent that they gave refuge to the companies and with little thought of idealistic considerations or a spirit of service. And so these conditions were generally enforced, as also were others of a more technical character, such as those relating to the giving of notice, filing of proofs, exactly truthful warranties, etc. There was a period, too, when insufficient financial resources, inadequate or uncertain premium rates, ignorance of the business, of the law, of what did or should properly constitute a legitimate accident risk, or what obligations were or should be assumed under the contract as written, led to resistance of claims upon unreasonable grounds, untenable theories and specious reasonings. There were some judicial decisions in favor of companies which would be regarded today as at least surprising if not inconceivable. These successes by the companies doubtless encouraged defenses even less justifiable and the non-success of which soiled the pages of accident insurance history and helped to bring about a revulsion of judicial attitude and a swing of the judicial pendulum rather far in the opposite direction.

There was a good deal of litigation in the early days and the courts in those times were prone to deal with technicalities without regard to the merit behind the cause. These practices soon produced a record of which present day administrators of accident insurance would not be proud. Nor does that record reflect either the terms or conditions of present day policies, or the ideals and methods of present day administration. But accident insurance of today is not yet wholly freed of the onus for methods

and practices of other times. Court records of forty or fifty years ago are still available, still cited in cases of far different character, still used to suggest an attitude and a practice that no longer exist and still influence judicial minds against really meritorious defenses.

Development of the Accident Policy

Insurance men first guessed, then studied and finally learned in the hard school of experience how to put the business on a sound footing and to alter its whole theory and practice. Knowledge of costs was gained, methods of underwriting selection were devised, the way was charted and confidence replaced fear. Policies generally were cleared of the old exceptions and few now remain that attempt to exclude anything that may be fairly and reasonably regarded as an injury and its cause an accident. The standard accident policy of today usually aims to furnish effective accident insurance, the most of it possible at the least possible cost and under terms and conditions as fair to the insured as can be devised with reasonable precaution against fraud and imposition. The companies today are criticized chiefly for overextending the policy coverage, for giving too much for too little, for too greatly risking their resources in what is by some termed a mad scramble for business, by others regarded as healthy competition and by still others as the natural growth of the spirit of service in a business only lately out of its swaddling clothes and a bit overcome with youthful enthusiasm. It is true that some policies still are issued that contain rather numerous restrictions, and others that limit their coverage to special or particular hazards, but they are exceptional and do not represent common practice.

Thus, in studying the accident policy of today, it must be borne in mind that evolutionary experimental developments, the court records of the past, the judicial decisions even under policies of a different sort, the legal interpretations of words and phrases, still have an important part in influencing the drafting of the contract. While it may seem a simple matter for one to say plainly and in few words exactly what one means, those same words may be susceptible of surprisingly different understanding

in the mind of another who reads the words without knowledge of the thought behind them. Or, mayhap, another may choose to twist the words to his own advantage though fully conscious of the policy draftsman's intent.

The chief problem in contract drafting, therefore, is to find means of expressing surely the true intent of the contract. The contract should mean what it is intended to mean and yet be proof against distortion into an undertaking far more extended than is contemplated by the insurer or paid for by the insured. The perfect policy will be one that the insurer and the insured will always read alike and as a final test will always be read the same by the courts. There are no perfect policies. The approach to perfection is a continuous one of approximation, characterized by discovery and correction of faults or weaknesses, by changes in the light of new decisions by the courts or new experience of the business.

The evolution of the accident policy is marked also by ready response to public need and by accommodation to changing conditions of life. Its scope has been continuously extended by removing restrictions and by adding new benefit provisions. To the early provisions for quick death and total disability for a limited period there were added provisions for loss of limb and sight, double insurance against accidents of travel, partial disability, removal of the period limit for total disability, payment for death or dismemberment occurring after long intervals of time, with payment of disability benefit during those intervals. Then there came a period of indulgence in the so-called "frills," providing extra payments for surgical operations, hospital confinement, nursing service, medical treatment of non-disabling injuries, so-called identification, the extension of the double benefit provision to include accidents not incident to travel but selected for rarity. Then came the inclusion of a limited form of travel insurance for the beneficiary and finally for the children of the family. Ingenuity in the selection of window dressing features, of which the premium costs were incalculable separately and often assumed to be equally costless collectively, somewhat replaced considerations of service value. Some of these excrescences have been removed and probably the future will see the accident policy restored fully to its normal functions.

Formative Stage of the Health Policy

The past career of the health policy is more brief and less checkered. From its inception it was in the hands of men of experience, qualified as underwriters and actuated by a desire to render service. Under their guidance accident insurance had been elevated to a plane of dignity and quality; strong, ably officered and well managed life and casualty companies had become its leaders; the accident policy had become a contract proudly advertised as containing "no exceptions"; the business was growing apace in volume, prestige and public favor and its extension into the field of health insurance was a natural and logical step. It was again a new field, however. Knowledge of costs was lacking, applicability of experience in other countries was doubtful and, even with the training, courage and vision acquired in the closely kindred line of accident insurance, cautious experimentation was deemed the better part of valor.

Prior to 1897 such health insurance as had been attempted had been issued by mutual benefit associations, generally short lived and of dubious responsibility, operating under varying and often peculiar conditions. Their experience was neither available nor suitable as a standard for commercial operations. These were to be another pioneer undertaking.

The first offering by a responsible, old-line company was in the form of a supplement to the accident policy and it insured only against eight or ten diseases specifically named. Later the list was extended to cover seventeen, twenty, twenty-four and more diseases. But always there was careful selection of diseases to be covered, a few of common occurrence being included among a much greater number of rarest incidence, of non-disabling nature, some children's diseases, some unknown in this country, some trifling blemishes dressed up in imposing Latin designations and running the gamut from Asiatic cholera to a pimple on the ear. This method of gaining experience soon proved both unsatisfactory and illusory. The public did not understand medical Latin, complained of being misled into believing health insurance insured against sickness, only too often to find, when sick, that "the policy did not cover." Efforts to "beat the game" followed and, with the cooperation of sympathetic doctors, diagnoses came to be influenced by the necessities of the list contained in the policy

more than by the tenets of medical science. Bronchitis, included in the list, covered a multitude of ills; typhoid fever cohabited with many strange clinical bedfellows. There were many disputed claims and many were paid that never were contemplated by the policy. Soon the companies found that they were losing not only friends and prestige but money also.

Development of the Health Policy

Within a few years followed the bolder step of insuring generally against sickness but limiting payment to the period of house confinement. The business was vigorously prosecuted and, under pressure of keen competition, the policy coverage was quickly extended even before the adequacy of premiums was fairly tested. The house confinement restriction was eliminated, provision for partial disability was added and soon there were further provisions for surgical operations, hospital confinement, nursing charges, quarantine detention, principal sum payments for blindness and paralysis. By this time the spirit of service had developed health insurance into a most complete form of protection. It also opened the door to the malingerer, the vacationer, the imposter. Progress ran ahead of experience, constant changes of policies and practice kept statistical data in a state of flux. Presently premiums were found insufficient to carry the whole load and during recent years various corrective measures have been tried, such as increasing premiums, reducing commissions, eliminating benefit provisions most abused, introducing waiting periods, restoring the house confinement clause, selecting risks more rigidly at issue and by re-selection after experience. There was, however, no uniformity of action and the best means of achieving permanent stabilization have not yet been determined, in respect either to policy coverage or to premium rates.

As a general rule health policies have always fixed a period limit of disability coverage, usually twenty-six weeks in earlier days, then generally extended to fifty-two weeks and with occasional experiments with longer periods. A few companies essayed the "life indemnity" form, with benefit payable during continuance of disability without limit, but though these forms were

issued at higher premiums and to specially selected risks, they seemed to accentuate all known difficulties. Experience under them was usually found prohibitive and they have been pretty generally abandoned. The most recent development is, of course, the non-cancellable policy, which must be regarded as of a different type altogether, limited in its operation to a particular class, operated by a few companies and abandoned by others and still in an experimental stage. This form has generally included the "life indemnity" feature but lately there is a tendency to substitute a form of period limitation known as the "aggregate indemnity" provision. It is usually issued with lengthy waiting periods and is mainly designed to cover only the more serious cases of prolonged disability. The drafting of this form of policy involves problems peculiar to itself, the solution of which probably awaits the development of experience.

The history of the accident and health policy thus presents a kaleidoscopic picture, the shifting views of which must be ever in the mind of one who designs a policy, one who interprets it and one who studies it.

II. The Present Day Contract

The stock in trade of accident and health policies is of great variety under widely diversified forms and this is especially true of accident policies.

The accident policy does not insure merely against a single contingency and promise a certain benefit therefor, as does nearly every other form of insurance policy, but insures against a multitude of events, with a variety of benefits. Such a policy offers a field for almost infinite variation, both as to events to be insured against and as to benefits payable for each. It may insure against all accidents and yet may vary the benefits payable for accidents of particular causation or the amounts payable for particular results. Likewise it may insure not against all accidents but against only a selected few of specified causation; or it may insure against all results of accidents covered or only particular results of specified character; or it may insure against

a majority of accidents and exclude a certain number or class. Thus, with the multitude of causative events and the variety of ensuing results there is practically no limit upon the possible variations except the limits of imaginative fecundity, or the aims, ideals and business policies of the many different companies.

The health policy approaches more nearly to the idea of insuring against a single event, that is, sickness due to disease, but still it is susceptible to many variations in amounts payable for particular results, or according to various circumstances attending the sickness, and the variety of policies probably equals the extent of the opportunity.

Synopsis of Present Day Contracts. Ten Basic Plans

A general synopsis of the various types of policies to be found upon the market would classify them about as follows:

1. The *general accident policy,* insuring against all accidents.

2. The *general accident and health policy,* insuring against all accidents and sicknesses.

3. The *non-cancellable accident and health policy,* insuring against all accidents and sicknesses with right of renewal vested in the insured up to a specified age. This form is issued by a small number of companies and subject to exceedingly careful selection.

4. The *restricted accident policy,* insuring against accidents in general but excluding those of certain kinds specified in greater or less number and omitting certain benefit provisions common to the general accident policy. This form is mostly favored by mutual and fraternal associations which aim to furnish insurance at lower rates than those prevailing among old line companies and consequently seek to confine the scope of the coverage within the limits permitted at a popular price.

5. The *limited accident policy,* insuring against specified accidents only, which may be confined to a single causative factor, such as railroad accidents or even train wrecks, or automobile accidents, or it may include a certain class of accidents regulated in scope by the premium fixed upon, which may be a dollar or a few dollars. Or the policy may be given away with a newspaper subscription or a pound of tea and its insurance value is neces-

sarily in proportion. Few companies issue them, because of their small service value, though the form covering automobile accidents receives the approval of a somewhat larger number.

6. The *limited health policy,* insuring against specified diseases only, which may be selected with the purpose of furnishing little or more insurance in proportion to the premium to be charged. This form is in the same category with the limited accident policy, is often combined with it and is issued by still fewer companies.

7. The *group accident policy,* insuring a large number of persons under a blanket form and without individual selection (generally employees of an establishment or other groups formed for purposes other than insurance) and usually confining the coverage to the major losses of life, limb or sight.

8. The *group health policy,* issued to similar aggregations, and usually covering disability only, whether due to accident or disease; this form may cover occupational accidents but more commonly excludes this risk and thus becomes a supplement to workmen's compensation.

9. The *double indemnity supplement of the life insurance policy,* insuring additionally against death due to accidental injury. This is nothing but straight accident insurance, though issued by life insurance companies that may not be dealing otherwise in accident insurance or issuing it in more complete form.

10. The *disability annuity supplement of the life insurance policy,* insuring against total disability, presumably permanent, and whether due to injury or disease. This is accident and health insurance of non-cancellable form with exclusion of a certain period of disability and limited in amount by life insurance issued concurrently.

Superimposed upon these general types of policies are a number of variants in substance.

III. Variants in General Types of Contracts

Waiting or Exclusion Periods

One of these variants is the exclusion period, or waiting period which provides that no benefit shall be payable for the beginning days or weeks of any disability. Formerly this was rarely in-

cluded in general accident or health policies but more recently is being adopted to some extent in both, but especially as to health insurance. The aim is to keep down the premium, reduce the operating cost and limit the moral hazard; the exclusion may vary from a few days to many weeks. The waiting period is commonly found in the non-cancellable policy, usually varying from a month to three months, though occasional shorter periods are used. The waiting period has in fact become almost universal in non-cancellable forms and with the longer exclusion periods most favored. It is nearly always found in group health policies but usually the period is short, mostly a week, sometimes less, seldom more. It is the rule in disability annuity provisions, varying a good deal in both period and terms, the shortest period being three months; in some cases, benefit may be payable from the beginning of disability, or from the end of the exclusion period, or payment may be conditioned upon proof of probable permanency after the expiration of that period; sometimes the exclusion period is longer and sometimes benefit is payable only after another waiting period following the filing of proof.

Period Limits for Disability Benefits

Another variant is the period limit for which disability benefit is payable. General accident policies are freely issued with no such limitation, though one is usually found in any restricted or limited form. General health policies usually limit the period to fifty-two weeks, but with occasional shorter or longer periods. Non-cancellable policies have been commonly issued without limitation but more recently an equivalent has been introduced in some in the form of a limitation of the aggregate amount of benefit collectible during the life of the policy. Group health policies are subject to variable period limits, such as thirteen, twenty-six, or fifty-two weeks, dependent upon the agreement in each case. Disability annuity supplements of course contain no limitation, as their whole purpose is to provide for permanent disability.

Another variant is the house confinement provision, which may be found at times in respect to health insurance and which undertakes to establish continuous confinement as a test of sickness

sufficiently serious to justify recognition as a total disability and payment of benefit is accordingly so conditioned.

It is apparent from the foregoing that accident and health insurance covers a wide field of usefulness and finds unlimited opportunity for public service, that it is adaptable in many forms to many needs and that in its every function different problems must be dealt with and different contracts must be constructed.

As a rule, however, accident and health insurance is identified chiefly with the separate contracts issued to individuals and of these there is a vast multiplicity of forms. The fundamentals of the various general accident policies are substantially the same, that is, they provide principal sum payments for death or dismemberment and weekly benefits for total and partial disability. The groundwork of the general health policy is the simple provision for weekly benefit for disability. But differences in minor features are many and varied, each company following its own bent in selecting or devising selling points or adopting others to meet competition. And so, new policies are continually being produced, little changes are constantly made and some companies maintain an equipment of scores of slightly differing forms from which agents or public may choose. It would serve no purpose to discuss in detail the ever-changing draperies with which the main structure of an ordinary accident or accident and health policy may be variously festooned according to taste. It may suffice to say that these variants are only inconsequential excrescences upon the body of a useful servant and at least do not detract from, if they do not add to, its service value. They seemingly promote at times the selling of accident and health insurance by their appeal to the human craving for novelty.

IV. Sources of Information on Policy Provisions

A publication by the National Underwriter Company of Cincinnati, Ohio, under the title of *The Time Saver,* revised and issued annually, and another under the title of *Policy Analysis,* in loose-leaf form with monthly changes and corrections, undertake to furnish, with a certain uniformity of arrangement, outlines of the various policies currently issued by different companies, setting forth benefits, special features and general condi-

tions and premium rates. A similar one of identical scope but different arrangement is published by the Alfred M. Best Co. Inc., of New York, under the title of *Best's Accident and Health Analyses*. Another publication by the Spectator Company of New York, under the title of *Accident Insurance Manual*, aims to serve the same purpose in the somewhat different form of a narrative description of the benefit provisions of the various policies, with their respective rate tables. While not wholly complete as to all forms, these publications include the policies principally advocated by the principal companies; the issues of from fifty to ninety different companies are dealt with and each company is represented by anywhere from three to twenty or more different forms. A review of one recent edition shows more than eight hundred policies offered by some ninety companies and there are many others not included because not deemed sufficiently active on the market to justify publication.

Then there is the plethora of limited policies. Though issued by few companies, their number and variety are usually regulated only by the particular ideas of the particular agency or instrumentality through which they are to be sold. They are not commonly sold by direct canvass of individual agents but mostly through special advertising, mail orders, etc.; often they form a part of a newspaper campaign for increased circulation and one newspaper may offer ten thousand dollars of accident insurance while another at the same time for the same price, one dollar, offers one thousand dollars of accident insurance, in connection with a subscription to the newspaper. Insurance "stunting" of this type seems to be more popular in Europe than in the United States.* Other limited policies may sell at five dollars or ten dollars and may include sicknesses as well as accidents in their coverage, but in all cases the selection of particular accidents and sicknesses to be covered is in proportion to the price. These forms of policies, while necessarily included as a part of the business of accident and health insurance, are to be recognized as a separate and passing phase wholly without relation to the main function of such insurance. They are condemned by some and

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* *See: Manes, Alfred. Versicherungswesen.* Vol. I, pp. 5 and 221. Leipzig. Teubner. 1930; and *Carl Casper Speckner. Das Recht der Abonnentenversicherung.* Erlangen. 1930.

defended by others. Certain it is that great numbers of them are sold, especially when cleverly advertised, because in these days people give up a dollar with little thought. In the nature of things many must pay the dollar where one may receive benefit.

V. Constituents of the Contract

An insurance policy is composed of six constituent parts—(1) the insuring clause, which exactly specifies the general scope of coverage (2) defining or limiting provisions, where such are necessary to clarify the general terms, to confine interpretation within intended limits, or to exclude particular risks if any are to be excepted from the general undertaking (3) benefit provisions, which fix amounts payable under the several contingencies insured against and prescribe particular conditions applicable to each (4) the consideration clause, which states specifically the money and other considerations necessary to the validation of the contract (5) the copy of the application, which is a component part of the contract (6) general conditions of performance, which pertain to the effectiveness and continuance of the insurance and the rights and obligations of the parties in the various circumstances that may arise in course of operation.

VI. The Insuring Clause

Standard Accident Clause

Dealing with policies designed to furnish the most complete form of protection and which, for want of an established generic term, we may designate as "standard" because most commonly issued and generally regarded as the best type, we find some minor variations in phraseology of the insuring clause as used by different companies, but with substantially identical intent and scope. A typical insuring clause reads as follows:

> "The company hereby insures John Brown, by occupation lawyer, classified Select, for the term of twelve months from May 1, 1931, noon, standard time at the place where the

insured resides, and subject to the provisions and limitations herein contained, in the

Principal Sum of Five Thousand Dollars
Weekly Indemnity of Twenty-five Dollars

against the results of bodily injuries sustained while this policy is in force and caused directly and independently of all other causes by violent and accidental means."

Standard Accident and Health Clause

The foregoing represents the insuring clause of a policy of accident insurance only, while for purposes of combined accident and health insurance the clause would be changed, beginning with the word "against" to read as follows:

"against (a) the results of bodily injuries sustained while this policy is in force and caused directly and independently of all other causes by violent and accidental means and (b) the results of disease or sickness contracted while this policy is in force."

Death and Dismemberment Clause

For a form of accident policy, known as the "death and dismemberment" form, sometimes issued to those who are not employed in any regular occupation or business and therefore are not eligible for insurance against occupational disability, or those who for other reasons elect to insure only against the major losses of life, limb, or sight, the specifications of the insuring clause merely omit reference to any weekly indemnity and thus it becomes suitable, with the benefit provisions correspondingly constructed. Likewise, for a form sometimes issued and designed to insure only against disability and not against death, the insuring clause is suitably adjusted by omitting reference to any principal sum.

Limited Accident Insurance

For a form of limited accident insurance designed to cover only specifically named accidents, such as those occurring in public conveyances, or in automobiles, or other selected risks, the specification of particular risks to be insured against is sometimes added to the usual insuring clause and sometimes reserved for

inclusion in the benefit provisions. Likewise, for a form of limited health insurance, designed to cover only specifically named diseases, either of the same methods may be followed.

External, Violent and Accidental Means

The function of an accident policy, stated in its simplest terms, is to insure against the effects of accidental injuries, but the problem of so expressing that intent as to stand the many tests to which it may be subjected, gives rise to differences of opinion among authorities and results in a number of variants. In some policies the specification of the moving cause of the injury is "external, violent and accidental means," the aim being to establish the agency as one originating in an external source as well as operating independently of the insured's volition and involving a violent action sufficient to cause physical injury; this, indeed, was the original theory of design. In others the word "external" has been omitted in the belief that it added nothing to the descriptive quality of the phrase and seldom received consideration in the process of legal interpretation. In still others, both of the words "external and violent" were omitted on similar reasoning and with the idea of simplification.

But the theory that these words were merely redundant, in the light of previous judicial decisions, was somewhat shaken by later rulings apparently influenced by legal presumptions that different wording implied different intent and justified distinguishment from earlier decisions founded on the more carefully worded terms. In consequence some companies have restored both words and some have restored only the word "violent" as the more indicative of definite intent. In a few instances the term "accidental bodily injuries" has been substituted for "bodily injuries caused by accidental means," but whether this new expression is more definite of intent, or shall prove to import any different significance, remains to be determined; other efforts have been made to rephrase the clause so as to harmonize the expression of intent with the many legal interpretations, often seemingly inconsistent one with another, sometimes doing violence to the plain meaning of words used and not infrequently most confusing. One such effort uses the phrase "personal bodily injury which is effected solely and independently of all

other causes by the happening of a purely accidental event." Another effort, resulting from study and collaboration under the auspices of the Health and Accident Underwriters Conference, suggests use of the term "accidental injury without contributing causes" supported by a secondary defining clause to the effect that "accidental injury as used in this policy means bodily injury suffered while this policy is in force and which is effected solely and independently of all other causes through accidental means."

The thought has been expressed by some that, in view of the difficulty in procuring any fixed and uniform judicial interpretation, applicable equally to many varying sets of circumstances and reconcilable with other decisions of the past, the wisest course would be to abandon completely the phraseology hitherto relied upon and to substitute some entirely new clause. But even that method confronts the companies with the possible necessity of engaging in much undesired and costly litigation in order to secure such interpretations in the many jurisdictions as may satisfy lawyers who in absence of exactly fitting decisions may be led to embark in experimental actions. Others hold the view that most by far of existing decisions are reasonably reconcilable with a fair interpretation of the true intent of the present wording.

The Intent of the Insuring Clause

The accident policy at its best is necessarily a form of limited insurance. It insures against death but not all deaths; it insures against disability but not all disabilities. If it undertakes or is construed to cover death and disability due to disease it becomes life and health insurance as well as accident insurance—and must disappear as impossible to operate. In order, therefore, to preserve it to its undoubtedly useful place in the scheme of public service, where it may furnish large protection at small cost against the results of definite injuries actually sustained and caused by truly accidental events, *and those only,* it is highly essential that it be carefully constructed to make its legitimate limitations specific and clear. And when that is done the contract is entitled to be respected for what it is by every insured and by every court.

The thing the accident policy insures against is the effect of a bodily *injury* which, in its common and ordinary acceptance and meaning, connotes a hurt, a mechanical damage to the body structure, as distinguished from disease or the physical changes naturally brought about by the ordinary processes of disease, degeneration or disintegration. In the absence of this distinction there ceases to be any difference between disease and injury, between the orderly development of natural processes and the *violent* interposition of fortuitous *events*. And such an injury must be immediately and definitely recognizable as the direct result of some violent force sufficient of itself to cause damage to a substantially normal body structure. An accident is an *event*, something that happens that is unintended, unforeseen and unexpected by the person it happens to and that *by its happening produces the force that causes the injury*. Summed up, then, there must be a series of occurrences—first, an accident must happen, second, that accident must set violence in motion and, third, that violence must cause bodily injury, without other concurring causes or cooperating conditions.

Accidental Means and Means Not Accidental

But often there is confusion in the minds of policyholders, attorneys and courts (sometimes from faulty reasoning, sometimes from wrongheadedness, sometimes from prejudice or cupidity, sometimes from determination to revamp a contract to meet a need after the event) *between accidental means causing injuries and unlooked for results of means not accidental*, between effects actually due and conditions merely subsequent to an accident, between an *injury* and a *disease*, between a sudden violent force causing immediate damage to the body and the normal contraction of disease and its usual progress to an ultimate disfunction. Not infrequently attorneys representing the companies have betrayed such inadequate conception of these distinctions that they have failed to present the true questions that should be at issue or to set them out with sufficient clarity. Occasionally courts entirely disregard the actual terms of the contract, though plain and unambiguous, and substitute some judicial conception of what the agreement ought to have been in order to cover an existing situation and, to support an opinion, indulge in irrele-

vant dicta which later are cited and given the force of principles of law by other courts. And so the problem has grown until the adequacy of the English language to the expression of thought and the freedom of parties to make a specific contract often appear at least doubtful.

Missouri Suicide Cases

As long as thirty years ago very able lawyers went before the Missouri Supreme Court admitting that suicide was death from external, violent and accidental means (Logan vs. Casualty Company, (1898) 146 Mo. 144) and years later others contested suicide cases in that state without raising the fundamental point that an intentional act is not accidental (Whitfield vs. Ins. Co. (1903) 205 U. S. 489; Applegate vs. Ins. Co. (Mo. 1910) 132 S. W. 2). Then, after twenty years the Missouri Supreme Court blandly remarked that it never had held that suicide of a sane person was an accidental death and appeared mildly astonished that companies, counsel, courts of that state and the United States Supreme Court should have mistakenly assumed such to be the import of its decisions (Scales vs. Ins. Co. (Mo. 1919) 212 S. W. 8). And the same court was required to and did reaffirm that principle, despite a delightful theory quoted in the opinion that "even in these days when the leaven of reform is working in all the law and the strife is toward a legal millennium whereat every man shall be his own lawyer" (Brunswick vs. Ins. Co. (1919) 213 S. W. 45). Again in the following year (Bayha vs. Casualty Co. (1920) 217 S. W. 269) and yet again before its seriousness was accepted (Tillotson vs. Ins. Co. (1924) 263 S. W. 819). But for twenty years the companies were wrongfully under judicial compulsion to recognize deliberate self-destruction as an accident in Missouri—until the courts righted themselves.

Sunstroke

A similarly anomalous situation existed for a period of years in respect to sunstroke, clearly a condition of disease not due to an accidental injury and in earlier days specifically excluded from coverage. But one insured objected to that exclusion and the word was stricken from the policy, though without other change

in its expressed undertaking, and when the insured died of sunstroke the company was held liable on the theory of doubt as to the intent involved in this alteration and the preliminary negotiation was deemed to be indicative of that intent, thus illustrating the danger of opening the way for construction of the contract out of material other than its content (Mather vs. Ins. Co. (Minn. 1914) 145 N. W. 963). Later policies specifically agreed to cover sunstroke *if due to violent and accidental means* and in two cases this was held not to apply to sunstroke occurring in the course of ordinary activities and with no accident or injury operating as a cause (Semancik vs. Casualty Co. (Pa. 1915) 43 Pa. Cty. 498 and Cas. Co. vs. Pittman (Ga. 1916) 89 S. E. 716). Soon, however, it became well established by repeated decisions in various jurisdictions that the *express inclusion* of sunstroke as a cause of injury or death had the effect of establishing that cause as one intended to be covered by the policy independently of any other event (Bryant vs. Cas. Co. (Texas 1916) 182 S. W. 673; Higgins vs. Cas. Co. (Ill. 1917) 118 N. E. 11; Elsey vs. Cas. Company (Ind. 1918) 120 N. E. 42).

These decisions often are quoted, and sometimes with misleading effect, in support of claims for sunstrokes and other unexpected and suddenly appearing diseases *under policies that do not expressly undertake such risks* and one court went so far afield as to declare sunstroke an accident because "popularly" so regarded though scientifically a disease and to find a responsible element of accidental means in the fact of sunstroke while returning from a trip into the desert, the distance of the objective having been miscalculated and thus involving an "unforeseen" period of exposure (Richards vs. Ins. Co. (Utah 1921) 200 Pac. 1017). Such a decision, however, may be regarded as so contrary to all reason as to be classed as a mere judicial vagary. But these experiences teach that an accident policy cannot be lifted even partly out of its legitimate field and still function as an accident policy.

Occasionally faulty wording of a policy, with consequent ambiguity, results in decisions wholly inapplicable to any other policy. Thus, where a policy insures against *"accidental death"* it will not be construed as insuring against *death from injury by accidental means* but covers death due to rupture of heart from

lifting or exertion, mere "accidental death" being an undesigned or unforeseen *result* even of an intended act or course of action (Pledger vs. Assn. (Texas 1917) 197 S. W. 889) and again where a policy insures against injury by external, violent OR accidental means, the expression being in the subjunctive, it is sufficient that the means be either external *or* violent though not accidental (Assn. vs. Norton (Okla. 1915) 145 Pac. 1138). But these decisions often are cited in other cases without directing attention to the different phrasing and the full consequential significance of that difference is not always recognized or given effect.

Accidental Means and Accidental Result

Even with most careful phrasing the dual condition of the insuring clause, i.e., that there must be an *accident* and that that accident must cause *injury,* is sometimes lost sight of, with resultant failure to discriminate between a *means* and a *result.* Thus so-called ptomaine poisoning has been held to be covered as an *unexpected result,* though following the intended act of eating exactly what was intended to be eaten (Johnson vs. Cas. Co. (Mich. 1915) 151 N. W. 593). This also fails to distinguish between an actual injury due to violence and the development of disease by orderly processes. The contrary is held in very similar circumstances (Martin vs. Assn. (Ia. 1919) 174 N. W. 577) while the same principle is established by rulings that death from dilatation of the heart following a cold plunge, though an unforeseen *result,* is not by accidental *means* (Cas. Co. vs. Johnson (Ohio 1915) 110 N. E. 475) that death from taking more liquor than presumably intended is not by accidental means (Calkins vs. Assn. (Ia. 1925) 204 N. W. 406) that death due to too violent inhalation of a nasal douche is not by accidental means (Smith vs. Ins. Co. (Mass. 1914) 106 N. E. 607) that a wound intentionally made by a barber in removing an ingrowing hair is not made by accidental means (Kendall vs. Assn. (Ore. 1918) 169 Pac. 751).

The distinction between a *means* and a *result* is well stated by the U. S. Circuit Court of Appeals where it says that under a policy insuring against death effected through injury by external, violent and accidental means the *means or cause* of death must

be accidental and it is not enough that the *death itself* is accidental in the sense of being unintended, unexpected or unforeseen, that a *means* is not accidental when employed intentionally though it produces a *result* not expected or intended. In this case the insured had a boil on his neck which he rubbed with soiled hands, thereby breaking the scab and admitting erysipelas germs, and died of that disease (Cas. Co. vs. Spitz (1917) 246 Fed. 817).

This distinction is again well stated by the Missouri Supreme Court in an opinion exhaustively reviewing many cases, and concluding that if a result is such as follows from ordinary *means voluntarily employed* in a not unusual or unexpected manner, it cannot be called a result effected by accidental means; but only if *in the act which precedes the injury* something unforeseen, unexpected or unusual occurs *which produces the injury* then the injury results from accidental means. The court finds from a review of cases that this conclusion is not contrary to a number of preceding decisions of the Supreme Court of Missouri but is contrary to a number of decisions of the subordinate Courts of Appeal of that state (from which it would appear again that those courts had misinterpreted the pronouncements of the Supreme Court) and moreover declares its present conclusion to be in harmony with the weight of authority throughout the country and in accord with the better reasoning. In this case the insured was operated for a disease but died instead of recovering as expected and it was contended that death was due to the unintended stoppage of blood vessels and that this was an unexpected *result* of the operation. (Caldwell vs. Ins. Co. (1924) 267 S. W. 907). A studious reading of this opinion will not only develop an understanding of the law as soundly applied to a plainly worded contract but will indicate that courts can go wrong, possibly through misapprehension or insufficient deliberation, possibly because of inadequate or inept presentation of the issue, possibly through psychological waves of sentiment to which judges as individuals are susceptible, possibly because of too great readiness to follow, without complete analysis, some previous decision astutely set up in a brief—but also that wrong decisions of courts can be righted by proper and able appeal to their fair judgment.

The New York Appellate Division also rules that a hernia appearing in the ordinary course of accustomed work is not an injury by accidental *means,* the insured doing only what he meant to do in the way he meant to do it; therefore it cannot be said that the *means* was accidental and the most that could be said is that the result was accidental (Fane vs. Assn. (1921) 188 N. Y. Supp. 222).

The Indiana Supreme Court holds that rupture of a blood vessel in the lung during exertion in shaking a furnace is not injury by accidental means (Husbands vs. Assn. (1921) 133 N. E. 130).

The Georgia Supreme Court holds that it is necessary to show that *in the act which precedes* the injury something unforeseen, unexpected or unusual occurred and that the straining of the body in pulling and pushing a boat, rupturing a blood vessel in the stomach, is not sufficient to make a jury question (Fulton vs. Cas. Co. (1917) 91 S. E. 228).

The California Supreme Court rules that death due to rupture of the heart while lifting or carrying a burden (Rock vs. Ins. Co. (1916) 156 Pac. 1029) or during the exertion of holding a plow in the course of work is not by accidental means (Ogilvie vs. Ins. Co. (1922) 209 Pac. 26).

The U. S. Circuit Court of Appeals reaffirms the principle in a case of rupture of a blood vessel during the exertion of steering and controlling an automobile in heavy going due to having accidentally strayed from the right road, holding that both the accidental and external elements were lacking (Lyon vs. Assn. (1928) 25 Fed. (2nd) 596) and still later that death due to exposure to excessive heat is merely the result of intended acts and there was no accident or injury (Nickman vs. Ins. Co. (1930) 39 Fed. (2nd) 763).

The Texas Court of Civil Appeals holds that there is a well established difference between "accidental injuries" and "injuries resulting from accidental means" and that an unexpected result of a voluntary act is not an injury from accidental means (Ins. Co. vs. Cherry (1931) 36 S. W. (2nd) 807).

These decisions, and many others of identical import, fairly reflect the law properly applicable to the language used to express the intent of an accident policy and constitute the authority given over the years for the use of that language. It will be observed

that all of these litigations grew out of obvious efforts to collect under accident policies for death or other effects due to disease, or in some instances mere failure of remedial measures to effect a cure. There are, of course, some decisions of contrary effect, as there are decisions contrary to every principle of law, however sound, but many of the contrary decisions may be reconciled by careful analysis while some must be regarded as mere variants from the rule recognized by the great weight of authority.

Independently of Other Causes

The insuring clause of an accident policy stipulates that the accidental means must be the *sole cause* of injury or, as more commonly expressed, must cause the injury "directly and independently of all other causes." Likewise the benefit provisions stipulate that the effects of the injury, i.e., loss of life, limb or sight, or disability, must result from the injury *alone,* "directly and independently of all other causes."

It is the plain purpose of these stipulations to confine the coverage to injuries and their resultant effects for which an accident is *alone,* rather than partly or even chiefly, responsible, for when disease is a causative factor, either in producing the injury or in developing the physical effects that follow, it is at once obvious that, with all the various degrees of causative influence, there would be great uncertainty as to the intent of the contract and frequent controversies and litigations with varying results, if such a definite line of demarkation were not clearly established.

The presence of these stipulations, however, and their significance are sometimes overlooked or disregarded, with confusing results. It was once held by the Kansas City Court of Appeals that, although an insured was fatally diseased and so afflicted that he would die from such affliction within a few hours, yet if by some accidental means his death were sooner caused the death was by accident (Hooper vs. Ins. Co. (1912) 148 S. W. 116). This clearly substituted a different contract and the St. Louis Court of Appeals later ruled that the burden is upon the plaintiff to show that accidental injury was the *sole cause* of death (Koprivica vs. Ins. Co. (1920) 218 S. W. 689). It has

been held that, where death is due partly to disease and partly to an accident that could not have caused injury but for the disease, the true question is whether he would have died *at the time he did* had it not been for the accident (Ins. Co. vs. Meldrum (Ga. 1919) 101 S. E. 306). This also reconstructed the contract and there was a vigorous dissenting opinion in which it was argued that the plain terms of the policy should be given effect.

These decisions are distinctly in opposition to the great weight of authority, holding that the *injury must be the sole cause* of death or other resultant loss, that if disease exists prior to the accident and the accident would not alone cause the death, or if the accident aggravates the effects of the disease or the disease aggravates the effects of the accident *and the two concur* to cause death, then the accident is not the cause of death independently of other causes (Assn. vs. Shryock (U. S. C. C. A.) 73 Fed. 774; Cas. Co. vs. Morrow (U. S. C. C. A. 1914) 213 Fed. 599); it is not enough that an accident is the proximate cause if death would not have resulted but for pre-existing disease (Ins. Co. vs. Ryan (U. S. C. C. A. 1918) 255 Fed. 483; Smith vs. Ins. Co. (U. S. D. C. 1925) 6 Fed. (2nd) 283); the plaintiff must show that disease did not contribute to death (Assn. vs. Nicholson (U. S. C. C. A. 1925) 9 Fed. (2nd) 7). In various jurisdictions the principle is upheld that mere concurrence of disease and accident does not establish liability under such a policy (Stokely vs. Cas. Co. (Ala. 1915) 69 So. 64; McEwen vs. Ins. Co. (Cal. 1916) 155 Pac. 84; Kellner vs. Ins. Co. (Cal. 1919) 181 Pac. 61; Leland vs. Assn. (Mass. 1919) 124 N. E. 517; Robinson vs. Ins. Co. (Texas 1925) 276 S. W. 900) and the same is true where a pre-existing disease is accelerated by accident (Penn. vs. Ins. Co. (N. C. 1912) 76 S. E. 262; Smith vs. Ins. Co. (N. Y. 1924) 202 N. Y. Supp. 857), (Kirkwood vs. Ins. Co. (La. 1930) 131 So. 703).

This, of course, does not mean that the mere existence of some disease or presence of some physical defect at a time when an accident occurs absolves the company from liability for the effects fairly attributable to that accident and defenses predicated upon that theory have been quite commonly unsuccessful. The principle applies only where disease is an active factor in causing the accident or in producing or increasing the physical effects thereof.

VII. The Defining or Limiting Clause

A defining or limiting clause may be employed to restrict the scope of the policy by expressly excluding coverage of certain accidents or diseases that otherwise would be covered under the insuring clause, in which case the exclusions are usually regulated by the extent of insurance to be granted and the premium to be charged and its main function then is to limit the insurance. Or it may be designed chiefly to define the insuring clause and to protect the policy against extension or distortion through unrestrained interpretation, while incidentally excluding a particular hazard deemed uninsurable, such as aviation, military service, or the like. One such clause of an accident policy reads as follows:

> "This insurance shall not cover suicide or any attempt thereat while sane or insane; nor shall it cover injuries, fatal or non-fatal, sustained while participating in aviation or aeronautics except as fare paying passenger; nor shall it cover accident, injury, disability, death or any other loss caused wholly or partly, directly or indirectly, by disease or bodily or mental infirmity or medical or surgical treatment therefor; nor shall it cover injury, disability, death or any other result caused wholly or partly, directly or indirectly, by ptomaines or disease germs or any kind of infection, whether introduced or contracted accidentally or otherwise (excepting only septic infection of and through a visible wound caused directly and independently of all other causes by violent and accidental means); nor shall it cover hernia of any kind, whether incurred before or after the date of this policy, or disability, death or any other loss resulting therefrom whether the hernia be caused or aggravated by violent or accidental means or otherwise. All insurance under this policy shall be automatically suspended if the insured shall become blind or insane, or if the insured shall engage in military or naval service in time of war, in which event the portion of the premium unearned during the period of such suspense shall be refunded."

If the policy includes health as well as accident insurance the following would be added to the foregoing:

> "The insurance against disease or sickness shall not cover any disease, sickness or disability contracted or suffered while engaged in military or naval service in time of war, or while outside the limits of United States, Canada or Europe; nor

> shall it cover any disease, sickness or disability caused wholly or partly by the use of intoxicants or narcotics or by accidental violence, or which results from or is the sequel of any disease contracted or infirmity existent prior to the date of this policy."

There would appear to be no reason in logic for stipulating that accident insurance should not cover disease, the effects thereof or results of treatment therefor, but there does appear to be reason in fact for fearing, at least occasionally, astonishing interpretations when this is not done. In other forms of contracts the affirmative specification of agreements to be undertaken is usually held to be conclusive of the whole intent, but in insurance contracts a negative statement frequently seems necessary to limit the search for means of determining intent not affirmatively expressed. Especially in the courts where, under the established rule, contracts are construed most strongly against the maker, distinctions often are made between policies containing and those not containing the negative provision and sometimes its omission is invested with unanticipated significance.

For example, a policy insuring against "injuries sustained through accidental means and resulting directly and independently of all other causes in death" has been held to cover death caused only partly by accident which accelerated an existing disease, the court ruling that "if the company intended to make its liability dependent upon the physical condition of the insured it *should have so stated* in plain terms in the policy" (Cas. Co. vs. Meyer (Ark. 1913) 152 S. W. 995) and to cover typhoid fever contracted by drinking polluted water in consequence of a mistaken connection of a feed pipe with the wrong water supply (Christ vs. Ins. Co. (Ill. 1924) 144 N. E. 161). And only recently the California Supreme Court departed from its long established and consistently followed doctrines to find that the accidental contraction of infectious disease by a professional nurse in the course of duty was covered under such a policy, holding that the company *should have excluded* such a risk if it was not intended to be assumed (Moore vs. Cas. Co. (1928) 265 Pac. 207, reversing on rehearing 258 Pac. 375). Again, where insured is on way to hospital for operation of appendectomy and is jolted in the ambulance, there would be liability if this accident hastened

death or prevented an otherwise probable recovery, the court in this instance *distinguishing other cases where the policies contained a negative clause* (Ins. Co. vs. Armbruster (Ala. 1928) 116 So. 164).

These decisions may be regarded as at odds with reason, as occasional strayings from the path of doctrinal rectitude, or even sometimes as mere judicial spasms, and they certainly are at variance with the doctrine of contract interpretation laid down by the New York Appellate Division that contracts of insurance, like other contracts, are to be considered according to the sense of the meaning of terms the parties have used and if they are plain and unambiguous the terms are to be taken and understood in their plain and ordinary sense (Sasse vs. Assn. (1915) 154 N.Y. Supp. 558). They are at variance also with many other decisions, such as the ruling that where death results from erysipelas in foot with no evidence as to exact means of infection it cannot be assumed that it entered through an accidental abrasion, when it appears that it also may have been otherwise contracted (Ins. Co. vs. Murray (Va. 1916) 90 S. E. 620); where death is from cancer developed soon after an accident and expert testimony is that cancer might have resulted from the accident or from the habitual position during daily work the evidence is insufficient to show death from accident (Green vs. Assn. (Ia. 1923) 190 N. W. 934); where loss of sight of an eye results from an embolus due to insured's general condition, but possibly aggravated by violent exertion, it is not a result of accidental means exclusively (Salinger vs. Casualty Co. (Ky. 1917) 198 S. W. 1163); where a rupture of a blood vessel occurs during an attack of vomiting it is the proximate result of sickness and not an injury due to accidental means (Assn. vs. Ross (Tex. 1927) 292 S. W. 193); where mastoiditis is attributed to infection through nose from diving into a swimming pool there was no accidental means and it is mere conjecture as to how or when the germs entered the system (Henderson vs. Ins. Co. (Mass. 1928) 160 N. E. 415); where gonorrheal infection of the eye follows use of a common towel it is mere contagion of the ordinary, normal tissues without aid of violent injury (Ins. Co. vs. Herndon (Ga. 1930) 151 S. E. 399).

However, the great importance of the negative clause, as a

means of escape from confusion at least, is illustrated by contrasting the Christ and Moore cases, above cited, with a more recent decision (Chase vs. Ins. Co. (U. S. D. C. 1931) 51 Fed. (2nd) 34). Here, exactly as in the Christ case, death was due to typhoid fever contracted by drinking polluted water believed to be pure, *but the policy contained a clause excluding injury caused directly or indirectly by disease* and the court held that the "injuries" were caused by disease and *were excluded from the coverage.* Under a policy similarly constructed the Moore case ought to be as clearly distinguishable.

Effects of Treatment for Disease

In absence of definite exclusion of liability for effects of treatment for disease there is danger that the company may be held liable, or at least involved in litigation, in cases where medical or surgical treatment fails to cure or some unexpected *result* follows. It has been held that, where a surgeon while operating for disease punctures an artery which was not where it should be in a normal person and this is assigned as a cause for following complications and death, the injury was by accidental means (Ins. Co. vs. Brand (U. S. C. C. A. 1920) 265 Fed. 6) and where novocaine was administered in preparation for an operation and the patient died, the death was held to be accidental on testimony that the insured had hyper-susceptibility to novocaine and therefore the unexpected and unusual *result* was accidental (Ins. Co. vs. Dodge (U. S. C. C. A. 1926) 11 Fed. (2nd) 486. It also has been held that, where a dentist in operating on the insured unintentionally introduced virulent germs by means of instruments he believed to be clean, the death was due to external, violent and accidental means (Horton vs. Ins. Co. (Cal. 1920) 187 Pac. 1070). On the other hand death following extraction of a tooth which made a port of entry for bacteria and resulted in blood poisoning is not due to injury by accidental means exclusive of all other causes (Ramsey vs. Cas. Co. (Tenn. 1920) 223 S. W. 841); where loss of sight of an eye follows extraction of a tooth there is no evidence to support the theory that it resulted from accidental means (Whipple vs. Cas. Co. (Va. 1922) 113 S. E. 878) and death fol-

lowing administration of nitrous oxide gas preliminary to extracting a tooth, the unusual *effect* being due to insured's abnormal condition, is not due exclusively to external, violent and accidental means (Barnstead vs. Assn. (N. Y. 1923) 198 N. Y. Supp. 416); or death resulting from anesthetics administered in preparation for a surgical operation and said to be due to hypersusceptibility, was not due to accidental means, there was no accident, no injury and the result would not be independent of other causes when due to hyper-susceptibility, which was a condition already existing (Hesse vs. Ins. Co. (Pa. 1930) 149 Atl. 96).

Notwithstanding the weight of authority in favor of reading the insuring clause to mean only what it affirmatively agrees to cover, however, it is coming to be deemed the part of wisdom to include the negative clause for defining effect. Where such a clause appears it usually is given its intended effect of excluding results of disease, of itself or in concurrence with a minor injury (Brown vs. Ins. Co. (1930) 39 Fed. (2nd) 443; Ins. Co. vs. Yates (Tex. 1930) 29 S. W. (2nd) 980; Naseef vs. Ins. Co. (N. Y. 1930) 245 N. Y. Supp. 430).

And such a clause must be constructed with exceeding care, for it will be construed as favorably as possible to the insured. Thus a policy excluding liability for *injury* caused or contributed to by disease has been held not to exclude *death* due partly to pre-existing disease, on the ground that the policy was doubtful or ambiguous in applying the exclusion only to the cause of injury and not to the cause of *death* (Cas. Co. vs. Thrush (Ohio 1926) 152 N. E. 796) and a policy excluding accident, injury, loss of limb or sight resulting wholly or partly from disease has been held to cover death from disease hastened by accident on the ground that the clause, apparently by inadvertence, did not specifically mention *death* partly due to disease as one of the risks not assumed and therefore was interpreted as discriminating between disability and death, notwithstanding the fact that the insuring clause insured against death only if due exclusively to injury (Ins. Co. vs. Hoehn (Ala. 1926) 110 So. 7). Likewise, where the policy stipulates that *injuries* must result *solely* from accident but as to death merely requires that it result from injuries, death is covered even though accelerated or contributed

to by other causes (Ins. Co. vs. Leifson (U. S. C. C. A. 1930) 37 Fed. (2nd) 488. It also has been held that where a policy or membership certificate, purported to insure against "accidental death" while the by-laws of the association restricted the insurance to death from injury by external, violent and accidental means, there is a repugnant conflict and the terms of the policy must prevail; consequently in this case death unexpectedly following extraction of a tooth was held to be an *accidental death*, though *not death due to accidental injury*, and this decision often is cited where the policy is differently worded (Francis vs. Assn. (Tex. 1924) 260 S. W. 938) and where a *special provision* is added to a policy to cover septic poisoning the *result of external inoculation through accidental contact* with septic matter, it covers inoculation of a dentist from a patient afflicted with pyorrhea and this decision also is cited frequently, sometimes with misleading effect, in support of claims under policies not including such a special undertaking (Merrick vs. Ins. Co. (Mo. 1916) 189 S. W. 392).

Hernia

The exclusion of hernia and ptomaines is a precaution against misconception by the insured, or interpretation by the courts, growing out of the "popular" theory that a hernia is an injury produced by some force or violence of a particular occasion, as it once was thought to be and in consequence miscalled a "rupture," instead of the gradual development of a natural process originating in a physical defect, as it is now known to be, and the similar idea that ptomaines, or food poisoning, arise from the taking of a foreign and poisonous substance, instead of being a mere manifestation of disease, or ill effects unexpectedly following the eating or drinking of food or drink intended to be eaten or drunk. Both of these conditions belong in the domain of health insurance, but as to these sources of popular misconception it is believed to be simpler to point to the exclusion than to explain the reason.

Infections

The subject of infections is a different one, for here the intent is to insure against the results of infections *entering through actual injury* and thus becoming merely one of the effects of the injury, which is the wholly responsible cause. And yet the necessity of excluding disease contracted through ordinary infection or contagion is apparent from some of the decisions already cited. By this means the contract establishes the line of demarkation between *injury accidentally sustained,* which is the legitimate subject of accident insurance, and *disease accidentally contracted,* which is the proper subject of health insurance.

Suicide

The exclusion of suicide, while sane or insane, relates to an intentional act and therefore not an accidental occurrence, if committed while sane, or an effect of disease, if committed while insane. In either event such an exclusion is not only a proper insurance practice but in accord with considerations of public policy.

Air Risks

Risks of aviation or aeronautics are excluded as so far within the control and volition of the insured and so hazardous as not to be deemed insurable. In many policies this exclusion is absolute as to all accidents occurring in consequence of such risks, while in others incidental participation as a fare paying passenger is permitted under certain restrictions, as that the flight be between established airports and under control of licensed pilots, etc., or, as in the foregoing clause, with no such restrictions.

Exclusions and Limitations in Health Insurance

The exclusions necessary as to health insurance are more simple, aiming to confine the insurance within such climatic conditions as to conform to the experience upon which rates have been calculated, to prevent double claims under both accident and

sickness provisions where the two causes are concurrent and, more important, to prevent imposition by obtaining insurance after a disease has been contracted or a condition acquired that soon or eventually will necessitate surgical operation, institutional care, or the like.

Special Exclusions

The limiting clause of an accident policy of course may be extended by excluding coverage of certain kinds or classes of accidents and sometimes this is done for the purpose of restricting the scope of insurance and reducing the cost. The extent to which this may be done is regulated only by the degree of insurance proposed to be granted and is subject to much variation and the limiting clause therefore performs a different function. An extreme example of such a clause is as follows:

> "Association shall not be liable in case of injuries of which there are no visible marks upon the body (the body itself not being deemed such a mark in case of death), or in case of injury happening to the member while in any degree under the influence of intoxicating liquors or narcotics or by reason of and in consequence of the use thereof; or when caused wholly or in part by any bodily or mental infirmity or disease, dueling, fighting, wrestling, or in acting as a soldier or sailor, by participation in war or riot, in public or agreed automobile racing, or by wrecking, mining, blasting, the moving or transportation of gunpowder or dynamite or other explosive substances, murder, disappearance, or hazardous adventure; injury resulting from an altercation or quarrel, voluntary over-exertion (unless in a humane effort to save human life), voluntary or unnecessary exposure to danger or to obvious risk of injury or by intentional injuries or acts inflicted by the member or any other person upon him while sane or insane, or when the member dies as the result of injuries sustained as a result of a gunshot wound or the alleged accidental discharge of firearms when there is no eyewitness except the member himself; injury received either while avoiding or resisting arrest, while violating the law or violating the ordinary rules of safety of transportation companies, or caused by disease or caused directly or indirectly by epilepsy, sunstroke, paralysis, apoplexy, fits, lumbago, vertigo, unconsciousness, sleep-walking, venereal diseases, cerebral, meningeal or spinal hemorrhage, or by ptomaine

poisoning, or by voluntary or involuntary, conscious or unconscious, inhalation of any gas, anesthetic, or vapor; provided, however, that in the event of disability from carbon monoxide poisoning from escaping gas from an automobile that death or disability benefits shall be paid when the death or disability was caused by accidental means. Association shall not be liable in case of injury resulting from any poison or infection, unless the infection is introduced into, by and through an open wound (which open wound must be caused by external, violent and accidental means and be visible to the naked eye) or from anything accidentally or otherwise taken, administered, absorbed or inhaled; death, loss of either hand, foot, arm, leg, sight of either eye or disability resulting from medical, mechanical, dental or surgical treatment (operation made necessary by the particular injury for which claim is made and occurring within six calendar months from date of accident excepted)."

At times the limiting clause is similarly extended in its relation to health insurance by excluding liability for disability due to certain diseases or by reducing the amount of benefit payable and the period limit. An example of such a clause is as follows:

"No indemnity for sickness shall be paid when disability is due to any of the following diseases or causes: hernia, orchitis, syphillis, venereal disease, circumcision, disease of the genital organs; or on account of corns, bunions, in-growing toe nail or abrasion of the feet, or by the use or abuse of intoxicating liquors, narcotics or other drugs, asphyxiation or suffocation, voluntary or unnecessary exposure to infectious or contagious disease or to the elements; nor for any disability caused or induced by violent, external or accidental means. No benefits for disability due to rheumatism, paralysis, neurasthenia or any nervous trouble, insanity or any mental trouble, tuberculosis, delirium or fits shall be paid in an amount to exceed $12.50 (half the amount insured) per week, nor for more than 10 weeks."

VIII. The Benefit Provisions

Death and Dismemberment

The first benefit provision usually is that which prescribes the specific sums payable for the major losses of life, sight and limb. To reduce the percentage of error in the clerical operation of issue it is customary to designate these as the full or a proportion of the principal sum already stated in the insuring clause. A typical clause reads as follows:

> "If such injuries, directly and independently of all other causes, shall, from the date of the accident, wholly and continuously disable and prevent the insured from performing any and every kind of duty pertaining to his occupation and if, during the period of such total and continuous disability and within 200 weeks from the date of the accident, such injuries shall, directly and independently of all other causes, result in any one of the losses named in the following schedule, the Company will pay the amount set opposite such loss and, in addition thereto, the weekly indemnity above specified from the date of the accident to the date of such loss.
>
> Or, if such injuries shall not so disable the insured, but shall, directly and independently of all other causes and within 90 days from the date of the accident, result in any one of the losses named in the following schedule, the Company will pay the amount set opposite such loss.

Schedule Referred to in Clause 1

For loss of life	The full principal sum above specified
For total and irrecoverable loss of sight of both eyes	The full principal sum above specified
For loss of both hands by severance at or above the wrist joints	The full principal sum above specified
For loss of both feet by severance at or above the ankle joints	The full principal sum above specified
For loss of one hand and one foot by severance at or above wrist and ankle joints	The full principal sum above specified

For loss of one hand by severance at or above the wrist joint and the total and irrecoverable loss of sight of one eye	The full principal sum above specified
For loss of one foot by severance at or above the ankle joint and the total and irrecoverable loss of sight of one eye	The full principal sum above specified
For loss of one hand by severance at or above the wrist joint	One-half of the said principal sum
For loss of one foot by severance at or above the ankle joint	One-half of the said principal sum
For total and irrecoverable loss of sight of one eye	One-third of the said principal sum

Provided always that, if more than one of the losses enumerated in the above schedule shall be sustained, payment shall be made only for the one for which the largest amount is specified."

This clause may and often does vary in several particulars. It may confine coverage of the respective losses to their occurrence within ninety days, or thirty days, or similar period after the accident, irrespective of disability during the interval; it is occasionally found to stipulate both for the short period and intervening disability; it may in either event provide only for payment of the specific sum or, as is more common, may provide as in the foregoing for loss occurring within ninety days or similar short period irrespective of disability and for loss occurring within the longer period in case total disability exists throughout the interval and for payment of disability benefit during that interval—thus stipulating in such cases for a continuous condition and a connected train of events, between the accident and the loss, sufficient to assure reasonable proof that the loss is due to the accident alone.

There may be variations also in the specifications of particular losses; some of those included in the foregoing may be omitted or others may be added, such as loss of thumb and index finger of the same hand in the same accident or loss of speech or hear-

ing; different sums may be provided for loss of arm or leg above the elbow or knee joints; different proportions of the principal sum may be allowed in different policies for the same particular loss. Mostly, however, these variations apply to losses or combination losses of rarest occurrence and are designed to supply "talking points" for selling purposes without contemplation of noticeable change in insurance cost.

From a technical standpoint the most vital part of this provision is its initial stipulation that the specific loss shall result solely from injuries insured against, that is, directly and independently of all other causes. In absence of this stipulation the policy might prove susceptible to the construction that whereas the injury must be due alone to accident it is not necessary that the death, or loss of sight or limb, be due alone to the injury.

It is essential also that loss of sight be designated as both total and *irrecoverable,* else minor impairments of vision might be held to be a loss of sight or recovery of benefit might be had as a preliminary to operative or other treatment resulting in recovery of sight also, as in cataract cases, for example.

It is held that the sight of an eye is deemed lost when there is no ability to distinguish or recognize objects, though light can be distinguished from darkness, but not when the sight is merely so impaired that the eye is not useful in particular work or at particular times, though normally objects could be distinguished (Murray vs. Ins. Co. (U. S. S. C. 1916) 243 Fed. 285); the insured must show that loss of sight is both entire and irrecoverable (Wilkins vs. Cas. Co. (Ga. 1917) 91 S. E. 224; Vinginerra vs. Cas. Co. (N. Y. 1916) 156 N. Y. Supp. 573) and color blindness, though disqualifying the insured from his occupation as railroad brakeman, is not complete loss of sight (Kane vs. Assn. (Neb. 1918) 168 N. W. 598). Where the policy stipulates for loss of sight within a stated period after the accident there is no liability where the loss occurs later (Buford vs. Ins. Co. (U. S. C. C. A. 1925) 3 Fed. (2nd) 263; Murray vs. Ins. Co. (U. S. S. C. 1916) 243 Fed. 285).

It is likewise essential to specify that loss of limb shall be *by severance* and at a *definite point,* else loss of *use* of the limb, which may even not prove permanent, may be construed as the loss of limb intended, while, if a definite point of severance is

not specified, various degrees of approximation may be substituted for that contemplated.

Thus, where the policy provided merely for "loss of arm" it is not necessary that it be severed but only that it appear useless (Assn. vs. Hancock (Tex. 1915) 174 S. W. 657) but where the policy stipulates for severance loss of use is not sufficient to establish liability (Cas. Co. vs. Shelby (Miss. 1917) 76 So. 839). Likewise, where the policy provides for loss by severance but without specifying the point of severance, removal of any material portion is sufficient (Assn. vs. Brazington (Ind. 1919) 123 N. E. 221) while, with the point of severance stipulated, the removal of any lesser portion is not sufficient (Assn. vs. Walsh (Ohio 1914) 59 Ohio Law Bull. 255; Newman vs. Ins. Co. (Mo. 1915) 177 S. W. 803; Cas. Co. vs. Bows (Fla. 1916) 72 So. 278; Hardin vs. Cas. Co. (Tex. 1917) 195 S. W. 653). It is also held that where the policy stipulates for severance within a stated period after the accident there is no liability for loss occurring at a later time (Orenstein vs. Ins. Co. (Minn. 1917) 163 N. W. 747).

Disability in Accident Insurance

Total and partial disability are provided for in the shape of a stated weekly benefit for each and these clauses may, for purposes of accident insurance, read as follows:

> "If such injuries shall not result as specified in Clause 1, but directly and independently of all other causes, shall, within two weeks from the date of the accident, continuously and wholly disable and prevent the insured from performing any and every kind of duty pertaining to his occupation, the Company will pay the insured the weekly indemnity above specified for the entire period of such total disability."
>
> "If such injuries shall not result as specified in Clause 1, but, directly and independently of all other causes, shall, within two weeks from the date of the accident or immediately following total disability, continuously disable and prevent the insured from performing some one or more important daily duty or duties pertaining to his occupation, the Company will pay the insured one-half of the weekly indemnity above specified for the period of such partial disability, not exceeding 26 weeks."

In many policies these clauses stipulate that the disability shall begin immediately or from the date of accident, thus to provide for an immediate development as evidence of cause and effect, and leaving it to discretionary practice to recognize disabilities developing after an interval when the claims appear meritorious. Or the clause may, like the foregoing, specifically allow the stated period of two weeks between accident and disability. The total disability clause may vary also by fixing a maximum period for which benefit is payable, instead of covering the entire period, as the partial disability clause uniformly does. Period limits in either clause are of course subject to variation in different policies and there may be variation also in the proportion of benefit payable for partial disability, though the most usual rate is one-half.

More recently a further provision has been rather generally added to the total disability clause, fixing a different definition for such disability when it exceeds fifty-two weeks in duration, as follows:

> "If such disability shall continue for the period of 52 weeks and if the insured shall be then and thereafter continuously and wholly disabled by such injuries, independently of all other causes, from engaging in any and every occupation or employment for wage or profit, the Company will continue the payment of the weekly indemnity so long as the insured shall be so disabled."

In some policies two degrees of partial disability are provided for, with different rates of benefit, in which case the one of greater degree is denominated "intermediate" disability and is defined in the policy as inability to perform "a major portion of the daily duties pertaining to the occupation" or, in some instances, "prevent performing work substantially essential to the duties of the occupation." At times either of these expressions is used to identify partial disability without discrimination between so-called intermediate and partial and without difference in benefit payable.

Disability in Health Insurance

Total disability for purposes of health insurance is similarly provided for under substantially identical conditions except for the stipulation for medical treatment, usually included, the pur-

pose of which is to preclude claims for voluntary absence, with allegation of petty ills impossible to verify, and upon the reasonable theory that an insured sick enough to necessitate total abstention from work should be under the care of a physician and should be prepared to furnish competent certification. Partial disability is not commonly provided for but when it is it usually is restricted to a period of recuperation following a totally disabling sickness as the only means of judging as to the actual existence of a partial disability and of protecting the body of fair dealing policyholders against increased cost of insurance by reason of petty impositions by a limited number.

Following are examples of these clauses:

> "If such disease or sickness, directly and independently of all other causes and while this insurance is in force, shall continuously and wholly disable and prevent the insured from performing any and every kind of duty pertaining to his occupation and shall require and receive the continuous care and treatment of a legally authorized physician, the Company will pay the weekly indemnity for the period of such total disability, not exceeding 52 weeks.
>
> "If such disease or sickness, directly and independently of all other causes and immediately following such total disability of not less than seven consecutive days' duration, shall continuously and wholly disable and prevent the insured from performing some one or more important daily duty or duties pertaining to his occupation, and shall throughout the period of such partial disability require and receive the continuous care and treatment of a legally authorized physician, the Company will pay one-half of the weekly indemnity for the period of such partial disability, not exceeding 10 weeks."

In some policies a different clause is used, in which total disability is contractually measured by the factor of house confinement and in such cases there may or may not be an additional provision for reduced benefit during total disability while not confined to house. Examples of such clauses are as follows:

> "A. If such disease shall wholly and continuously disable the insured and prevent him from performing any and every duty pertaining to his occupation and shall confine him to the house, the Company will pay the weekly indemnity hereinafter specified for the period of such continuous disability and confinement to the house.
>
> B. And if, immediately following such a period of total

disability and confinement to the house, such disease shall wholly and continuously disable the insured and prevent him from performing any and every duty pertaining to his occupation, but shall not confine him to the house, the Company will pay weekly indemnity of one-half the amount hereinafter specified for the period of such continuous disability.

Indemnity under Sections A and B of this Part for confining or non-confining disability, singly or combined, shall be payable for not exceeding fifty-two consecutive weeks."

In some policies further conditions are included in these clauses, i.e., that the insured shall, while confined to the house, be regularly visited therein and treated by a physician, or that such visits or treatments shall be of a stated frequency, or in rare instances that the insured be confined to bed; these variants are usually for the purpose of limiting the insurance to cover the more serious illnesses and thus reducing the cost. These clauses may also be qualified by a condition that sickness occurring within a stated period, such as thirty or sixty days, after the policy date shall not be covered, the purpose of course being to protect the Company against the obtaining of insurance when illness is known to be impending.

In some policies the disability, whether from accident or sickness, is contractually specified as inability to work in any and every occupation or business for wages or profit.

What Constitutes Total or Partial Disability

What constitutes total or partial disability, in the light of the plain terms of a policy, is, in simple reason and logic, obvious enough. In common practice little difficulty attends the ascertainment of liability and pursuant adjustment of claims. The vast majority of claims are made fairly in accordance with the policy terms and, where misunderstandings occur or excessive demands are made, the insured is alive and available for negotiation and reconciliation of possibly differing views; amounts at stake are not often very great and, with the commonly prevailing spirit of liberality on the part of the companies, combined with their privilege to cease insuring one found unfair, unreasonable or predatory, astonishingly little litigation results in proportion to the enormous number of claims dealt with.

Even where disputes are referred to the courts the various cases are so variously affected by varying facts and circumstances that one case rarely fits another with any degree of exactness. Certain principles of law, however, have been reasonably well established, though with the occasional divergencies of opinion that always constitute the hazards of litigation.

It is reasonably held that, where there is serious injury or disease and after a period of total disability there is an attempt to resume work with quick development of an even more serious condition, there was continuous total disability; (Joiner vs. Cas. Co. (Tex. 1915) 178 S. W. 806) and that total disability does not imply that there is no physical ability to attend to some duties, where the injury is such that common care and prudence require the insured to desist from his work (Cas. Co. vs. Bryant (Tex. 1916) 185 S. W. 979) but it is less easy to find a distinction between total and partial disability in a ruling that one able to do a third of his work is *totally* disabled upon the theory that disability from *any and every* duty means inability to do *all* the substantial or material acts required in the occupation (Cas. Co. vs. Logan (Ky. 1921) 229 S. W. 104). The plain terms of the policy are generally given their proper effect and a cotton factor who showed only inability to sample cotton was held not to be totally disabled where it appeared that there were many other duties in the occupation of cotton factor that he could perform (Cas. Co. vs. Chew (Ark. 1909) 122 S. W. 642) and where in other occupations there was ability to perform at least a part of the regular duties (Cas. Co. vs. Henderson (Ark. 1917) 192 S. W. 206; Ins. Co. vs. McCullogh (Ky. 1921) 229 S. W. 1034). Likewise, where the policy insures against disability from *any and every occupation* or from work of any kind, it does not mean disability from the usual occupation or the one in which the insured is at the time employed but means any occupation for which the insured is fitted (Assn. vs. Roos (Ind. 1916) 113 N. E. 760; Ins. Co. vs. Jones (Miss. 1917) 73 So. 566).

Again, however, the faultily worded policy produces a decision which, upon careless reading, may appear at odds with reason and at variance with other authorities. Thus, under a policy insuring against disability merely from "every occupation" the insured may recover though he returned to work to perform a

part of his duties (Cas. Co. vs. Bowman (Ind. 1917) 114 N. E. 992) and a little analysis will show that "every" occupation does not mean "any and every" occupation, nor does the word "any" alone have the same significance, whether used to qualify the word "occupation" or the word "duty."

Immediate and Continuous Disability

Where the policy provides for disability immediately or from the date of accident the factor of time is quite uniformly given its intended effect and naturally so, not only because of the terms of the policy but also because in such cases the relation of cause and effect is at least exceedingly dubious; hence disability developing after intervals of weeks or months from the date of accident is held not to be immediate (Hefner vs. Cas. Co. (Tex. 1913) 160 S. W. 330; Mullins vs. Assn. (Mo. 1914) 168 S. W. 843; Hefner vs. Cas. Co. (Tex. 1920) 222 S. W. 966; Feitel vs. Cas. Co. (La. 1920) 84 So. 491; Assn. vs. Farrar (Ind. 1920) 126 N. E. 435; Herwig vs. Assn. (Mo. 1921) 234 S. W. 853; Thompson vs. Ins. Co. (La. 1923) 98 So. 746; Ins. Co. vs. Penzel (Ark. 1924) 261 S. W. 920; Penquite vs. Ins. Co. (Kan. 1926) 246 Pac. 498). These authorities give essential protection against attempts to attribute disease to some ancient accident or to predicate claims for disability occurring after expiration of insurance upon events alleged to have happened while the insurance was in force.

Similarly the stipulation that disability shall be continuous is given its intended effect and intermittent disabilities speculatively attributed to a single originating cause, and recurrence after a definite termination of disability, are held not to be within the specification of continuous disability (Mullins vs. Assn. (Mo. 1914) 168 S. W. 843; Harper vs. Ins. Co. (Ky. 1919) 209 S. W. 349; Cas. Co. vs. Logan (Ky. 1921) 229 S. W. 104).

House Confinement as Measure of Disability

Where the policy stipulates for house confinement as the measure of total disability from sickness that stipulation is usually interpreted in the light of reason. It has been rather erratically held that the purpose of this stipulation is to give the company evidence of disability but that nevertheless in absence of such

evidence the existence of such disability may be determined otherwise — even from argumentative assertions of facts not included in the actual testimony (Cas. Co. vs. Hawes (Ky. 1912) 149 S. W. 1110). More reasonably it is held that merely going out for air occasionally, or ability to leave the house only for purposes connected with the sickness, or being removed from one place to another for treatment, does not negative the fact of substantial confinement (Ins. Co. vs. King (Miss. 1912) 59 So. 807; Hines vs. Ins. Co. (N. C. 1916) 90 S. E. 131; Ins. Co. vs. Willetts (U. S. C. C. A. 1922) 282 Fed. 26).

But where the evidence fails to show that there is a real confinement it is not sufficient to show disability existed notwithstanding (Bruzas vs. Cas. Co. (Me. 1914) 89 Atl. 199; Cas. Co. vs. Niedlinger (Miss. 1917) 73 So. 875; Rocci vs. Ins. Co. (Mass. 1917) 116 N. E. 477; Pirsher vs. Cas. Co. (Md. 1917) 102 Atl. 546; Reeves vs. Cas. Co. (Wis. 1919) 174 N. W. 475; Cas. Co. vs. Sanderson (Ark. 1920) 222 S. W. 51; Heymann vs. Cas. Co. (La. 1920) 86 So. 550; Sheets vs. Assn. (Kan. 1924) 225 Pac. 929).

One court aptly remarks that, where there is total disability but no confinement, the "court is unable, with only judicial construction as the instrument, to perform the major operation of removing the appendix of confinement to the house from the body of total disability" and refers to without endorsing another opinion in which it is said that "courts incline to pit judicial astuteness against the astuteness of the policy maker" but refrains from engaging in that pastime (Bucher vs. Cas. Co. (Mo. 1919) 215 S. W. 494).

It is startling to find that such a sentiment as that last quoted could appear as a consideration in the deliberations of learned administrators of American justice, for it would amount to a denial by judicial fiat of the right of freedom of contract and an assumption of power to unmake any agreement that may be made. It suggests, however, a mistaken conception that comparison can fairly be made between a contract limited in scope in consideration of a lesser price and a more complete one at a greater cost, with the right of choice vested in the one party equally with the other. It is equally startling to find another court asserting that an insured is given no protection at all if he is not given both

health and life insurance when he buys accident insurance only and then seeking an intent not expressed in the policy by interpreting the mere name of the policy, i.e., the "business woman's disability policy" to imply an intent to insure against anything that happens to an employed woman, converting the mere title of the occupational classification, i.e., "preferred" as implying that there could be no hazard connected therewith that was not to be covered, and thus rebuilding a contract from material never provided by the parties. But these are merely occasional episodes that do not by any means represent or reflect the wisdom and balance prevailing in our courts.

Attendance by Physician

Where the stipulation is that the insured shall be not only confined to the house but attended therein by a physician, it is held that communication with a physician through members of the family, or over the telephone, and visits to the physician after confinement terminates, do not meet requirements of the policy, even though evidence of total disability is conclusive (Campana vs. Assn. (N. Y. 1921) 186 N. Y. Supp. 82).

The stipulation for treatment by a legally qualified physician also is held valid and "just as good" treatment by a chiropractor, though permitted by law to practice that profession, is not the thing specified by the policy (Isaacson vs. Assn. (Wis. 1925) 203 N. W. 918).

Where the policy provides only for total and permanent disability from *any and all* gainful occupations an insured who has lost one arm cannot recover, since he is not thereby prevented from following all occupations though he cannot return to his former occupation (Buckner vs. Ins. Co. (N. C. 1916) 90 S. E. 897) and an insured whose disability has in fact terminated cannot recover for *permanent* disability, notwithstanding a provision for proof after sixty days continuance of such disability; permanent does not mean temporary and, while fairness requires that reasonable proof of permanency be accepted and benefit paid while such permanency lasts, liability ceases when disability terminates (Hawkins vs. Ins. Co. (Ia. 1928) 218 N. W. 313). A clause presuming permanency after three months' duration is in-

tended to extend benefits where doubt exists but insured's admission of recovery when presenting claim is sufficient to prevent recovery of benefit (McKenzie vs. Ins. Co. (N. Y. 1931) 251 N. Y. Supp. 528).

Double Benefits

The double benefit clause, while not contained in all policies, is very commonly included. It found its origin in the prevalent belief that unusual hazard is involved in travel and in the common custom of buying extra insurance in the form of "trip tickets" when starting on a journey. In order to furnish this additional insurance, automatically as needed and at less cost and greater convenience, a clause was introduced into the accident policy under which the insurance was doubled in event of injury in consequence of the wrecking of a railroad train; this was soon extended to include the foundering of a steamship and later to cover any accident occurring while traveling in any public passenger conveyance and, most generally, without regard to whether the conveyance shall be wrecked, damaged, or otherwise involved in the accident.

Some of these double benefit clauses still are conditioned upon wrecking of or accident to the conveyance but more commonly they are of the broader form.

An example of such a clause is as follows:

> "If such injuries be received (a)—while the insured is riding as a passenger in or on any public conveyance (except aerial conveyances) of a common carrier regularly provided for passenger service (including the platform, steps or running board of such conveyance but not while or in consequence of attempting to enter or leave such conveyance); or (b)—while riding as a passenger in a regular passenger elevator car; or (c)—in consequence of the burning of any building in which the insured shall be at the commencement of the fire; the amounts payable for any of the losses enumerated in the preceding clauses shall be doubled."

In some policies this clause is carried further to include, in the specified causes of accident subject to double benefit, collapse of outer walls of a building, stroke of lightning, explosion of a steam boiler, cyclone or tornado, and earthquake. Any or all of these

may be found in various policies without difference in premium and occasionally double benefit may be provided for accidents to private automobiles but in that event an additional premium is charged.

As may be expected such a clause, holding possibilities of double recovery and especially in cases of fatal accidents involving important sums, has been somewhat subject to attempts to carry it beyond its intended meaning. And so it has been necessary for the courts to rule that a caboose attached to a cattle train is not a passenger conveyance (Zantow vs. Ins. Co. (Neb. 1920) 178 N. W. 507) that a picnic wagon furnished by a transfer company is not a public conveyance of a common carrier (Ins. Co. vs. Easter (Ala. 1915) 66 So. 514) that an automobile is not a public conveyance (Rubens vs. Cas. Co. (Ind. 1919) 122 N. E. 786) and the same is true of automobiles hired from garages for specific trips (Rathbone vs. Ins. Co. (Ill. 1921) 132 N. E. 754, and Cheney vs. Ins. Co. (U. S. C. C. A. 1925) 4 Fed. (2nd) 826) and that an airplane taking passengers by special arrangement on agreed flights is not a public conveyance nor operated by a common carrier (Ins. Co. vs. Pitts (Ala. 1925) 104 So. 21, and Brown vs. Ins. Co. (U. S. C. C. A. 1925) 8 Fed. (2nd) 996). A taxicab operated by a company carrying all comers but subject to the orders of the passenger is held not to be a public conveyance (Darnell vs. Cas. Co. (Tenn. 1915) 46 Ins. Law Journal 523) while the contrary is held under most similar conditions (Anderson vs. Cas. Co. (N. Y. 1920) 127 N. E. 584).

Where the clause is silent as to double benefit while getting *on or off* of the specified conveyances nice questions are likely to arise. In such case, a passenger in act of alighting, with one foot on the step and the other on the pavement, is still a passenger and double benefit applies (Gibson vs. Cas. Co. (N. Y. 1913) 140 N. Y. Supp. 1045) and another who falls while boarding a car, with his body on the platform and legs hanging down, is in or on the conveyance (Rosenfeld vs. Ins. Co. (N. Y. 1916) 161 N. Y. Supp. 12) but one who endeavored to board a moving train, missed his hold and fell to the ground, was not riding as a passenger (Anable vs. Cas. Co. (N. J. 1906) 63 Atl. 92) and such a clause requires that the passenger be at least on the steps of the car (Fay vs. Ins. Co. (Mo. 1916) 187 S. W. 861).

It has been necessary also to rule that a subway *station* platform is not the platform of a *conveyance* (Weil vs. Ins. Co. (N. Y. 1917) 166 N. Y. Supp. 225) and that the word "on" will not be construed to mean adjacent or alongside, as the word is used to describe a city as "on" a river, in order to apply the double benefit clause to one killed by the sudden starting of an automobile while standing on the ground in front of it (Turner vs. Cas. Co. (Mo. 1918) 202 S. W. 1078).

Occasionally this clause is more closely conditioned to cover only while riding in a place regularly provided for occupancy of passengers during transportation, in which case it is held not to apply either while boarding or while on the platform (Mitchell vs. Ins. Co. (Mo. 1914) 161 S. W. 362 and Ins. Co. vs. Fleming (Md. 1916) 96 Atl. 281).

A passenger elevator is one customarily used for conveying passengers (Wilmarth vs. Ins. Co. (Cal. 1914) 143 Pac. 780) and this would not include an elevator in a garage designed for conveying automobiles and the fact that persons were permitted at times to ride on it did not change its character (Losie vs. Ins. Co. (N. Y. 1918) 171 N. Y. Supp. 174).

Where double benefit is provided for injury or death in consequence of the burning of a building it does not mean injury or death from burns sustained while in a building, or even if the building subsequently is burned, but the burning of the building must precede and be the cause of injury or death of the insured (Cas. Co. vs. Edgar (U. S. C. C. A. 1913) 203 Fed. 656; L'Ecuyer vs. Ins. Co. (Kans. 1916) 155 Pac. 1088; Farley vs. Ins. Co. (Mo. 1918) 207 S. W. 281; Kreiss vs. Ins. Co. (N. Y. 1920) 127 N. E. 481; Arnold vs. Ins. Co. (R. I. 1927) 136 Atl. 690).

Medical and Surgical Benefits

Medical Attendance

Accident policies commonly contain a provision for payment of doctors' bills in case of minor injuries that do not cause disability or furnish other basis for benefit claim. An example of such a clause follows:

> "If any injury covered by this policy and sustained by the insured does not cause a result for which an indemnity is

provided by this policy, but requires and receives treatment by a legally authorized physician, the Company will reimburse the insured for the cost of such treatment, not exceeding one week's indemnity as provided in Clause 2."

Surgical Operation Fees

Provision for additional payment of stated sums in case of certain surgical operations as specifically listed in the policy is commonly made. Where the policy is for accident insurance only the schedule of operations includes only those necessitated by accidental injury, while a policy of accident and health insurance includes many others necessitated by disease. The stated amounts fixed for the various operations are, of course, regulated by the amount of the insurance. An example of such a clause applicable to both accident and health insurance is as follows, and this would be modified in case of accident insurance by merely omitting the reference to disease.

"If any injury or disease covered by this policy shall, within ninety days from the date of the accident or of the contraction of the disease, alone and necessarily require any surgical operation named in the Schedule of Surgical Operations endorsed hereon, the Company will pay the insured the sum set opposite the said operation in the said schedule, provided always that, if more than one such operation shall be necessitated as the result of any one accident or disease, payment shall be made only for the operation first occurring."

Hospital Benefit

There is variation in practice in respect to increased benefit during hospitalization. There is often no such provision as respects accident insurance but it is more common in policies of accident and health insurance and occasionally it is found in accident policies only. There is variation also in the amount of additional benefit provided and in the number of weeks for which it may be payable, some policies allowing double the regular weekly benefit and others an increase of 50 per cent., while in still others the additional benefit is regulated by the actual amount expended for hospital expenses but with a certain limit in proportion to the amount of insurance. The period for which additional benefit is allowed may be ten, twelve or twenty weeks,

or various other periods, and the longer periods may be coincident with the smaller amounts of additional benefit. Examples of clauses of both types are as follows:

> "If such disease or sickness, directly and independently of all other causes and while this insurance is in force, and within ninety days from the beginning of such disease or sickness, shall necessitate the removal of the insured to any regular hospital, the weekly indemnity payable for the period, not exceeding 10 weeks, during which he shall be continuously and necessarily confined in the said hospital, shall be doubled, provided that the insured shall not make claim under Clause 12 (surgical operations) on account of the same disease or sickness."
>
> "If the insured is necessarily and continuously confined in a hospital by reason of injuries, or disease or illness covered by this policy, the Corporation, in addition to the Indemnity otherwise payable, and in lieu of Surgical Indemnities or Graduate Nurse Expense, will pay the amount expended for hospital expenses, not exceeding one-half the single weekly indemnity specified in Section Two, for each week that the Insured is so confined, but for not more than ten consecutive weeks."

Nursing Benefits

Occasionally policies include a further provision for additional benefit for the cost of professional nursing in lieu of the surgical or hospital benefits. An example of such a clause is as follows:

> "In lieu of any sum payable for Surgical Indemnities or Hospital Expense, the Corporation, in addition to the indemnity otherwise payable, will pay the amount expended each week for graduate nurse, not exceeding one-half the single weekly indemnity provided in Section Two, but for not more than ten consecutive weeks."

Identification

This clause, quite commonly included in accident policies, usually appears as follows:

> "If the insured shall, wholly by reason of injury covered by this policy, be rendered physically unable to communicate with friends, the Company will, upon receipt of a telegram or other message giving this policy number, immediately transmit to the relatives or friends of the insured any information respecting him and defray all expenses necessary

to place the insured in communication with and in the care of friends, not exceeding a sum equal to four weeks' indemnity at the rate per week provided in Clause 2."

Accumulations

In former years a practice was in vogue in which the principal sum of the policy was increased on each year's renewal, sometimes at the rate of 10 per cent. and other times at the rate of 5 per cent. annually, such increases continuing until the principal sum had been increased by a total of 50 per cent. The purpose of this, of course, was to encourage persistency of renewal and thereby to reduce lapsation. The effectiveness of this provision was soon destroyed by a competitive practice whereby a company to which the insurance might be transferred assumed the accumulations acquired under the policy in the former company and this practice presently developed into one of issuing policies originally for principal sum equal to the fully accumulated amount at the same premium as formerly charged with the accumulation provision. An example of such clause which occasionally still appears in some policies is as follows:

"If all premiums are paid annually, the original principal sum hereby insured will be increased ten per cent. beginning with the second year and continuing for five consecutive years, until such increases amount to fifty per cent. of the original principal sum and thereafter, so long as this Policy is maintained in force by annual premium payments, the amount insured shall be the original principal sum plus the accumulations.

"If premiums are paid otherwise than annually, the original principal sum hereby insured will be increased five per cent. beginning with the second year and continuing for ten consecutive years, until such increases amount to fifty per cent. of the original principal sum and thereafter, so long as this Policy is maintained in force, the amount insured shall be the original principal sum plus the accumulations."

Blindness and Paralysis

Some policies include a special provision for an additional lump sum payment at the expiration of the disability period limit in case of permanent blindness or paralysis resulting from disease. An example of such a clause is as follows:

"If such disease or sickness, directly and independently of all other causes and while this policy is in force, shall result in the total and irrecoverable loss of sight of both eyes, or in permanent paralysis whereby the insured shall entirely lose the use of both hands or of both feet or of one hand and one foot, and if, wholly because of such loss of sight or such paralysis, the insured shall be continuously and wholly disabled and prevented from performing any and every kind of duty pertaining to his occupation for a period of one year, and at the end of said period of one year shall still survive and shall be permanently unable to perform any and every kind of duty pertaining to his occupation, the Company will pay a sum equal to the weekly indemnity for 100 weeks, in addition to any sums payable under Clause 9 on account of the same disease, sickness or disability."

Participation in Divisible Surplus

One company issues a participating form of accident and health insurance similar in effect to the practice common in life insurance. An example of such a clause is as follows:

"This policy is a participating contract and, commencing not later than the end of the third policy year, the Company will annually, if and while this policy is in force, ascertain and apportion any divisible surplus accruing hereon, after setting aside such an amount for a contingency reserve as the directors of the Company shall deem necessary."

IX. The Consideration Clause

The consideration clause of such a policy expresses two considerations, viz: the statements of fact in the application and the payment of the premium. An example of such a clause is as follows:

"In consideration of the statements in the application, copy of which is attached hereto, and of the payment of the premium."

In earlier days the statements in the application were expressly made warranties, with the effect that the validity of the contract was conditioned upon the exact truth of each and all of such statements, irrespective of any question of materiality or intent, because a warranty must be literally and strictly true or the policy will not take effect (Kahn vs. Ins. Co. (Cal. 1918) 178 Pac. 331; McManus vs. Cas. Co. (Me. 1915) 95 Atl. 510).

In present practice, however, and in accordance with the terms of the Standard Provisions laws, the statements in the application are deemed representations of fact and the policy is voided only if false statements are made with intent to deceive or materially affect either acceptance of the risk or the hazard assumed by the company. Statements relative to the previous condition of the insured are material (Porter vs. Ins. Co. (Cal. 1916) 157 Pac. 825) as also are statements relative to previous cancellations or refusals to insure by other companies (Cas. Co. vs. Eddy (U. S. C. C. A. 1917) 239 Fed. 477) or collection of claims from other companies (Cas. Co. vs. Collins (Ind. 1920) 126 N. E. 86) or as to past medical treatment (Stanulevich vs. Ins. Co. (N. Y. 1920) 127 N. E. 315) or as to the character of occupation and duties (Murray vs. Ins. Co. (Ia. 1925) 201 N. W. 595) or that earnings exceed the weekly benefits provided by the insurance (Wicklow vs. Ins. Co. (N. Y. 1927) 221 N. Y. Supp. 157).

The actual payment of premium is in fact a condition precedent to the validation of the policy, but this may be modified by a course of action. Thus the physical delivery of the policy and the agreed extension of credit for payment puts the insurance in force (Huestis vs. Ins. Co. (Minn. 1916) 155 N. W. 643; Lafferty vs. Cas. Co. (Mo. 1921) 229 S. W. 750). But where an insured refused to accept a policy issued and offered to him, declaring that he did not want it but failed to return the policy, there was no liability for accident occurring while it was in his possession (Cas. Co. vs. Grace (Miss. 1916) 70 So. 577) and insurance is not kept in force by the issue of a renewal and the forwarding of the same to the company's agent with privilege of returning if not paid and the insured does not pay (Amos vs. Cas. Co. (Md. 1917) 102 Atl. 1001) nor even by remittance of premium by the agent to the company where the insured declared he did not intend to renew and refused to pay (Grogan vs. Ins. Co. (Colo. 1914) 139 Pac. 1045).

X. Copy of Application

The copy of the application, contractually made a part of the policy, is attached to or endorsed upon the policy. This may be by photostatic or other copy fastened to the policy or by printing the application form upon the policy and filling in the written

parts to correspond with the original. Thus the insured is at all times in possession of a copy of the statements he has made over his signature and for the truthfulness of which he is responsible.

XI. Conditions of Performance

The general conditions of performance, pertaining to the effectiveness and continuance of the insurance and the rights and obligations of the parties during its operation, were formerly subject to great variation and sometimes rather onerous conditions were included. The standard provisions, now statutory in a considerable number of states and commonly used in all policies, have for some years established a standard of fairness and reasonableness as a result of practically arbitral judgment of the lawmaking power as between the respective rights of the parties.

No other conditions inconsistent with or contradictory to any of the statutory provisions are permissible but certain provisions necessary to comply with special requirements of particular states, or relating to subjects not included within the statutory provisions, are commonly inserted under the caption of special or additional provisions, the intent and purpose of which are readily apparent from the reading. An example of such a clause is as follows:

> "If the age of the insured has been misstated in the application the indemnities payable hereunder shall be such as the premium paid would have purchased at the correct age. The copy of the application attached hereto is hereby made a part of this contract. No provisions of the charter, constitution, or by-laws of the Company not included herein shall avoid the policy or be used in evidence in any legal proceedings hereunder. This policy is issued by the Company and accepted by the insured subject to the following provisions prescribed by law and shall be void if any of the statements or answers in the application are false and such false statements or answers are made with intent to deceive or if such false statements or answers materially affect either the acceptance of the risk or the hazard assumed by the Company. Failure of the insured or beneficiary to comply with any of the provisions or requirements of this policy shall invalidate all claims.
>
> "This policy may, with the consent of the Company, and subject to all of the terms, conditions and provisions of this

policy, be periodically renewed upon each successive expiration, for a further period of equal number of months, upon the payment of the premium herein stated, as the premium for each such successive renewal. This provision for renewal shall cease to be in force upon the expiration of the period next preceding the sixtieth birthday of the insured. Upon each such renewal a grace of thirty-one days, without interest charge, shall be granted for the payment of the premium, during which period the insurance shall continue in force."

Such a clause is of course subject to certain variation; for example, the reference to misstated age would not be included in a policy for which the premium does not vary with age, provision for grace may be omitted, the reference to renewal may be omitted or may be altered to vest right of renewal in the insured, as in case of a non-cancellable form, and other conditions may be added in certain forms of policies—always provided they are not in conflict with any of the standard provisions. An example of the renewal provision of a non-cancellable policy is as follows:

"The insurance under this policy does not cover the insured after he passes the age of sixty years, but until that time he shall have the right to renew this policy from year to year by payment of the premium as herein provided."

Other provisions sometimes included in non-cancellable policies are as follows:

"After the first twelve months of disability, no indemnity shall be payable for any period of disability during which the insured is not continuously within the United States (not including Alaska, the Panama Canal Zone or the insular possessions of the United States) unless a written permit to reside elsewhere be granted by the Company.

"Indemnity for disability will not be paid under this policy at a rate in excess of the average earnings of the insured for the period of time that he has been actually employed during the two years immediately preceding the commencement of the disability for which the Company is liable, and all premiums paid during said two years, for that portion of the disability indemnity in excess of the amount of such earnings, will be returned upon request of the insured. The insured shall have the right to reduce all or any of the indemnities of this policy on any anniversary of the date hereof and upon his request and temporary surrender of the policy for endorsement, the Company will endorse it, making such reduction of indemnities and a proportionate reduction in premium.

"At any time during the life of this policy, if the insured changes his occupation to one different from that stated in this policy, the Company hereby agrees upon the surrender of this policy to issue in lieu thereof upon the written request of the insured, a new policy containing the same provisions as this policy except a change in the amount of the benefits payable, the new policy to provide such an amount payable for disability as the premium paid for this policy will purchase at the rates but within the limits fixed by the Company for such different occupation.

"If the age of the insured has been misstated, any amount payable under this policy shall be that amount which the premium paid would have purchased at the rate fixed by the Company for the insured's correct age."

Where a non-cancellable policy is issued upon the aggregate disability benefit basis the premiums are quoted at a certain rate for each $1,000 of aggregate disability benefit and the policy then contains a clause of which the following is an example:

"AGGREGATE DISABILITY INDEMNITY—This indemnity shall be payable as it becomes due under the provisions of this policy in monthly installments of..... Dollars. Such Monthly Installments are hereinafter termed "Monthly Indemnity" and the total of all Monthly Indemnity payable on any one claim or payable in the aggregate on all claims arising under this policy shall not be greater than the said aggregate Disability Indemnity stated in policy. When the full amount has been paid on any one claim or in the aggregate on all claims arising under this policy no further Monthly Indemnity shall be payable and all insurance under policy shall terminate. Any premium paid for any further period of insurance will be returned to the insured upon request. All provisions for payment of Monthly Indemnity are subject to limit of Aggregate Disability Benefit as stated above."

XII. Standard Provisions

The standard provisions uniformly used are largely self-explanatory and require but little comment.

Standard provision No. 1 is designed to adjust the insurance in fair and proper relation to its cost if the insured changes his occupation and thereby changes the cost of his insurance. Premium rates for accident insurance are based upon the occupation just as definitely and just as necessarily as rates for life insurance

are based upon age, but many persons change their occupations after becoming insured and this provision merely sees to it that they shall continue to get their money's worth of insurance. Because policyholders when changing their occupation do not always think of their accident insurance or take steps to rearrange it, their interest requires that the policy thus provide for readjustment, if and when necessary, immediately, automatically and equitably.

Standard provision No. 2 is designed to protect both the insured and the company against unauthorized attempts to alter or waive the provisions of the policy and to prohibit either party from setting up verbal statements or outside understandings to the advantage or disadvantage of either.

Standard provision No. 3 fixes in advance the terms upon which the policy may be reinstated if premium is not paid when due and protects the company against attempts to reinstate a lapsed policy after an injury has been sustained or a sickness contracted.

Standard provisions Nos. 4, 5, 6 and 7 regulate the conditions that may be imposed upon a policyholder in perfecting a claim under a policy.

Standard provision No. 8 reserves to the company the right of medical examination in order to verify the facts as to injury or sickness for which claim is being made. It is a necessary measure for protection against attempts at fraud in occasional cases and it is a businesslike precaution to confirm the fact and the amount of liability in all cases. The right to an autopsy is, of course, intended to function only in those rare cases in which no other means exist for determining the fact as to the cause of death and consequently the liability of the company. Needless to say this right is exercised in only the rarest instances.

Standard provisions Nos. 9, 10 and 11 describe merely the mode of payment of indemnities due under the policy and leave with the insured the option of collecting in installments in case of prolonged disability.

Standard provision No. 12 is a method prescribed for meeting the situation when an insured changes his occupation to one of lesser hazard, in which case he might not only be entitled to a lower rate of premium but in some cases might be eligible for a different and more desirable form of insurance. The insured is

thus given the right to demand cancellation of his policy and to receive refund of unearned premium and to start over by applying for a new policy at such rate and of such form as may be suitable to the new circumstances.

Standard provision No. 13 requires no comment.

Standard provision No. 14 is designed to allow the company in disputed cases sufficient time for investigation and preparation and also to fix an ultimate date upon which the case may be considered closed, so that old cases may not be brought up after such an interval when evidence would no longer be available.

Standard provision No. 15 is intended to adjust the policy to any particular statutes relative to time of giving notice or furnishing proofs that may be found in different states.

Standard provision No. 16 reserves to the company the right to cancel the policy. This provision is often confused with the question of the company's right to refuse renewal upon expiration. The actual cancellation during the term of a policy is an action rarely taken and only when an insured is found to be wholly unsafe to deal with even for the balance of the policy term, as for example, when he is known to be engaged in criminal practices or nefarious dealings, or is found to have procured the policy by false and fraudulent representations, or is seeking to perpetrate a fraud upon the company. The right of the company to cancel or to refuse to renew is a measure of protection against ascertained moral hazard. It is availed of in both forms only to a small extent in actual practice, the best estimates indicating refusal to continue of from one-half to one per cent. of the policies. In particular cases it is an important protection to the company against repeated attempts at imposition and permits termination of relations with known malingerers. It also permits the termination of insurance in cases where policyholders retire from active business or cease to follow legitimate occupations and thereby remove the necessary and fundamental basis of all disability insurance, namely, the fact of an established occupation on which a claim for disability might be based. This provision is of course omitted from the non-cancellable forms of policies.

Standard provision No. 17 is included in some policies but not very commonly. Its purpose is to protect the company against over-insurance through the obtaining from other companies of

similar insurance to an amount in excess of that which the particular policyholder is legitimately entitled to carry.

Standard provision No. 18 is included in some policies and not in others. It is more likely to be found in monthly payment policies in order that premiums currently due may be deducted from the proceeds of a claim.

Standard provision No. 19 is very little used and is designed chiefly for the benefit of companies which permit the local issue of policies by agents or general agents and it is designed to protect the company against the obtaining of a number of policies in the same company through different agents or offices so that the company may, before receiving its reports, be engaged on a single risk in an amount that it would not willingly undertake.

XIII. Standard Provisions Laws

Standard provisions laws, identical with a form approved by the National Convention of Insurance Commissioners, or substantially so, have been enacted in some twenty-two states; similar laws, but with sufficient variations to necessitate printing special forms, exist in the state of Iowa and the Dominion of Canada, while Massachusetts requires the stipulation concerning charter, by-laws, etc., which is included in the "Special Provisions" clause, and also requires the "brief description" to be in 18 point instead of 14 point type.

These provisions relate to such subjects as change of occupation, alterations or waivers, past due premiums, notices and claims, medical examinations, payment of indemnities, rights of beneficiary, legal proceedings, compliance with special statutory enactments, all of which are mandatory; also cancellations, notice of other insurance, deduction of premiums from claims, limitation of aggregate amount of insurance, age limits, all of which are optional.

New York State

The standard provisions law of the state of New York, as a fair example of provisions enacted with an aim to uniformity, is as follows:

107. STANDARD PROVISIONS FOR ACCIDENT AND HEALTH POLICIES

Subdivision (a). On and after the first day of January, nineteen hundred and fourteen, no policy of insurance against loss or damage from the sickness, or the bodily injury or death of the insured by accident shall be issued or delivered to any person in this state by any corporation organized under article two of this chapter, or, if a foreign corporation, authorized to do business in this state, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with the superintendent of insurance; nor shall it be so issued or delivered until the expiration of thirty days after it has been so filed unless the said superintendent shall sooner give his written approval thereto. If the said superintendent shall notify, in writing, the company, corporation, association, society or other insurer which has filed such form that it does not comply with the requirements of law, specifying the reasons for his opinion, it shall be unlawful thereafter for any such insurer to issue any policy in such form. The action of the said superintendent in this regard shall be subject to review by any court of competent jurisdiction, provided, however, that nothing in this section shall be so construed as to give jurisdiction to any court not already having jurisdiction.

Subdivision (b). No such policy shall be so issued or delivered (1) unless the entire money and other considerations therefor are expressed in the policy; nor (2) unless the time at which the insurance thereunder takes effect and terminates is stated in a portion of the policy preceding its execution by the insurer; nor (3) if the policy purports to insure more than one person; nor (4) unless every printed portion thereof and of any endorsements or attached papers shall be plainly printed in type of which the face shall be not smaller than ten point; nor (5) unless a brief description thereof be printed on its first page and on its filing back in type of which the face shall be not smaller than 14 point; nor (6) unless the exceptions of the policy be printed with the same prominence as the benefits to which they apply, provided, however, that any portion of such policy which purports, by reason of the circumstances under which a loss is incurred, to reduce any indemnity promised therein to an amount less than

that provided for the same loss occurring under ordinary circumstances, shall be printed in bold face type and with greater prominence than any other portion of the text of the policy.

Subdivision (c). Every such policy so issued shall contain certain standard provisions, which shall be in the words and in the order hereinafter set forth and be preceded in every policy by the caption, "Standard Provisions." In each such standard provision wherever the word "insurer" is used, there shall be substituted therefor "company" or "corporation" or "association" or "society" or such other word as will properly designate the insurer. Said standard provisions shall be:

(1) A standard provision relative to the contract which may be in either of the following two forms: Form (A) to be used in policies which do not provide for reduction of indemnity on account of change of occupation, and Form (B) to be used in policies which do so provide. If Form (B) is used and the policy provides indemnity against loss from sickness, the words "or contracts sickness" may be inserted therein immediately after the words "in the event that the insured is injured."

(A): 1. This policy includes the endorsements and attached papers, if any, and contains the entire contract of insurance. No reduction shall be made in any indemnity herein provided by reason of change in the occupation of the insured or by reason of his doing any act or thing pertaining to any other occupation.

(B): 1. This policy includes the endorsements and attached papers, if any, and contains the entire contract of insurance except as it may be modified by the insurer's classification of risks and premium rates in the event that the insured is injured after having changed his occupation to one classified by the insurer as more hazardous than that stated in the policy, or while he is doing any act or thing pertaining to any occupation so classified, except ordinary duties about his residence or while engaged in recreation, in which event the insurer will pay only such portion of the indemnities provided in the policy as the premium paid would have purchased at the rate but within the limits so fixed by the insurer for such more hazardous occupation.

If the law of the state in which the insured resides at the time this policy is issued requires that prior to its issue a statement of the premium rates and classification of risks pertaining to it shall

be filed with the state official having supervision of insurance in such state, then the premium rates and classification of risks mentioned in this policy shall mean only such as have been last filed by the insurer in accordance with such law, but if such filing is not required by such law then they shall mean the insurer's premium rates and classification of risks last made effective by it in such state prior to the occurrence of the loss for which the insurer is liable.

(2) A standard provision relative to changes in the contract, which shall be in the following form:

2. No statement made by the applicant for insurance not included herein shall avoid the policy or be used in any legal proceeding hereunder. No agent has authority to change this policy or to waive any of its provisions. No change in this policy shall be valid unless approved by an executive officer of the insurer and such approval be endorsed hereon.

(3) A standard provision relative to reinstatement of policy after lapse which may be in either of the three following forms: Form (A) to be used in policies which insure only against loss from accident; Form (B) to be used in policies which insure only against loss from sickness; and form (C) to be used in policies which insure against loss from both accident and sickness.

(A): 3. If default be made in the payment of the agreed premium for this policy, the subsequent acceptance of a premium by the insurer or by any of its duly authorized agents shall reinstate the policy, but only to cover loss resulting from accidental injury thereafter sustained.

(B): 3. If default be made in the payment of the agreed premium for this policy, the subsequent acceptance of a premium by the insurer or by any of its duly authorized agents shall reinstate the policy but only to cover such sickness as may begin more than ten days after the date of such acceptance.

(C): 3. If default be made in the payment of the agreed premium for this policy, the subsequent acceptance of a premium by the insurer or by any of its duly authorized agents shall reinstate the policy but only to cover accidental injury thereafter sustained and such sickness as may begin more than ten days after the date of such acceptance.

(4) A standard provision relative to time of notice of claim

which may be in either of the three following forms: Form (A) to be used in policies which insure only against loss from accident; Form (B) to be used in policies which insure only against loss from sickness, and Form (C) to be used in policies which insure against loss from both accident and sickness. If Form (A) or Form (C) is used the insurer may at its option add thereto the following sentence "In event of accidental death immediate notice thereof must be given to the insurer."

(A): 4. Written notice of injury on which claim may be based must be given to the insurer within twenty days after the date of the accident causing such injury.

(B): 4. Written notice of sickness on which claim may be based must be given to the insurer within ten days after the commencement of the disability from such sickness.

(C): 4. Written notice of injury or of sickness on which claim may be based must be given to the insurer within twenty days after the date of the accident causing such injury or within ten days after the commencement of disability from such sickness.

(5) A standard provision relative to sufficiency of notice of claim which shall be in the following form and in which the insurer shall insert in the blank space such office and its location as it may desire to designate for such purpose of notice.

5. Such notice given by or in behalf of the insured or beneficiary, as the case may be to the insurer at.....or to any authorized agent of the insurer, with particulars sufficient to identify the insured, shall be deemed to be notice to the insurer. Failure to give notice within the time provided in this policy shall not invalidate any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

(6) A standard provision relative to furnishing forms for the convenience of the insured in submitting proof of loss as follows:

6. The insurer upon receipt of such notice, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not so furnished within fifteen days after the receipt of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting within the time fixed in the policy for

filing proofs of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

(7) A standard provision relative to filing proof of loss which shall be in such one of the following forms as may be appropriate to the indemnities provided:

(A): 7. Affirmative proof of loss must be furnished to the insurer at its said office within ninety days after the date of the loss for which claim is made.

(B): 7. Affirmative proof of loss must be furnished to the insurer at its said office within ninety days after the termination of the period of disability for which the company is liable.

(C): 7. Affirmative proof of loss must be furnished to the insurer at its said office in case of claim for loss of time from disability within ninety days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within ninety days after the date of such loss.

(8) A standard provision relative to examination of the person of the insured and relative to autopsy which shall be in the following form:

8. The insurer shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim hereunder, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

(9) A standard provision relative to the time within which payments other than those for loss of time on account of disability shall be made, which provision may be in either of the following two forms and which may be omitted from any policy providing only indemnity for loss of time on account of disability. The insurer shall insert in the blank space either the word "immediately" or appropriate language to designate such period of time, not more than sixty days, as it may desire; Form (A) to be used in policies which do not provide indemnity for loss of time on account of disability and Form (B) to be used in policies which do so provide.

(A): 9. All indemnities provided in this policy will be paid .....after receipt of due proof.

(B): 9. All indemnities provided in this policy for loss other than that of time on account of disability will be paid..... after receipt of due proof.

(10) A standard provision relative to periodical payments of indemnity for loss of time on account of disability, which provision shall be in the following form, and which may be omitted from any policy not providing for such indemnity. The insurer shall insert in the first blank space of the form appropriate language to designate the proportion of accrued indemnity it may desire to pay, which proportion may be all or any part not less than one-half, and in the second blank space shall insert any period of time not exceeding sixty days:

10. Upon request of the insured and subject to due proof of loss.....accrued indemnity for loss of time on account of disability will be paid at the expiration of each..... during the continuance of the period for which the insurer is liable, and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of due proof.

(11) A standard provision relative to indemnity payments which may be in either of the two following forms: Form (A) to be used in policies which designate a beneficiary, and Form (B) to be used in policies which do not designate any beneficiary other than the insured.

(A): 11. Indemnity for loss of life of the insured is payable to the beneficiary if surviving the insured, and otherwise to the estate of the insured. All other indemnities of this policy are payable to the insured.

(B): 11. All the indemnities of this policy are payable to the insured.

(12) A standard provision providing for cancellation of the policy at the instance of the insured which shall be in the following form:

12. If the insured shall at any time change his occupation to one classified by the insurer as less hazardous than that stated in the policy, the insurer, upon written request of the insured and surrender of the policy will cancel the same and will return to the insured the unearned premium.

(13) A standard provision relative to the rights of the bene-

ficiary under the policy which shall be in the following form and which may be omitted from any policy not designating a beneficiary.

13. Consent of the beneficiary shall not be requisite to surrender or assignment of this policy, or to change of beneficiary, or to any other changes in the policy.

(14) A standard provision limiting the time within which suit may be brought upon the policy as follows:

14. No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of this policy, nor shall such action be brought at all unless brought within two years from the expiration of the time within which proof of loss is required by the policy.

(15) A standard provision relative to time limitations of the policy as follows:

15. If any time limitation of this policy with respect to giving notice of claim or furnishing proof of loss is less than that permitted by the law of the state in which the insured resides at the time this policy is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

Subd. (d). No such policy shall be so issued or delivered which contains any provision (1) relative to cancellation at the instance of the insurer; or, (2) limiting the amount of indemnity to a sum less than the amount stated in the policy and for which the premium has been paid; or, (3) providing for the deduction of any premium from the amount paid in settlement of claim or, (4) relative to other insurance by the same insurer; or, (5) relative to the age limits of the policy; unless such provisions which are hereby designated as optional standard provisions, shall be in the words and in the order in which they are hereinafter set forth, but the insurer may at its option omit from the policy any such optional standard provision. Such optional standard provisions if inserted in the policy shall immediately succeed the standard provisions named in subdivision (c) of this section.

(1) An optional standard provision relative to cancellation of the policy at the instance of the insurer as follows:

16. The insurer may cancel this policy at any time by written

notice delivered to the insured or mailed to his last address, as shown by the records of the insurer, together with cash or the insurer's check for the unearned portion of the premium actually paid by the insured, and such cancellation shall be without prejudice to any claim originating prior thereto.

(2) An optional standard provision relative to reduction of the amount of indemnity to a sum less than that stated in the policy as follows:

17. If the insured shall carry with another company, corporation, association or society other insurance covering the same loss without giving written notice to the insurer, then in that case the insurer shall be liable only for such portion of the indemnity promised as the said indemnity bears to the total amount of like indemnity in all policies covering such loss, and for the return of such part of the premium paid as shall exceed the pro rata for the indemnity thus determined.

(3) An optional standard provision relative to deduction of premium upon settlement of claim as follows:

18. Upon the payment of claim hereunder any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(4) An optional standard provision relative to other insurance by the same insurer which shall be in such one of the following forms as may be appropriate to the indemnities provided, and in the blank spaces of which the insurer shall insert such upward limits of indemnity as are specified by the insurers' classification of risks, filed as required by this section.

(A): 19. If a like policy or policies, previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity in excess of $....., the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured.

(B): 19. If a like policy or policies, previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for loss of time on account of disability in excess of $..... weekly, the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured.

(C): 19. If a like policy or policies, previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for loss other than that of time on account of disability in excess of $....., or the aggregate indemnity for loss of time on account of disability in excess of $..... weekly, the excess insurance of either kind shall be void and all premiums paid for such excess shall be returned to the insured.

(5) An optional standard provision relative to the age limits of the policy which shall be in the following form and in the blank spaces of which the insurer shall insert such number of years as it may elect:

20. The insurance under this policy shall not cover any person under the age of ..... years nor over the age of ..... years. Any premium paid to the insurer for any period not covered by this policy will be returned upon request.

Subd. (e). No such policy shall be so issued or delivered if it contains any provision contradictory, in whole or part, of any of the provisions hereinbefore in this section designated as "Standard Provisions" or as "Optional Standard Provisions"; nor shall any endorsements or attached papers vary, alter, extend, be used as a substitute for, or in any way conflict with any of the said "Standard Provisions" or the said "Optional Standard Provisions"; nor shall such policy be so issued or delivered if it contains any provision purporting to make any portion of the charter, constitution or by-laws of the insurer a part of the policy unless such portion of the charter, constitution or by-laws shall be set forth in full in the policy, but this prohibition shall not be deemed to apply to any statement of rates or classification of risks filed with the Superintendent of insurance in accordance with the provisions of this section.

Subd. (f). The falsity of any statement in the application for any policy covered by this section shall not bar the right to recovery thereunder unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Subd. (g). The acknowledgment by an insurer of the receipt of notice given under any policy covered by this section, or the

furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

Subd. (h). No alteration of any written application for insurance by erasure, insertion or otherwise, shall be made by any person other than the applicant without his written consent, and the making of any such alteration without the consent of the applicant shall be a misdemeanor. If such alteration shall be made by any officer of the insurer, or by any employee of the insurer with the insurer's knowledge or consent, then such act shall be deemed to have been performed by the insurer thereafter issuing the policy upon such altered application.

Subd. (i). A policy issued in violation of this section shall be held valid but shall be construed as provided in this section and when any provision in such a policy is in conflict with any provision of this section, the rights, duties and obligations of the insurer, the policyholder and the beneficiary shall be governed by the provisions of this section.

Subd. (j). The policies of insurance against accidental bodily injury or sickness issued by an insurer not organized under the laws of this state may contain, when issued in this state, any provision which the law of the state, territory or district of the United States under which the insurer is organized, prescribes for insertion in such policies, and the policies of insurance against accidental bodily injury or sickness issued by an insurer organized under the laws of this state may contain, when issued or delivered in any other state, territory, district or country, any provision required by the laws of the state, territory, district or country in which the same are issued, anything in this section to the contrary notwithstanding.

Subd. (k). (1) Nothing in this section, however, shall apply to or affect any policy of liability or workmen's compensation insurance or any general or blanket policy of insurance issued to any municipal corporation or department thereof, or to any employer whether a corporation, copartnership, association or individual, or to any police or fire department, underwriters' corps, salvage bureau, or to any association of fifty or more members having a

constitution or by-laws and formed in good faith for purposes other than that of obtaining insurance where not less than seventy-five percentum of the members or employees are insured for their individual benefit against specified accidental bodily injuries or sickness while exposed to the hazards of the occupation or otherwise in consideration of a premium intended to cover the risks of all the persons insured under such policy.

(2) Nothing in this section shall apply to or in any way affect contracts supplemental to contracts of life or endowment insurance where such supplemental contracts contain no provisions except such as operate to safeguard such insurance against lapse or to provide a special surrender value therefor in the event that the insured shall be totally and permanently disabled by reason of accidental bodily injury or by sickness; provided that no such supplemental contract shall be issued or delivered to any person in this state unless and until a copy of the form thereof has been submitted to and approved by the superintendent of insurance, under such reasonable rules and regulations as he shall make concerning the provisions in such contracts and their submission to and approval by him.

(3) Nothing in this section shall apply to or in any way affect fraternal benefit societies.

(4) The provisions of this section contained in clause (5) of subdivision (b) and clauses (2), (3), (8) and (12) of subdivision (c) may be omitted from railroad ticket policies sold only at railroad stations, or at railroad ticket offices by railroad employees.

Subd. (l). Any company, corporation, association, society or other insurer or any officer or agent thereof, which or who issues or delivers to any person in this state any policy in willful violation of the provisions of this section shall be punished by a fine of not more than five hundred dollars for each offense, and the superintendent of insurance may revoke the license of any company, corporation, association, society or other insurer of another state or country, or of the agent thereof, which or who willfully violates any provision of this section.

Subd. (m). The term "indemnity" as used in this section means benefits promised.

108. DISCRIMINATIONS UNDER ACCIDENT OR HEALTH POLICIES PROHIBITED

No insurance corporation authorized to make insurance in this state under subdivision two or section seventy of this chapter, nor any agent of such corporation, shall make or permit any discrimination between individuals of the same class in the amount of premiums, policy fees, or rates charged for any policy of accident or health insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such insurance contract, or in any other manner whatsoever. Any person or corporation violating any provision of this section shall be guilty of a misdemeanor, and shall forfeit to the people of the state the sum of five hundred dollars for each such violation.

XIV. Commentary

Let us pause to repeat and to answer briefly a few questions occasionally asked. Is an accident and health policy, or particularly an accident policy, a "technical" contract? Is the business of accident and health insurance a business of technicalities? Why not "scrap" all these conditions, provisos, points of law and other causes of dispute and just apply the theory that "the customer always is right" and "make him satisfied"?

That "the customer is right" is a rule perhaps applicable within rather wide limits in merchandising transactions, for the complaining customer usually wants only to return goods purchased or to have them perfected if need be. But when the dealings are in money the situation changes. No one ever heard of a bank agreeing that a customer is right when he deposits dollars and expects to check out hundreds or thousands, and insurance is a very similar transaction, for it involves the deposit of a stipulated premium and the right to withdraw a stipulated benefit under stipulated circumstances.

The true facts are that such policies are no more "technical" than any written contract is bound to be if it is to agree to do certain things in return for a certain consideration; that, at least in present-day practice, more technicalities are offered by policyholders seeking to collect unjustified claims than are conceived

by companies in opposing them; but that the vast majority of claims made under such policies are honest, are promptly and fairly dealt with and the customers are satisfied.

In every-day operation claim adjusters find no technicalities, or look past them to the merits of the claims, and it is rare indeed that anything in the nature of a technical defense is advanced unless to support justified resistance of an unrighteous claim. Not "must we pay" but "should we pay" is the rule and guide to action, failure to comply with technical requirements of the policy is daily overlooked, claims omitting to include collateral benefits of which the claimants are unaware are added to in accord with the right, the benefit of doubt within reason is quite generally given the insured and even a moderate amount of aggression submitted to in the effort to give satisfaction, while the number of disputes is exceedingly small in proportion to the number of claims paid and litigations so few as to be hardly calculable in terms of percentage.

But the actual price of insurance to the honest man is but the sum of the calculable cost of the thing bought and the incalculable cost of the impositions that may be permitted to be practiced by the dishonest or predatory. It is to the interest of the fair dealing majority that reasonable precautions be taken against the machinations of an unscrupulous minority, as well as against distortions of the contract by means of legalistic subtleties or sophistries, and it is imperative that a policy be constructed in the light of the precedents that have been set up, the pitfalls that have been met, the hazards that attend litigation with a document in any respect loose, uncertain or susceptible of forced interpretation.