

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

DONALD J. FRIEL : CIVIL ACTION
 :
 v. :
 :
 UNUM LIFE INSURANCE COMPANY :
 OF AMERICA : NO. 97-1062

MEMORANDUM AND FINAL JUDGMENT

HUTTON, J.

November 16, 1998

Presently before the Court are Defendant UNUM Life Insurance Company of America's Motion for Summary Judgment (Docket No. 16), Plaintiff Donald J. Friel's Reply (Docket No. 19), Defendant's Sur Reply (Docket No. 20). For the reasons stated below, Defendant's Motion for Summary Judgment is **GRANTED**.

I. BACKGROUND

Taken in the light most favorable to the nonmoving party, the facts are as follows. In December 1991, Plaintiff Donald J. Friel (Plaintiff or "Friel") experienced numbness in his legs and left hand. Also in December 1991, but prior to December 26, 1991, Plaintiff spoke to his insurance broker, Michael Schwartz, by telephone and supplied information to apply for disability income insurance coverage from Defendant UNUM Life Insurance Company of America ("UNUM" or Defendant).

On December 26, 1991, Plaintiff consulted with a neurologist, David S. Roby, M.D. Plaintiff reported the following to Dr. Roby: (1) facial numbness seven years ago and (2) a decrease in sexual function during the past several years, but which had worsened in the previous year. Dr. Roby conducted a pin prick test and determined that Plaintiff was numb from the waist down. Based on this information, Dr. Roby recommended to Friel that he undergo an x-ray and MRI of his spine. On that same day, Plaintiff made arrangements through Dr. Roby's office for the x-ray and MRI to take place on January 3, 1992. In a letter to Friel's primary care physician, Richard Mintz, D.O., Dr. Roby also recommended further testing, including spine films and magnetic scanning of the spine. Plaintiff states, however, that Dr. Roby informed him that an infection most likely caused the numbness.

On December 30, 1991, four days after his appointment with Dr. Roby and three days before the x-ray and MRI of his spine, Plaintiff reviewed the UNUM application for disability insurance that he asked his insurance broker to fill out. See Pl.'s Dep. at 13-14. Plaintiff "agreed with" each of the answers Schwartz wrote at his direction. See id. Plaintiff then signed the application.

Question 18(a) of the application read: "Other than already mentioned in this application, have you in the past five years: (a) consulted a physician, psychiatrist, psychologist, counselor, chiropractor or other practitioner (include regular

checkups)?" In response to Question 18(a), Plaintiff identified only a checkup that he underwent six months earlier with his primary care physician, Dr. Mintz. Plaintiff did not disclose that he consulted Dr. Roby about being numb from the waist down only four days earlier.

Question 18(b) of the application read: "Other than already mentioned in this application, have you in the past five years: (b) had or been advised to have any surgical operations, hospitalization, medical care, electrocardiogram, x-ray, blood test or other diagnostic test?" In response to this question, Plaintiff responded "no." Plaintiff failed to disclose that Dr. Roby advised the Plaintiff four days earlier to undergo an x-ray and MRI of his spine. Plaintiff also failed to disclose that these tests were scheduled for January 3, 1993.

On January 3, 1992, Plaintiff underwent several tests of his spine. Thereafter, Plaintiff continued to consult with Dr. Roby and underwent several more tests. On June 12, 1992, four days after an MRI on his brain, Plaintiff submitted an application to UNUM for a second disability policy. This application had similar responses to Questions 18(a) and (b) as the first application. Plaintiff admitted that he did not provide the information in the second application and that someone forged both of his signatures on this application.

Defendant UNUM issued two policies based on the representations in these applications. The first policy, No. LAD174019, provided for monthly disability benefits of \$1,500.00, or \$1,622.00 with automatic riders, and had an effective date of December 31, 1991. The second policy, No. LAD192373, provided for a monthly disability benefit of \$750.000, or \$780.00 with automatic riders, and had an effective date of July 2, 1992.

In May 1994, Plaintiff's broker gave Defendant UNUM notice that Plaintiff became unable to work as of February 1994. Plaintiff could no longer work due to multiple sclerosis and a fractured hand. By letter dated, July 1, 1994, Defendant notified the Plaintiff that it was refunding Plaintiff's premiums and rescinding both policies based on the material misrepresentations in both applications.

On January 8, 1997, Plaintiff filed a two-count complaint alleging breach of contract and bad faith in connection with Defendant's decision to not pay the disability benefits due under the two policies. On February 12, 1997, Defendant removed the case to federal court. On February 19, 1997, Defendant filed an answer and brought a counterclaim which sought rescission of both policies issued to Plaintiff. Defendant now moves for summary judgment in its favor and an order rescinding both policies.

II. SUMMARY JUDGMENT STANDARD

Summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). The party moving for summary judgment has the initial burden of showing the basis for its motion. See Celotex Corp. v. Catrett, 477 U.S. 317, 323 (1986). Once the movant adequately supports its motion pursuant to Rule 56(c), the burden shifts to the nonmoving party to go beyond the mere pleadings and present evidence through affidavits, depositions, or admissions on file to show that there is a genuine issue for trial. See id. at 324. A genuine issue is one in which the evidence is such that a reasonable jury could return a verdict for the nonmoving party. See Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986).

When deciding a motion for summary judgment, a court must draw all reasonable inferences in the light most favorable to the nonmovant. See Big Apple BMW, Inc. v. BMW of N. Am., Inc., 974 F.2d 1358, 1363 (3d Cir. 1992). Moreover, a court may not consider the credibility or weight of the evidence in deciding a motion for summary judgment, even if the quantity of the moving party's evidence far outweighs that of its opponent. See id. Nonetheless, a party opposing summary judgment must do more than rest upon mere

allegations, general denials, or vague statements. See Trap Rock Indus., Inc. v. Local 825, 982 F.2d 884, 890 (3d Cir. 1992).

III. DISCUSSION

A. The December 31, 1991 Disability Insurance Policy

Defendant first argues that December 31, 1991 disability insurance policy should be rescinded. Section 757 of the Pennsylvania Insurance Law governs the rescission of disability insurance contracts. See 40 Pa. Cons. Stat. Ann. § 757 (West 1995). This section states:

The falsity of any statement in the application for any policy covered by subdivision (b) of this article 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 hazard assumed by the insurer.

Id. The Third Circuit, in interpreting this section, held that an insurer may bring an rescission action of a health or accident insurance where either: (1) the insured made false statements in the application with actual intent to deceive or (2) the insured knowingly made false statements in the application and the false statements materially affected the acceptance of the risk or the hazard assumed. See Connecticut Mut. Life Ins. Co. v. Wyman, 718 F.2d 63, 67 (3d Cir. 1983).

Under Pennsylvania law, therefore, an insurer may rescind an insurance policy if the insurer can prove three elements. See Provident Life & Accident Ins. Co. v. Charles, No. CIV.A.90-7584,

1993 WL 121504, at *4 (E.D. Pa. Apr. 14, 1993), aff'd, 14 F.3d 48 (3d Cir. 1993) (unpublished table decision). First, the insurer must show that the application contained a representation that was false. See id. Second, the insurer must prove that the false representation was material to the risk being insured. See id. Third and finally, the insurer must show that the insured knew when making the representation that the representation was false. See id.

1. False Representations

Defendant argues that the representations in Questions 18(a) and (b) of Friel's December 30, 1991 application for disability insurance were false. Defendant contends that Friel failed to disclose his consultation with Dr. Roby only four days earlier and Dr. Roby's recommendation of testing. Friel admits that he visited Dr. Roby on December 26, 1991. Friel states, however, that he had not visited Dr. Roby at the time he instructed his insurance broker, Mr. Schwartz, to fill out the application.¹

Nevertheless, the Court concludes that UNUM established that the statements to Questions 18(a) and (b) were false. Before signing the application, Friel stated that he reviewed the application, on December 30, 1991, in order to verify the

¹ Friel also states that his responses to Question 17 were accurate. Question 17 asks the Plaintiff if any doctor diagnosed Plaintiff with certain diseases. Defendant challenges Friel's answer to Question 18. Therefore, Question 17 is of no import to this Court.

information he gave to Mr. Schwartz. This was four days after his visit with Dr. Roby who recommended subsequent testing. By signing the application, Plaintiff failed to disclose his visit with Dr. Roby and Dr. Roby's opinion that Plaintiff should undergo testing. See American Franklin Life Ins. Co. v. Galati, 776 F. Supp. 1054, 1060 (E.D. Pa. 1991) (finding that an insured who signs an application affirms that he read and understood the document).

2. Materiality

"Information on an insurance application is material if knowledge or ignorance of it would influence the decision of the issuing insurer to issue the policy, or the ability of the insurer to evaluate the degree and character of the risk, or the determination of the premium." Provident Life, 1993 WL 121504, at *5. A statement is material, even if it is unrelated to the loss incurred, as long as it is relevant to the risk assumed. See id. Inquiries into prior medical attendance and hospitalizations are material as a matter of law. See Knepp v. Nationwide Ins. Co., 471 A.2d 1257, 1263 (Pa. Super. Ct. 1984).

The Court finds that the knowledge of Friel's visit to Dr. Roby and Dr. Roby's recommendation that Friel undergo testing of his spine due to numbness would have influenced UNUM's decision to issue the policy. UNUM submitted an affidavit of John Najarian, the Director of Macro Risk in Individual Disability for UNUM, who reviewed Mr. Friel's file. See Aff. of John Najarian at ¶ 10. In

his affidavit, Mr. Najarian states that had Mr. Friel answered Questions 18(a) and (b) truthfully, UNUM would not have issued the two disability insurance policies based on UNUM's established underwriting policies. See id.; see also Monarch Life Ins. Co. v. Pistone, No. CIV.A.91-2203, 1992 WL 96282, at *4 (E.D. Pa. Apr. 16, 1992) (finding that insurer demonstrated, through affidavit, that insured's untrue statement on his insurance application was material to the insurer's acceptance of the risk or the hazard specified in the policy), aff'd, 983 F.2d 1051 (3d Cir. 1992) (unpublished table decision). Clearly, the numbness below the waist was important information for UNUM to consider in evaluating the risk of issuing a disability insurance policy to Mr. Friel.

3. Insured's Knowledge

An insured's knowledge that statements on an insurance application were false at the time they were given is ordinarily a question of fact for the jury. See Provident Life, 1993 WL 121504, at *6. However, if it is established by uncontradicted documentary evidence that the insured consulted physicians so frequently or underwent medical or surgical treatment so recently, that "a person of ordinary intelligence could not have forgotten these incidents in answering a direct and pointed question in an application for insurance," the court may infer as a matter of law that the insured knew the statements were false. See Grimes v. Prudential Ins. Co., 585 A.2d 29, 31, (Pa. Super. Ct. 1991).

In this case, an ordinary person could not have forgotten his visit with a doctor only four days prior to signing the application for disability insurance. Moreover, an ordinary person could not forget that the doctor instructed him to undergo an x-ray and MRI of his spine to inquire into the source of numbness from the waist down. While Plaintiff asserts that the doctor told him that the numbness may be caused by an infection, Plaintiff still had to respond truthfully to Question 18 which inquired into recent visits with any doctors and any instructions by such doctors to undergo treatment or tests. This Court finds that, as a matter of law, Mr. Friel knew that he responded untruthfully to Question 18 because no ordinary person could forget that he visited a doctor, four days earlier, who instructed him to undergo testing of his spine. See id. (finding that "bad faith may be inferred as a matter of law if the insured denies in his answer that any physical has been consulted, or any medical or surgical treatment has been received during the period of inquiry"); see also Equitable Life Assurance Soc'y of U.S. v. Bordner, No. CIV.A.92-7247, 1994 WL 52757, at *4 n.4 (E.D. Pa. Feb. 23, 1994) (finding that, as a matter of law, insured knew that his representations were false because he had undergone medical treatment for his severe lumbosacral sprain in 1990 and could not have forgotten this fact when he applied for disability insurance in early 1991). Therefore, the Court grants summary judgment for the Defendant on

this issue and rescinds the December 31, 1991 disability insurance policy.

B. The July 2, 1992 Disability Insurance Policy

Defendant next argues that July 2, 1992 disability insurance policy should be rescinded. In his response to the Defendant's motion for summary judgment, the Plaintiff concedes that the July 2, 1992 policy should be rescinded because it was the product of a forged application. See Pl.'s Mem. of Law in Resp. to Def.'s Mot. for Summ. Judg. at 11-12. Therefore, the Court grants summary judgment for the Defendant on this issue and rescinds the July 2, 1992 disability insurance policy.

C. Bad Faith Claim

Finally, Defendant argues that summary judgment should be granted on Plaintiff's bad faith claim. Plaintiff brought a statutory claim of bad faith conduct in the handling of insurance policies. See 42 Pa. Cons. Stat. Ann. § 8371 (West 1995). This statute provides:

In an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured, the court may take all of the following actions:

- (1) Award interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus 3%.
- (2) Award punitive damages against the insurer.
- (3) Assess court costs and attorney's fees against the insurer.

Id. Defendant argues that Plaintiff's bad faith claim is barred by the statute of limitations.²

As a threshold issue, it is unclear which of Pennsylvania's statute of limitations applies to claims brought pursuant to 42 Pa. Cons. Stat. Ann. § 8371. This Court must attempt to predict whether the Pennsylvania Supreme Court would find that an insured's action under 42 Pa. Cons. Stat. Ann. § 8371 is subject to the two year statute of limitations for torts, the four year statute of limitations for contracts, or the six year "catchall" statute of limitations. See Packard v. Provident Nat. Bank, 994 F.2d 1039, 1046 (3d Cir. 1993) (noting that, when the highest court of a state has not addressed an issue of law, a federal court sitting in diversity must predict how that court would decide the issue were it confronted with the problem). Currently, the courts are split on this issue. Compare Nelson v. State Farm Mut. Auto. Ins. Co., 988 F. Supp. 527, 534 (E.D. Pa. Dec. 12, 1997) (predicting that the Supreme Court of Pennsylvania would conclude that an action under § 8371 sounds in tort and thus would be subject to a two year statute of limitations); Samuels v. John Hancock Mut. Life Ins. Co., No. CIV.A.96-1548 (E.D. Pa. Apr. 18, 1997) (same), with Cynthia Miller v. Cincinnati Ins. Co., No. CIV.A.97-1223 (E.D. Pa. July 9, 1997) (predicting that the six year

² Defendant also argues that summary judgment should be granted on Plaintiff's bad faith claim because there is no substantive evidence of bad faith on Defendant's part. Because the Court finds that Plaintiff's bad faith claim is time barred, it does not address this argument.

statute of limitations should apply to § 8371 actions because it sounds in contract and tort); Woody v. State Farm Fire and Cas. Co., 965 F. Supp. 691, (E.D. Pa. 1997) (same).

This Court finds the reasoning of Nelson persuasive and concludes that Pennsylvania's two year statute of limitations applies to actions under § 8371. The Nelson court's reasoning is persuasive for three reasons. First, the Pennsylvania General Assembly apparently enacted § 8371 in response to the Pennsylvania Supreme Court's refusal to create a "new tort" for bad faith conduct in the handling of insurance policies. See Nelson, 988 F. Supp. at 531-32. Second, the overwhelming majority of state supreme courts hold that a bad faith cause of action against an insurer is a tort. See id. at 533-34 (listing states that hold the bad faith claim against insurance companies is a tort). Third and finally, like the Nelson court, this Court cannot perceive why the Pennsylvania General Assembly would intend to provide a six year limitations period for a bad faith claim which sounds in areas of law with two and four year limitations period. See id. at 534 n.11. Therefore, the Court agrees with the reasoning employed by Nelson and finds that Pennsylvania's two year statute of limitations applies to Plaintiff's bad faith claim against UNUM.

Because the Court finds that the two year statute of limitations applies to Plaintiff's bad faith claim, it must also find that Plaintiff's claim is time barred. UNUM notified the

Plaintiff of its intent to refund Plaintiff's premiums and rescind the policies by letter dated July 1, 1994. Any cause of action for UNUM's bad faith in handling these policies arose on the date that Plaintiff received this letter. See Samuels, No. CIV.A.96-1548, at 2. Plaintiff filed suit against UNUM on January 8, 1997, three and a half years after any bad faith claim against UNUM arose.³ Therefore, because Plaintiff failed to file suit before the two year statute of limitations ran, the Court grants summary judgment for the Defendant on Plaintiff's bad faith claim.

This Court's Final Judgment follows.

³ The Plaintiff does not dispute these facts. Indeed, in response to Defendant's statute of limitations argument, Plaintiff argues only that the issue of which Pennsylvania statute of limitations should apply to claims under § 8371 must be decided by the court of appeals. Nevertheless, because the court of appeals has yet to address this issue, this Court must first decide the issue. See Nelson, 988 F. Supp. at 531 n.7 (noting that the issue of which Pennsylvania statute of limitations applies to § 8371 claims has yet to be reviewed by the Third Circuit).

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FINAL JUDGMENT

AND NOW, this 16th day of November, 1998, upon consideration of Defendant's Motion for Summary Judgment, Plaintiff's Reply, and Defendant's Sur Reply thereto, IT IS HEREBY ORDERED that the Defendant's Motion for Summary Judgment is **GRANTED.**

IT IS FURTHER ORDERED that:

(1) The insurance policy number LAD174019 issued to Donald J. Friel by UNUM Life Insurance Company of America is hereby **RESCINDED;**

(2) The insurance policy number LAD192373 issued to Donald J. Friel by UNUM Life Insurance Company of America is hereby **RESCINDED;**

(3) The Defendant is directed to return to Donald J. Friel all premiums that he previously paid plus interest;

(4) Counts I and II of Plaintiff's complaint are **DISMISSED;** and

(5) The Clerk is directed to close the docket of this case.

BY THE COURT:

HERBERT J. HUTTON, J.