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MISREPRESENTATION IN PROCUREMENT OF INSURANCE: THE ARKANSAS LAW

D.F. Adams*

The enactment of the Arkansas Insurance Code of 19591 has worked substantial changes in the law concerning the effect of false representations made by an applicant for insurance in order to induce an insurer to issue a policy. Some of these changes are not readily apparent in the wording of the statute, and the effect of the legislation remains unsettled in a number of respects. It is the purpose of this paper to review the history of Arkansas’ law governing misrepresentation in procurement of insurance, then to attempt an assessment of the impact of the 1959 statute.

The subject cannot be treated meaningfully without some investigation of the law relating to insurance warranties, but treatment of warranties will be restricted to those based on representations made to an insurer as inducements to contract.2

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2. Arkansas cases have recognized that warranties may be affirmative or promissory, the difference being that an affirmative warranty relates to facts existing before or at the inception of the insurance, while a promissory warranty relates to events which may occur after the insurance has taken effect. Mechanics Ins. Co. v. Thompson, 57 Ark. 279, 21 S.W. 468 (1893), illustrates a promissory warranty. An applicant for fire insurance on a gin house answered “yes” to a question in the application for insurance: “Will you warrant not to work at night, or by artificial light, and to permit no smoking about the premises?” The agreements in the application were incorporated into the policy subsequently issued. Referring to this agreement, and another in the application, the court said: “They thereby became what are denominated promissory warranties, and their performance was made a condition upon which the insurance company should become liable for losses by fire without which the assured was not entitled to recover.” 57 Ark. at 283, 21 S.W. at 469. Since promissory warranties do not relate to misrepresentations of past or present fact (except in the sense that the warrantor may impliedly represent that he presently intends to keep his promise, a type of misrepresentation of present fact of which no point has been made in the Arkansas insurance warranty cases), warranties of this type are outside the scope of this paper.

An affirmative warranty is illustrated, and distinguished from a promissory warranty, in Western Assurance Co. v. Altheimer, 58 Ark. 565, 25 S.W. 1067 (1894). Policies of fire insurance on a merchant’s stock of goods contained an “iron-safe” clause, providing in part: “The assured, under this policy, hereby covenants to keep a set of books showing a complete record of business transacted, . . . together with the last inventory of said business . . . and in case of loss the assured agrees and covenants to produce such books and inventory, and,
I. PRE-1959 LAW

Although an occasional statute affected Arkansas' law of misrepresentation in procurement of insurance in the years prior to the adoption of the Insurance Code, the bulk of the law was decisional. The first reported case dealing with the subject was not decided until 1889, but there was abundant authority to be drawn upon in the decisions of courts elsewhere in the United States, and a body of Arkansas law of considerable subtlety quickly developed.

In common with other American courts, the Arkansas Supreme Court, in its pronouncements of doctrine, drew a sharp distinction between statements made by an insurance applicant which were "warranted" to be true and "representations" (often in the event of a failure to produce the same, this policy shall be deemed null and void . . . .) The policies further provided: "This policy shall be void, and of no effect, if the interest of the assured be other than the entire, unconditional and sole ownership." The court commented: "The stipulation of the 'iron-safe' clause constituted an express promissory warranty, and of the clause as to ownership, an affirmative warranty; they were in the nature of conditions precedent to recovery, and a strict compliance with their terms was necessary, according to the intent and understanding of the parties." 58 Ark. at 575, 25 S.W. at 1069. (One might quarrel with the characterization of the ownership clause as an affirmative warranty, in that it could be read as referring to ownership of merchandise not only at the time of issuance of the policy but also during the term of the policy. To the extent that it was prospective in operation, it would be more properly termed a promissory warranty. However, insofar as it related to ownership of the stock of goods on hand at the inception of the insurance, it was certainly affirmative.)

Affirmative warranties may or may not be based on representations actually made by the applicant for insurance. The ownership clause in the Altheimer case, though it created an affirmative warranty, does not appear from the report of the case to have been based on any actual assertion by the insured that he was the sole and unconditional owner of the property to be insured. The type of affirmative warranty with which this paper is concerned is illustrated by Southern Ins. Co. v. White, 58 Ark. 277, 24 S.W. 425 (1893), where, in his application for fire insurance on a gin, the insured answered "no" to the question: "Is any other party interested in the property?" The application was incorporated into the policy, and the policy provided: "This entire policy shall be void if . . . the interest of the insured in the property be not truly stated herein."


5. The statements and representations referred to in this paper are usually express. Implied representations, other than those which may be implied by express statements, are a rarity in the insurance cases. However, see Anderson v. Frank Reid Burial Ass'n, 218 Ark. 817, 239 S.W.2d 12 (1951), where an application for reinstatement as a member of an association providing burial benefits was treated as implying a representation of good health which, if fraudulent, would avoid the policy.

6. Providence Life Assurance Soc'y v. Reutlinger, 58 Ark. 528, 25 S.W. 835 (1894), is the leading case.
categorized, to sharpen the distinction, as "mere representation"). Misrepresentations warranted to be true were said to differ notably in legal effect from misrepresentations not so warranted. The distinction was described in a leading case in these words:

As a general rule, a warranty is a stipulation expressly set out, or by inference incorporated, in the policy, whereby the assured agrees "that certain facts relating to the risk are or shall be true, or certain acts relating to the same subject have been or shall be done." Its purpose is to define the limits of the obligation assumed by the insurer, and it is a condition which must be strictly complied with, or literally fulfilled, before the right to recover on the policy can accrue. It is not necessary that the fact or act warranted should be material to the risk; for the parties by their agreement have made it so.

On the other hand, representations are no part of the contract of insurance, but are collateral or preliminary to it. When made to the insurer at or before the contract is entered into, they form a basis upon which the risks proposed to be assumed can be estimated. They operate as the inducement to the contract. Unlike a false warranty, they will not invalidate the contract, because they are untrue, unless they are material to the risks, and need only be substantially true. They render the policy void on the ground of fraud, "while a non-compliance with a warranty operates as an express breach of the contract."8

If, then, an applicant for insurance9 made representations to the

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9. Misrepresentation by one other than the applicant for insurance occasionally can give the insurer a defense. For example, Wilbon v. Washington Fidelity Nat'l Ins. Co., 181 Ark. 1127, 29 S.W.2d 680 (1930), application was made for insurance on the life of a ten year old boy. The application was signed by the boy's father on behalf of the boy as applicant; the father also signed in his own behalf, consenting to the making of the application and certifying the answers given in the application to be true. The father was the beneficiary of the policy. In an action to enforce the policy, the trial court instructed the jury that if they found that a false answer had been given in the application to the effect that the boy had never had heart trouble, and that the falsity was known either to the assured or to the beneficiary, and that the truth was not disclosed to the insurer before the policy was issued, they should find for the defendant. Judgment on a verdict for the defendant insurer was reversed and the case remanded for new trial for error in instructions. The child of tender years could not be guilty of fraud, and the instruction permitted the jury to find for the defendant on that basis. If, however, the father was guilty of fraud, that would provide a defense for the insurer, since the father was required to consent to the application and certify the truth of the answers.
insurer to induce issuance of the policy, and those representations were, by the terms of the policy, warranted to be true, the insurer could establish immunity from liability on the policy simply by showing that the representations were not true. That the deviation from the truth was slight,\textsuperscript{10} or that the falsity of the representation did the insurer no demonstrable harm,\textsuperscript{11} was of no moment. This followed from the concept that the warranty was a term of the contract of insurance, operating as a condition precedent to the insurer's duty of performance, and the contract would be enforced according to its terms or not at all.\textsuperscript{12} A "mere representation", by contrast, if it was false, would provide the insurer with a defense\textsuperscript{13} only if it was "substantially" untrue\textsuperscript{14} and "material":\textsuperscript{15} it was grounds for avoid-

\textsuperscript{10} See Capital Fire Ins. Co. v. King, 82 Ark. 400, 402, 102 S.W. 194, 195 (1907) (statements in application for fire policy warranted true; court quotes from Providence Life Assurance Soc'y v. Reutlinger, 58 Ark. 528, 25 S.W. 835 (1894), that warranty "is a condition which must be strictly complied with, or literally fulfilled, before the right to recover on the policy can accrue."); Standard Life & Accident Ins. Co. v. Ward, 65 Ark. 295, 298, 45 S.W. 1065, 1066 (1898) (though discussing primarily question of materiality, court indicated that literal effect was to be given to warranty term in accident policy that policy should be void if statements made in application were "untrue in any respect"); Western Assurance Co. v. Altheimer, 58 Ark. 565, 575, 25 S.W. 1067, 1069 (1894) ("iron-safe" and "ownership" clauses in fire policy; court disapproved instruction that recovery could be had on policy if insureds had "substantially complied with the terms of the policy"); exact or literal compliance required).

\textsuperscript{11} See Mutual Reserve Fund Life Ass'n v. Farmer, 65 Ark. 581, 47 S.W. 850 (1898) (dictum that where answers in application for life insurance were warranted true, court cannot inquire into materiality of questions and answers); Capital Fire Ins. Co. v. King, 82 Ark. 400, 102 S.W. 194 (1907) (warranted statement in fire policy that house to be insured had cost $2000, when actual cost was $1700; though policy limit was $1200, policy held void for breach of warranty; dissenting opinion arguing that policy should be construed as limiting avoidance to material misstatements); Standard Life & Accident Ins. Co. v. Ward, 65 Ark. 295, 45 S.W. 1065 (1898) (materiality not to be inquired into).


\textsuperscript{13} An insurer believing that it has been relieved of responsibility on a policy by reason of misrepresentation or breach of warranty might be found asserting that contention either as defendant in an action, usually an action to recover on the policy, e.g., American Nat'l Ins. Co. v. Laird, 228 Ark. 812, 311 S.W.2d 313 (1958), or as plaintiff, e.g., American Republic Life Ins. Co. v. Edenfield, 228 Ark. 93, 306 S.W.2d 321 (1957) (suit in chancery for cancellation of policies); Walker v. Illinois Bankers' Life Ass'n, 140 Ark. 192, 215 S.W. 598 (1919) (action to recover payments made on policy claim). The legal principles governing the question of the insurer's liability do not differ significantly depending on whether the insurer is plaintiff or defendant. In this paper when reference is made to an insurer having a defense, the usage is a short-form way of saying that the insurer is not liable on the policy.

\textsuperscript{14} National Annuity Ass'n v. Carter, 96 Ark. 495, 499, 132 S.W. 633, 634-35 (1910) (quoting from Providence Life Assurance Soc'y v. Reutlinger, 58 Ark. 528, 25 S.W. 835 (1894)).

\textsuperscript{15} Inter-Ocean Cas. Co. v. Huddleston, 184 Ark. 1129, 45 S.W.2d 24 (1932); American
ance of the contract because of deception in the inducement to contract, not because it entered into the terms of the contract. 16

A further distinction between such warranties and representations soon developed: misrepresentation would not make a policy voidable unless the representation was made with knowledge of its falsity (or, possibly, without belief in its truth) and with intent to deceive the insurer, 17 while if a represented fact was warranted true,

Life & Accident Ass'n v. Walton, 133 Ark. 348, 202 S.W. 20 (1918); Mutual Life Ins. Co. v. Owen, 111 Ark. 554, 164 S.W. 720 (1914).


While nonfraudulent misrepresentation, in the absence of breach of warranty, did not make a contract of insurance voidable under the Arkansas law prior to the enactment of the 1959 Insurance Code, it was held in Standard Accident Ins. Co. v. Wilmans, 214 F. Supp. 53 (E.D. Ark. 1963) that such misrepresentation could justify rescission of the contract in equity on grounds of mutual mistake. No Arkansas Supreme Court decision has been found applying this theory in insurance situations involving misrepresentation.

17. Universal Life & Accident Ins. Co. v. Stuart, 219 Ark. 863, 245 S.W.2d 219 (1952) ("an insurance company is liable unless there were fraudulent misrepresentations made by the applicant to the company that induced the issuance of the policy"); National Life & Accident Ins. Co. v. Threlkeld, 189 Ark. 165, 70 S.W.2d 851 (1934) ("a misrepresentation will not avoid a policy unless wilfully or knowingly made with intent to deceive"); Missouri State Life Ins. Co. v. Witt, 161 Ark. 148, 256 S.W. 46 (1923) (approving instruction that the insurer had the burden of showing that false, material representations which induced the issuance of the policy were made to it by the insured knowingly, willfully and with intent to defraud the company, the reference to "intent to defraud" being treated as meaning "intent to deceive"); Mutual Life Ins. Co. v. Owen, 111 Ark. 554, 164 S.W. 720 (1914) (citing Metropolitan Life Ins. Co. v. Johnson, 105 Ark. 101, 150 S.W. 393 (1912), for the proposition that "where answers in an application for life insurance constitute merely representations, a misrepresentation or omission to answer will not avoid the policy unless willfully or knowingly made with intent to deceive"); German-American Ins. Co. v. Brown, 75 Ark. 251, 87 S.W. 135 (1905) (approving instruction that if the insured "knowingly made to the agents of the insurance companies a false and fraudulent statement of the value of the property to be insured, in order to procure the insurance, then the plaintiff cannot recover . . . but a misstatement of such value made in good faith, believing the same to be true, would not avoid the insurance").

The references to "willful" misrepresentations in some of these opinions are not clear in meaning. It is commonly defined as meaning deliberate, with intent to produce the result. See BLACK'S LAW DICTIONARY 1435 (5th ed. 1979). So used, the term adds nothing to the requirements that a misrepresentation be made with knowledge of its falsity and with intent to deceive the insurer. It is to be noted, however, that some of the cases speak of misrepresentations "knowingly or willfully made with intent to deceive." E.g., Threlkeld, 189 Ark. at 168, 70 S.W.2d at 853. That usage may indicate that a misrepresentation could be grounds for avoidance, even though the person making it did not know it to be untrue, if he did not actually believe it to be true and made it to induce the insurer to contract.

It has been suggested that it may not be accurate to say that Arkansas cases required that misrepresentations be made knowingly or willfully with intent to deceive, in order to avoid the policy, because some of the Arkansas cases making such an assertion involved
proof of its falsity would establish a defense for the insurer despite the applicant's good faith in making it.\textsuperscript{18}

These "black-letter" rules remained in force, for the most part,\textsuperscript{19} until the enactment of the Insurance Code in 1959.\textsuperscript{20} State-

representations of opinion or belief, not statements of fact. Whiteside & Hoggard, \textit{Recent Developments in Insurance Law}, 3 \textit{Ark. L. Rev.} 55, 57 (1948) (citing Magaw, \textit{Representations in the Law of Life Insurance}, II, 12 \textit{Temp. L.Q.} 55 (1937)). A representation of opinion or belief would presumably not be a misrepresentation unless the person making it did not genuinely hold the opinion or belief professed. \textit{See} Magaw, \textit{Representations in the Law of Life Insurance}, I, 11 \textit{Temp. L.Q.} 463, 486-90 (1937). It is true that many of the cases insisting that misrepresentations be fraudulent to the grounds for avoidance involved representations that could readily be treated as merely statements of opinion or belief. \textit{See}, e.g., Missouri State Life Ins. Co. v. Witt, 161 Ark. 148, 256 S.W. 46 (1923) (representation by layman applying for life insurance that he was in "good health"); German American Ins. Co. v. Brown, 75 Ark. 251, 87 S.W. 135 (1905) (assertion by applicant for fire insurance of the value of the property to be insured). Nevertheless, the cases did not in terms distinguish between representations of opinion or belief and representations of fact, and it is not possible to account for all the cases requiring fraudulent intent as involving statements of opinion or belief. This is so, for example, of the cases involving false answers to questions regarding prior consultations with or treatment by physicians. Mutual Life Ins. Co. v. Owen, 111 Ark. 554, 164 S.W. 720 (1914); Metropolitan Life Ins. Co. v. Johnson, 105 Ark. 101, 150 S.W. 393 (1912).

\textsuperscript{18} Progressive Life Ins. Co. v. Preston, 194 Ark. 84, 105 S.W.2d 549 (1937); Unionaid Life Ins. Co. v. Munford, 180 Ark. 1048, 24 S.W.2d 966 (1930); Mississippi Life Ins. Co. v. Meadows, 161 Ark. 71, 255 S.W. 293 (1923); Metropolitan Life Ins. Co. v. Johnson, 105 Ark. 101, 150 S.W. 393 (1912); National Annuity Ass'n v. McCall, 103 Ark. 201, 146 S.W. 125 (1912) (dictum).


\textsuperscript{20} In an article published in 1949 the authors appeared to take the position that Arkansas law did not treat breach of warranty as a defense unless the warranty was "substantially false," and they asserted without qualification that, "Whether classified as a warranty or a representation, it has long been settled in Arkansas that an insured's false statement to defeat his recovery must relate to a matter material to the risk . . . ." Whiteside & Hoggard, \textit{Recent Developments in Insurance Law}, 3 \textit{Ark. L. Rev.} 55, 56 (1949). If these observations are treated as stating a conclusion concerning the effect of Arkansas cases there is much truth in them, as the following text will show, but the Arkansas cases did not repudiate the "black-letter" rules that any breach of warranty, no matter how slight, is a bar to enforcement of the policy, and that materiality is not to be inquired into. It is conceded that cases can be found that appear to state the law as it is represented in the above-cited article, e.g., New Furniture & Undertaking Co. v. Tri-County Burial Club, 194 Ark. 1045, 109 S.W.2d 146 (1937) (breach of warranty regarding any fact material to the risk will avoid a policy); National Liberty Ins. Co. v. Spharler, 172 Ark. 715, 290 S.W. 594 (1927) (substantial compliance with warranty sufficient even in the absence of statute), but in most of these cases the statements were dicta or explainable in terms of the warranties involved; while they may indicate impatience with the strictness of the "black-letter" rules, they fall short of rejecting
ment of a rule is one thing; however, its application is quite another, and in applying the rules as to the effect of misrepresentations made to procure insurance the Arkansas Supreme Court often achieved results differing from those the rules appeared to call for.

A. Warranties

It is readily apparent that the law of warranty, as stated, is draconian. An insured could lose all protection under a policy for a slightly inaccurate statement made in the negotiations leading to issuance of the policy, though the statement was made in perfect good faith, and that despite the fact that the insurer was not misled by the statement in any way prejudicial to it. The classic answer to the argument that such a result would be unjust was that if the insured did not wish the result, he should not have agreed to make it a term of the policy that his statement was warranted to be true; the parties control the terms of their contracts, and the courts simply enforce the agreements as made by the parties. However, the supreme court early recognized the unreality of this argument. Aside from the question whether the average policyholder could be expected to understand warranty terms, his practical ability to bargain for their deletion was slight; the insurers, in reality, determined the terms of insurance contracts unilaterally. In consequence, the Arkansas cases, though not repudiating the standard warranty doctrine, sought and found numerous ways to soften its impact.

First, the decisions were insistent that any warranty be created by the terms of the policy when a written contract of insurance was made, as was usually the case. Thus, it was not enough to create a warranty by having the applicant for insurance sign an application form which stated that he warranted statements appearing on the form to be true, no matter how clearly worded the provision might be. The written policy subsequently issued had to contain the warranty, or at least incorporate the terms of the application by reference or attachment of a copy of the application. This requirement

the precedents announcing those rules. It is the thesis of this paper that the pre-Insurance Code cases dealing with warranties sought to avoid the harsher effects of the traditional rules by a variety of techniques, rather than make overt changes in the established doctrine, an observation which is helpful in appraising the effect of the 1959 Insurance Code.


23. Unionaid Life Ins. Co. v. Munford, 180 Ark. 1048, 24 S.W.2d 966 (1930); Modern Woodmen of American v. Whitaker, 173 Ark. 921, 293 S.W. 1045 (1927); American Life &
may have been based on the parol evidence rule, but no consideration was given to the doctrine recognized elsewhere in contract law that a condition precedent to the formation of the contract may be shown by parol evidence. The strict rule applied to insurance warranties probably served the practical purpose of lessening the possibility of surprise to a policyholder who recalled little of the terms of the application he had signed.

Assuming that this initial hurdle in the way of a successful warranty defense was surmounted, the insurer might encounter the argument that the language of the policy or incorporated application did not sufficiently show an intention to elevate representations made by the applicant to the status of warranties. Ostensibly, this presented a straightforward question of contract interpretation. However, a rule consistently applied to insurance contracts was that doubts as to meaning should be resolved against the insurer, and the pertinence of this rule was at times quite frankly stated to be to avoid the harshness of the operation of warranties. By broad application of this contra proferentem doctrine, it was often possible to

Accident Ass'n v. Walton, 133 Ark. 348, 202 S.W. 20 (1918); Metropolitan Life Ins. Co. v. Johnson, 105 Ark. 101, 150 S.W. 393 (1912). See also United States Fidelity & Guar. Co. v. Maxwell, 152 Ark. 64, 237 S.W. 708 (1922) (promissory warranty).

Insurance written by fraternal benefit societies was distinguished by a doctrine that the constitution and by-laws of the society were part of the contract of insurance and the insured member was bound by them whether he was aware of them or not and even if the certificate of insurance did not refer to them. Sovereign Camp Woodmen of the World v. Newsom, 142 Ark. 321, 219 S.W. 759 (1920); Supreme Royal Circle of Friends of the World v. Morrisson, 105 Ark. 140, 150 S.W. 561 (1912) (noting possible qualification where constitutional or by-law provisions conflict with terms of certificate issued to member); Woodmen of the World v. Hall, 104 Ark. 538, 148 S.W. 526 (1912); Woodmen of the World v. Jackson, 80 Ark. 419, 97 S.W. 673 (1906).


27. Maccabees v. Gann, 182 Ark. 1141, 34 S.W.2d 456 (1931); Modern Woodmen of America v. Whitaker, 173 Ark. 921, 293 S.W. 1045 (1927); Title Guar. & Sur. Co. v. Bank of Fulton, 89 Ark. 471, 117 S.W. 537 (1909). A reinforcing reason for the rule was that the insurer had chosen the wording of the policy. American Life & Accident Ass'n v. Walton, 133 Ark. 348, 202 S.W. 20 (1918); Title Guar. & Sur. Co. v. Bank of Fulton, 89 Ark. 471, 117 S.W. 537 (1909). The thought presumably was that the insurer had spelled out all the protection it wanted, so doubts regarding meaning could legitimately be resolved in favor of the insured.
conclude that statements which the insurer contended were the subjects of warranties were "mere representations".28

In *Title Guaranty & Surety Co. v. Bank of Fulton*,29 for example, an application for a fidelity bond covering a bank’s cashier was accompanied by an “Employer’s Declaration” in which the bank asserted that the cashier had always performed his duties faithfully and that his accounts were correct in every particular at the time of the most recent audit. The Declaration recited that, “The above and foregoing statements and representations are made for the purpose of inducing the Title Guaranty & Surety Company to execute said bond”, and the bond itself recited: “Whereas, the Employer has heretofore delivered to the Company certain representations and promises relative to the duties and accounts of the Employee, and other matters, it is hereby understood and agreed that those representations and such promises . . . shall constitute part of the basis and consideration of the contract hereinafter expressed.”30 A claim was subsequently made on the bond, and the insurer’s investigation apparently revealed that the cashier’s accounts had not been correct at the time of the audit referred to in the Declaration, though the bank officials who conducted the audit had failed to discover the irregularities. On the insurer’s appeal from a judgment for the bank, the court held that the statements in the Employer’s Declaration were mere representations and that the judgment appealed from was correct because the evidence warranted a finding that the statements in the Declaration were made in good faith. The court reasoned that statements made in connection with an application for a policy become warranties only if the policy so provides; that if the insurer intends to make such statements warranties, the policy must say so in express terms, or at least expressly provide that it is to be void if the statements are incorrect; and that it was not sufficient to include in the policy a provision that statements made in the appli-

28. An occasional case did not fit the pattern. See, e.g., Capital Fire Ins. Co. v. King, 82 Ark. 400, 102 S.W. 194 (1907) (compare opinion for the court with dissenting opinion). Moreover, 1925 Ark. Acts 139, § 14 declared that statements made by applicants for insurance to assessment companies organized under the act should be construed as warranties. This statute was applied in Southern Burial Ins. Co. v. Baker, 199 Ark. 468, 134 S.W.2d 1 (1939). Section 14 of the act was repealed by 1959 Ark. Acts 148, § 698.

On the other hand, the problem was eliminated in some policies by express provisions of the policies that statements made in the applications for them should be deemed representations and not warranties. See, e.g., American Republic Life Ins. Co. v. Edenfield, 228 Ark. 93, 306 S.W.2d 321 (1957).

29. 89 Ark. 471, 117 S.W. 537 (1909).

30. Id. at 474, 117 S.W. at 538.
cation should be the basis of the contract of insurance or form part of that contract, nor would it help that the policy recited that such statements were part of the consideration for the issuance of the policy. The policy had to be so worded that "it cannot be construed otherwise" than as making representations in the application warranties. It subsequently developed that even express use of the word "warrant" did not guarantee a finding that a warranty was intended.

If the policy language did make statements of the applicant warranties, the next issue might be: what was warranted? For example, assuming that by the terms of the policy the insurer's obligation was dependent on the truth of statements made by the applicant for insurance, that obligation might be dependent on the literal truth of the statements or on the statements having been made in the belief that they were true. This presented a question of interpretation of the contract, and again the principle of contra proferentem called for resolving doubts against the insurer.

31. Id. at 480, 117 S.W. at 540. See also Lincoln Reserve Life Ins. Co. v. Smith, 134 Ark. 245, 203 S.W. 698 (1918); Southern Sur. Co. v. Barham, 133 Ark. 220, 202 S.W. 231 (1918). Even more remarkable is a statement, though dictum, in Metropolitan Life Ins. Co. v. Johnson, 105 Ark. 101, 150 S.W. 393 (1912), that "the language of the application shows that the answers to the questions propounded . . . were intended by the parties to be representations merely, and not warranties," Id. at 105, 150 S.W. at 394, when the application declared that, "Every answer must be true or the policy will be void." Id. at 102, 150 S.W. at 394.

32. Modern Woodmen of America v. Whitaker, 173 Ark. 921, 293 S.W. 1045 (1927). See also American Life & Accident Ass'n v. Walton, 133 Ark. 348, 202 S.W. 20 (1918), which quotes with approval from an Illinois case, Spence v. Central Accident Ins. Co., 236 Ill. 444, 86 N.E. 104 (1908), in which it was held that a policy recital that the policy was issued "[i]n consideration of the warranties and agreements in the application for this policy" was insufficient to incorporate the application and any warranty language in it into the policy. Cf. United States Fidelity & Guar. Co. v. Maxwell, 152 Ark. 64, 237 S.W. 708 (1922).


Cases involving "delivery in good health" clauses, policy clauses providing that the insurance would not take effect unless the insured was in good health (sometimes, "sound health") at the time of delivery of the policy (or perhaps at the time of issuance of the policy), have varied in their treatment of such clauses. Taken literally, they create conditions precedent to the formation of the contract and are most naturally read as conditioning the insurer's obligation on the actual good health of the insured at the time specified. Some cases have so treated the clauses. National Life & Accident Ins. Co. v. Young, 200 Ark. 955, 141 S.W.2d 838 (1940); National Life & Accident Ins. Co. v. Matthews, 198 Ark. 277, 128
good faith belief that he was telling the truth were immaterial, there
could be doubt as to what facts were represented. Where the state-
ment was made in response to the insurer's question, dual problems
of interpretation were presented: (1) what information was asked
for, and (2) what information was given? By narrow construction of
questions, it could often be concluded that the responses asserted a
good deal less as fact than the literal wording of the questions and
answers would suggest. Thus, broad questions as to ailments of ap-
plicants or proposed insureds, or prior medical attendance, were fre-
quently held to involve representations relating only to serious
ailments or attendance of serious ailments, and questions about

S.W.2d 695 (1939) ("warranty of sound health"); Commonwealth Life Ins. Co. v. Tanner,
175 Ark. 482, 300 S.W. 927 (1927) (referring to the clause as a warranty). See also Life &
Casualty Ins. Co. v. McCrae, 193 Ark. 890, 103 S.W.2d 929 (1937) (clause expressly provi-
ding that insured's knowledge of the state of his health was immaterial). In other cases, the
 clauses have been held not to be warranties and not to afford the insurer a defense unless the
insured did not honestly believe himself to be in good health at the time specified. Aetna
Life Ins. Co. v. Mahaffey, 215 Ark. 892, 224 S.W.2d 21 (1949); Lincoln Reserve Life Ins. Co.
v. Smith, 134 Ark. 245, 203 S.W. 698 (1918). In the Mahaffey case Matthews, and apparently
Young as well, were distinguished on the ground that those cases had involved nonmedical
policies, i.e., policies issued without prior physical examination of the insured. The thought
seemed to be that the insurer had to rely on policy terms for its protection where no medical
examination was required prior to the issuance of the policy, whereas if there was a medical
examination, the insurer had the opportunity to find out for itself the true condition of the
insured's health, so a reading of the good health clause less favorable to the insurer was
justified in the latter case. (The Mahaffey case suggests a still further distinction, that where
a medical examination is conducted, the good health clause of the policy is directed only at
diseases and injuries developing or discovered by the insured after the physical examination.
See Denenholtz & Curtis, The Good Health Clause, 1964 PROCEEDINGS, ABA SECTION OF
INSURANCE, NEGLIGENCE & COMPENSATION LAW 263.) The Tanner case would be consis-
tent with the distinction, as it involved a nonmedical policy. It is not clear from the report
whether the Smith case involved a policy issued after medical examination, but the case did
involve another factual element that seemed to confuse the handling of delivery in good
health clauses. In Smith the insurer relied for defense, not only on a delivery in good health
case, but also on the falsity of statements concerning health appearing in the application
for the policy as representations of the applicant. The court concluded that the policy lan-
guage did not raise those representations to the level of warranties and that the representa-
tions would not be grounds for avoiding the policy unless they had been made in bad faith.
The court then declared, without explaining why, that the question whether the insurer was
excused from liability by the delivery in good health clause "turns also upon the good faith
and apparent state of health of the insured at the time of delivery and acceptance of the
policy." 134 Ark. at 250, 203 S.W. at 700. In several subsequent cases involving similar
facts, representations in applications were treated as not warranties and not grounds for
avoidance if made in good faith, and no independent significance was accorded to delivery
863, 245 S.W.2d 219 (1952) (nonmedical policy); Guardian Life Ins. Co. v. Johnson, 186
Ark. 1019, 57 S.W.2d 555 (1933) (not clear that nonmedical policy involved); American
Nat'l Ins. Co. v. Chavey, 185 Ark. 865, 50 S.W.2d 245 (1932) (nonmedical policy).

34. Southern Nat'l Ins. Co. v. Pillow, 206 Ark. 769, 177 S.W.2d 763 (1944); Woodmen
of the World Life Ins. Soc'y v. Reese, 206 Ark. 530, 176 S.W.2d 708 (1943) (four-inch space
previous use of alcohol or drugs were usually treated as referring to habitual use only.\textsuperscript{35} Similarly, though the “black-letter” law was that a breach of warranty gave the insurer a defense without regard to whether the facts represented made the risk to the insurer appear smaller than it was in fact, a question asked by the insurer could be construed as calling for an answer revealing only facts that would substantially increase the risk.\textsuperscript{36}


The great variety of questions asked of applicants by insurers presents many questions of interpretation, of course. Those referred to in the text at notes 34-36 are merely common examples. Other instances include: Liverpool & London & Globe Ins. Co. v. Payton, 128 Ark. 528, 194 S.W. 503 (1917) (question in fire insurance application regarding previous refusals to insure the same property construed to refer to refusals by companies or agents engaged in writing the same kind of insurance as that applied for); National Americans v. Ritch, 121 Ark. 185, 180 S.W. 488 (1915) (negative answer to question whether applicant for life insurance had “consulted or been under the care of any physician” within the past five years not false by reason of fact that applicant had, within the five year period, taken a physical examination in connection with application for pension, even though examining physician had discovered insured was suffering from chronic rheumatism and was in rundown condition); Supreme Lodge Knights of Pythias v. Davis, 90 Ark. 264, 119 S.W. 257 (1909) (where insured warranted that he used intoxicants only occasionally and in applying for change of beneficiary eight years later the warranty was repeated, latter warranty referred to use of intoxicants at time policy originally issued); Nabors v. Dixie Mut. Fire Ins.
There might also be a question whether the representation warranted true was a representation of the insurance applicant. This was likely to arise in a case where the agent soliciting the application or a medical examiner had filled in answers to questions in the application forms which were not answers actually supplied by the applicant. It might be held that the applicant was not responsible for the false assertions appearing in the application, and that they afforded the insurer no defense for that reason.

Even if the representation were that of the applicant for insurance, there was likely to be an issue whether the warranty of its truth was breached, that is whether the representation was false. The burden of proof rested with the insurer on this question of fact, no matter if the insurer was the plaintiff or defendant in the action; a

Co., 84 Ark. 184, 105 S.W. 92 (1907) (question in application for fire insurance whether there was other insurance on the property not falsely answered by "no" answer, where there was a policy issued by another company for a term overlapping that of the policy applied for but issuance of the policy applied for constituted breach of promissory warranty in prior policy).

37. In Mutual Reserve Fund Life Ass'n v. Farmer, 65 Ark. 581, 47 S.W. 850 (1898), the examining physician, after the applicant had signed the application, inserted answers in blanks in the medical examination form regarding prior illnesses of the applicant and prior medical attendance. Despite an assumption that the physician was the agent of the applicant in filling out the form, the court treated the question whether there was a breach of warranty of the truthfulness of the answers as turning on whether the applicant had authorized the insertions or adopted them after they had been made. The wording of the warranty is not given.

Logically, since a warranty operates as a condition of the insurer's obligation, the question whether the applicant authorized or adopted answers written into the application by another would be irrelevant unless the warranty was so worded as to limit its operation to the applicant's own answers. However, in any case where the warranty language was not absolutely clear, the contra proferentem principle could be invoked to justify that reading. See Mississippi Life Ins. Co. v. Meadows, 161 Ark. 71, 255 S.W. 293 (1923).

The burden was on the insurer to prove that the representations in the application were those of the insurance applicant. National Annuity Ass'n v. McCall, 103 Ark. 201, 146 S.W. 125 (1912).

38. Cases of this sort were more likely to be handled by resort to doctrines of waiver and estoppel. See, e.g., Washington Nat'l Ins. Co. v. Martin, 188 Ark. 306, 65 S.W.2d 551 (1933); Walker v. Illinois Bankers' Life Ass'n, 140 Ark. 192, 215 S.W. 598 (1919).

39. The expression "breach of warranty" is somewhat misleading since the critical question is not whether the breaching party has incurred liability to the insurer, but rather whether the insurer is excused from its own obligation by a condition of its promise, but the usage is convenient and commonly employed.


The law was less settled regarding the burden of proof concerning the state of the insured's health when a delivery in good health clause was involved. Such policy clauses were usually so worded as to condition the taking effect of the contract of insurance on payment of premium and delivery (or issuance) of the policy while the insured was in good (or
rule inconsistent with the general doctrine that in an action to enforce a contract the burden is on the plaintiff to establish satisfaction of all conditions precedent.\textsuperscript{41} The insurer's burden was increased in cases involving personal insurance by the statute treating as privileged information acquired by medical attendants while rendering professional services to patients,\textsuperscript{42} and, although the privilege could be waived, waivers were narrowly construed.\textsuperscript{43}

"sound") health. The cases appeared to be in agreement that the burden was on the party seeking to uphold the effectiveness of the contract to prove the payment of premium and delivery (or issuance), but they differed as to whether that party also had the burden of showing that the insured was in good (or sound) health at the time of delivery (or issuance) of the policy. Taking the position that the burden was on the party seeking to uphold the validity of the contract was Atlas Life Ins. Co. v. Bolling, 186 Ark. 218, 53 S.W.2d 1 (1932), which relied on New York Life Ins. Co. v. Mason, 151 Ark. 135, 235 S.W. 422 (1921), a case in which the issue was whether the policy had been delivered. Taking the view that the insurer had the burden of proof on the good health issue were Old American Ins. Co. v. Hartsell, 176 Ark. 666, 4 S.W.2d 25 (1928), and Sovereign Camp Woodmen of the World v. Cole, 192 Ark. 326, 91 S.W.2d 250 (1936).

41. See 5 S. Williston, A Treatise on the Law of Contracts, § 667A (3d ed. 1961); 3A A. Corbin, Contracts, §§ 749-750 (1960). See also Williams v. Newkirk, 121 Ark. 439, 181 S.W. 304 (1915); John A. Gauger & Co. v. Sawyer & Austin Lumber Co., 88 Ark. 422, 115 S.W. 157 (1908). The special rule regarding burden of proof with respect to satisfaction of insurance warranties, generally accepted in the United States, has been explained as required to relieve persons suing on insurance contracts from an intolerable burden, without which relief a great many policyholders would be unfairly deprived of effective insurance protection. See W. Vance, Handbook of the Law of Insurance, § 75 (3d ed. 1951).


43. In American Republic Life Ins. Co. v. Edenfield, 228 Ark. 93, 306 S.W.2d 321 (1957), the application for insurance on the life of the applicant provided: "To whom it may concern: I hereby request and authorize you to disclose, whenever requested to do so by American Republic Life Insurance Company, or its representative, any and all information and records concerning my condition when under observation by you." Apparently, no physician was named in the application as having treated the applicant, and the application contained a denial that the applicant had suffered from any mental or physical impairment. The court held that the quoted language did not constitute a waiver of the statutory privilege; applying contra proferentem, it reasoned that the wording did not clearly inform the insured that he was waiving the benefit of laws that would prevent his doctors from testifying regarding information they obtained while treating him professionally. In the same case it was held that the beneficiary had not waived the privilege by submitting a proof of death in which she expressly authorized "any physician, hospital or other person to give to the Company any information concerning the health or insurability of the Deceased, and hereby specifically waive all grounds of defense or objections based on rights of confidential relationship or privileged communication between Physician or Hospital and Patient." The court read this waiver as "limited for the purpose of adjustment and settlement of the claims on the policies and [not to] extend to the use of such information in a suit on the policies." Id. at 100, 306 S.W.2d at 325.

(This case, and Mutual Life Ins. Co. v. Owen, 111 Ark. 554, 164 S.W. 720 (1914), in-
Proof of violation of the warranty by the insurer did not guarantee it exemption from liability, for there remained possibilities of waiver and estoppel, nullifying the effect of the breach of warranty. In case after case it was held that insurers had lost warranty defenses, or at least that the evidence justified findings of fact leading to that conclusion, on one or the other of these grounds\(^4\) (which were seldom distinguished).\(^4\) The most common basis for their application was evidence that an agent of the insurer who dealt with the applicant, in taking the application or administering a medical examination, had learned\(^4\) of facts disclosing false representations involved misrepresentation, rather than breach of warranty, but there is no reason to suppose that the insurer did not encounter the same difficulties in warranty cases.)

\(^4\) Waiver and estoppel were used much more sparingly where the insurer's defense was not breach of warranty but lack of coverage. In Metropolitan Life Ins. Co. v. Minton, 188 Ark. 456, 66 S.W.2d 627 (1933), where the plaintiff sought disability benefits under a group policy, and by the terms of the certificate issued to him he was entitled to such benefits if he became disabled while insured and prior to his 60th birthday, the plaintiff prevailed in the trial court on proof that, although he was over 60 when the certificate was issued, an agent of the insurer, sent to explain the program prior to issuance of the certificate, had assured him that his age would not disqualify him for disability benefits. Reversing and dismissing, the Arkansas Supreme Court held that parol evidence could not be used to vary the terms of the contract and that doctrines of waiver and estoppel could not be used to avoid that rule. Cases involving noncompliance with conditions of the validity of the policy were distinguished. Bankers Nat'l Ins. Co. v. Hemby, 217 Ark. 749, 233 S.W.2d 637 (1950), is similar. However, a distinction was drawn between terms affirmatively defining coverage and terms excepting loss from a particular cause from a broader definition of coverage, waiver and estoppel being available to nullify excepted cause provisions. See also American Nat'l Ins. Co. v. Hale, 172 Ark. 958, 291 S.W. 82 (1927), casting doubt on the soundness of the holding in National Life Ins. Co. v. Jackson, 161 Ark. 597, 256 S.W. 378 (1923), where an excepted cause provision was strictly applied, even though the applicant for insurance had made a related misrepresentation which the insurer would probably not have been able to use as a defense because of waiver or estoppel. In National Life & Accident Ins. Co. v. Shibley, 192 Ark. 53, 90 S.W.2d 766 (1936), the \textit{Hale} case is referred to as disapproving the holding of \textit{Jackson}.

\(^4\) E.g., Pate v. Modern Woodmen of America, 129 Ark. 159, 195 S.W. 1070 (1917) ("waiver by estoppel"); People's Fire Ins. Ass'n v. Goyne, 79 Ark. 315, 96 S.W. 365 (1906) (waiver apparently used as synonym for estoppel); German Ins. Co. v. Gibson, 53 Ark. 494, 14 S.W. 672 (1890) (employing both terms); Insurance Co. v. Brodie, 52 Ark. 11, 11 S.W. 1016 (1889) (basing decision on estoppel but quoting cases invoking waiver). A careful distinction was made in Sovereign Camp Woodmen of the World v. Newsom, 142 Ark. 132, 219 S.W. 759 (1920), where the court was faced with a statute which it treated as precluding a finding of waiver but construed as leaving open the possibility of estoppel. (The case did not involve misrepresentation or breach of warranty, but the opinion clearly considers the law discussed as applicable to such cases.)

\(^4\) There were suggestions in the cases that an agent might be treated as having knowledge he did not actually possess, which would be imputed to the insurer. The earliest Arkansas case dealing with misrepresentation in procurement of insurance, Insurance Co. v. Brodie, 52 Ark. 11, 11 S.W. 1016 (1889), stated that an estoppel could arise against an insurer, preventing it from defending on the basis of falsity of answers in the application for insurance, where the insurer's agent writes false answers in the application "with notice or
which appeared in the completed application forms. The agent’s knowledge would be attributed to the insurer as his principal, and the insurer, having issued a policy with such knowledge, would be held to have waived the breach of warranty or to be estopped from using it as a defense. 47 There was a limitation that the agent must

knowledge of the inaccuracy of the answers written” and the company afterwards issues a policy and receives the premium, if the falsity of the answers is not asserted until after a loss within policy coverage has occurred. However, the cases did not go far with the notice idea.

Some cases invoked the imputed knowledge doctrine where the insurer’s agent filled in answers to questions in an application form without consulting the applicant and apparently without actual knowledge of the truth, e.g., Woodmen of the World Life Ins. Soc’y v. Sanders, 201 Ark. 478, 145 S.W.2d 28 (1940); Maloney v. Maryland Cas. Co., 113 Ark. 174, 167 S.W. 845 (1914), but in these cases it was usual to use as an alternative rationale that the false statements were not statements of the applicant but of the insurer’s own agent; moreover, in these cases the agent had actual knowledge which, if imputed to the insurer, should trigger waiver or estoppel as readily as the agent’s knowledge of the falsity of the answers, viz., knowledge of a lack of information.

In an occasional case the court came closer to extending the concept of notice beyond knowledge. In Mutual Aid Union v. Blacknall, 129 Ark. 450, 196 S.W. 792 (1917), an application for life insurance contained false representations that the applicant did not have kidney disease or rheumatism, but there was evidence that when the insurer’s agent took the application and filled in the answers, he could see that the applicant was suffering from serious physical and mental ailments. A recovery on the policy was approved. The court reasoned that the knowledge of the agent was imputable to the insurer, and it implied that it did not matter whether the agent knew of the falsity of the specific answers in the application if he knew that the applicant was suffering from ailments which would make him an unfit subject for insurance. In Life & Cas. Ins. Co. v. Dunham, 186 Ark. 121, 52 S.W.2d 620 (1932), the court appeared to treat a soliciting agent’s knowledge that the insured had been in an insane asylum as notice that the insured had been treated for a serious disease, so that the agent could be treated as knowing of the falsity of a representation that the insured had not been treated by a physician for a serious disease prior to issuance of the policy.

By contrast, in Standard Accident Ins. Co. v. Wilmans, 214 F. Supp. 53 (E.D. Ark. 1963) (a case decided after enactment of the Insurance Code but apparently uninfluenced by it) a federal district judge, applying Arkansas law, declined to rule that the general agent for an automobile insurer, who issued a renewal policy containing the same declarations as appeared in the original policy, should be deemed to have had notice that those declarations were no longer true because he could have acquired such knowledge by questioning the named insured.

47. The cases are numerous. Examples are: DeSoto Life Ins. Co. v. Johnson, 208 Ark. 795, 187 S.W.2d 883 (1945) (soliciting agent); Brotherhood of R.R. Trainmen v. Long, 186 Ark. 320, 53 S.W.2d 433 (1932) (medical examiner); Home Mut. Benefit Ass’n v. Rowland, 155 Ark. 450, 244 S.W. 719 (1922) (soliciting agent); Mutual Aid Union v. Blacknall, 129 Ark. 450, 196 S.W. 792 (1917) (soliciting agent); King v. Cox, 63 Ark. 204, 37 S.W. 877 (1896) (knowledge of general agent); Providence Life Assurance Soc’y v. Reutlinger, 58 Ark. 528, 25 S.W. 835 (1894) (knowledge of medical examiner); Insurance Co. v. Brodie, 52 Ark. 11, 11 S.W. 1016 (1889) (knowledge of soliciting agent).

In Southern Burial Ins. Co. v. Baker, 199 Ark. 468, 134 S.W.2d 1 (1939), it was held that a waiver or estoppel could not be based on the knowledge of the agent taking the application for insurance where the policy was issued by an assessment company organized under Act 139 of 1925. This decision was purportedly distinguished, but effectively overruled, in

The applicability of the reasoning discussed in the text to cases where the claimed waiver or estoppel was based on the knowledge of an officer of a local lodge of a fraternal benefit association was a question of some difficulty. It was accepted doctrine that the constitution and by-laws of such an association became part of the contract of insurance between the association and its members, see note 23 supra, and on this basis it was held that if the constitution or by-laws prescribed the terms on which insurance would be provided and also forbade officers of local lodges to waive such terms, the officers of local lodges had no power to waive the provisions of the constitution and by-laws dealing with the substance of the contract between the association and a member. Woodmen of the World v. Hall, 104 Ark. 538, 148 S.W. 526 (1912). In the Hall case, however, the court was willing to recognize an estoppel against such an association to rely on a breach of warranty of the truth of answers given in a member's application for insurance, where the physician of a local lodge administered an insurance physical examination and had knowledge of the falsity of the answers given to him in the course of the examination; the theory was that the physician would be acting as agent of the association in conducting the examination, and his knowledge of facts pertinent to his agency duties would be imputed to the insurer. The court decided, though, that the evidence did not show such a case. The dictum in Hall was followed in Peebles v. Eminent Household of Columbian Woodmen, 111 Ark. 435, 164 S.W. 296 (1914), where it was held that when the clerk of a local lodge had authority to deliver a benefit certificate to a member only if he was in good health at the time of delivery, and the clerk delivered the certificate knowing that the member was not in good health, the clerk's knowledge would be imputed to the association, and by continuing to accept payments of premiums thereafter, the association became estopped to claim forfeiture of the insurance by reason of the breach of the warranty of good health. Pate v. Modern Woodmen of America, 129 Ark. 159, 195 S.W. 1070 (1917), and Sovereign Camp Woodmen of the World v. Anderson, 133 Ark. 411, 202 S.W. 698 (1918), appeared to recede from the doctrine of the Peebles case, though they were distinguishable on their facts. Finally, in Sovereign Camp Woodmen of the World v. Newsom, 142 Ark. 132, 219 S.W. 759 (1920), the Arkansas Supreme Court undertook to settle the law. After exhaustive discussion of the Arkansas cases, as well as cases from other jurisdictions, the court ruled that officers of local lodges, in performing their official duties, were agents of the parent association; that principles of agency law applicable to agents of the same general character of ordinary insurance companies applied; that knowledge of such agents possessed while they were engaged in the discharge of their duties and pertinent to those duties was to be treated as the knowledge of the association; and that waiver and estoppel principles based on acts of the association taken with such imputed knowledge were just as applicable as in other insurance cases. Unfortunately the court, in making this ruling, had overlooked a statute, 1917 Ark. Acts 462, governing fraternal benefit associations, which provided in § 20: "The constitution and laws of the society may provide that no subordinate body, nor any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the law and constitution of the society, and the same shall be binding on the society, and each and every member thereof and on all beneficiaries of members." When this law was called to the court's attention, the court conceded that any waiver of provisions of the constitution and by-laws of a fraternal benefit association by officers of a subordinate lodge was precluded by the statute, if the organization's internal law prohibited such waivers, but it construed the statute as not touching the question whether an estoppel could arise from the behavior or knowledge of officers of local lodges. (The Act of 1917 was repealed by 1959 Ark. Acts 148, § 698, but § 20 of the 1917 act was replaced by an almost identically worded section of the 1959 Insurance Code, Ark. Stat. Ann. § 66-4722 (1980).) It would seem that if the agency doctrine that knowledge of an agent acquired within the scope of his agency is imputed to his principal is applicable to officers of local lodges of fraternal benefit societies, as was held in Newsom, the
have had\textsuperscript{48} or acquired\textsuperscript{49} such knowledge while acting within the scope of his agency, but even a soliciting agent whose authority was limited to seeking applications for insurance, assisting applicants to complete the applications, and transmitting those applications to higher authority for acceptance or rejection (a type of agent often said in other contexts to have no power to bind the insurer contractually and whose knowledge was said not to be imputable to the insurer)\textsuperscript{50} qualified as the insurer's alter ego in these breach of warranty cases.\textsuperscript{51} There was also a principle that the insurer would not

\textsuperscript{48} See Home Mut. Benefit Ass'n v. Rowland, 155 Ark. 450, 244 S.W. 719 (1922); Franklin Life Ins. Co. v. Galligan, 71 Ark. 295, 73 S.W. 102 (1903).

\textsuperscript{49} Woodmen of the World v. Hall, 104 Ark. 538, 148 S.W. 526 (1912); Phoenix Ins. Co. v. Flemming, 65 Ark. 54, 44 S.W. 464 (1898).

\textsuperscript{50} E.g., Holland v. Interstate Fire Ins. Co., 229 Ark. 491, 316 S.W.2d 707 (1958) (alleged waiver of breach of continuing warranty by soliciting agent's knowledge of breach and assurance that policy was good despite breach when collecting premiums after issuance of policy); Sadler v. Fireman's Fund Ins. Co., 185 Ark. 480, 47 S.W.2d 1086 (1932) (action to reform fire insurance policy to include loss-payable clause in favor of plaintiffs, on ground that insurer's soliciting agent had told plaintiffs that the policy, which had been issued but retained in the agent's possession, contained such a clause, as he had promised, prior to issue, that it would).

\textsuperscript{51} E.g., Walker v. Illinois Bankers' Life Ass'n, 140 Ark. 192, 215 S.W. 598 (1919) (knowledge of soliciting agent of falsity of statement of applicant's age, as shown in application for insurance, attributable to insurer despite recital in application that such knowledge of agent should not validate insurance); People's Fire Ins. Ass'n v. Goyne, 79 Ark. 315, 96 S.W. 365 (1906) (policy stipulation that no representative of insurer had power to waive any policy provision except by writing attached to policy ineffective to prevent knowledge of soliciting agent regarding truth of matters falsely inserted by him in applications for insurance from being attributed to insurer); Sprott v. New Orleans Ins. Ass'n, 53 Ark. 215, 13 S.W. 799 (1890) (though agent a solicitor, not a general agent for the insurer, insurer responsible for inaccuracy of diagram of premises to be covered by fire insurance which was made by solicitor and forwarded to insurer by its general agent along with application signed by prospective insured, even though application recited that solicitor was agent of applicant in preparing diagram); Insurance Co. v. Brodie, 52 Ark. 11, 11 S.W. 1016 (1889) (agent's knowledge imputed to insurer where agent authorized to fill in blank applications for insurance does so with "notice or knowledge" of inaccuracy of answers written, even though policy provided that applicant was responsible for agent's representations).
be deemed to have the knowledge of its agent, and could avoid a policy, if the agent and the applicant had colluded to keep the truth from the insurer, but that doctrine did not apply unless the applicant was guilty of actual fraud; his signing of an incomplete application form, signing a completed one without reading it or having it read to him, or failing to read over the application when a copy of it was returned to him with the policy were readily forgiven. Waiver and estoppel could deprive the insurer of a warranty defense in a number of other ways as well.


53. See Brotherhood of R.R. Trainmen v. Long, 186 Ark. 320, 53 S.W.2d 433 (1932); Home Mut. Benefit Ass'n v. Rowland, 155 Ark. 450, 244 S.W. 719 (1922). In Providence Life Assurance Soc'y v. Reutlinger, 58 Ark. 528, 25 S.W. 835 (1894), although it was said that an estoppel against an insurer would not result from its agent's knowledge of a breach of affirmative warranty if the applicant certified the truth of a false answer knowing that it appeared in the application or if the applicant, after delivery of the policy, discovered that the agent had inserted false answers in the application and remained silent, it was held that where the applicant relied on the agent's judgment as to what was an appropriate answer to a question in the application, the collusion limitation did not apply. But see Home Ins. Co. v. North Little Rock Ice & Electric Co., 86 Ark. 538, 111 S.W. 994 (1908) (dictum that knowledge of agent is not imputed to principal where agent is known to insured to have personal interest which might induce him to keep matter concealed from principal).


57. Washington Nat'l Ins. Co. v. Martin, 188 Ark. 306, 65 S.W.2d 551 (1933); Life & Cas. Ins. Co. v. Dunham, 186 Ark. 121, 52 S.W.2d 620 (1932); Walker v. Illinois Bankers' Life Ass'n, 140 Ark. 192, 215 S.W. 598 (1919). The willingness in warranty cases to overlook the insured's failure to read the policy after receiving it stands in marked contrast to the lack of sympathy shown for policyholders who were caught by surprise by other insurance policy terms. See American Nat'l Ins. Co. v. Otis, 122 Ark. 219, 183 S.W. 183 (1916); Remmel v. Griffin, 81 Ark. 269, 99 S.W. 70 (1907) (policyholder who applied for 10-payment life insurance policy but received 20-payment policy bound by premium note if he failed to read policy within reasonable time after receiving it and inform insurer of his rejection promptly thereafter). (More recent cases suggest a retreat from this stern position, by showing a readiness to find that the insurer misled the insured into believing that the policy issued was in accord with the policyholder's expectation. Providential Life Ins. Co. v. Clem, 240 Ark. 922, 403 S.W.2d 68 (1966); Lawrence v. Providential Life Ins. Co., 238 Ark. 981, 385 S.W.2d 936 (1965); Woodmen of the World Life Ins. Soc'y v. Counts, 221 Ark. 143, 252 S.W.2d 390 (1952).)

58. An insurer could be estopped from taking advantage of a breach of warranty by reason of its adjuster's having discovered facts showing breach in the course of his investigation of a claim on the policy, followed by a request for proofs of loss without contention that
Arkansas was by no means unique in the employment of these techniques for mitigating the harshness of the black-letter warranty law. Courts throughout the United States were accomplishing the same purpose in these ways, and more. Arkansas cases are fo-

the policy was unenforceable for breach of warranty. German Ins. Co. v. Gibson, 53 Ark. 494, 14 S.W. 672 (1890). If the insurer, after issuing a policy, learned facts inconsistent with a warranty but took no action to cancel the policy before loss occurred, the insurer was deemed to have waived the forfeiture, or to have become estopped to assert it. Eminent Household of Columbian Woodmen v. Heifner, 160 Ark. 624, 255 S.W. 29 (1923); German-American Ins. Co. v. Harper, 75 Ark. 98, 86 S.W. 817 (1905). Insurer defenses based on failures to answer questions in insurance applications or on conflicting answers were rejected on the ground that issuance of the policy despite such evident defects in the applications amounted to a waiver of the defects. Security Mut. Ins. Co. v. Berry, 81 Ark. 92, 98 S.W. 693 (1906); Mutual Reserve Fund Life Ass'n v. Farmer, 65 Ark. 581, 47 S.W. 850 (1898). See also Southern Ins. Co. v. Floyd, 174 Ark. 372, 295 S.W. 715 (1927), implying that where an application for life insurance failed to reveal prior attendance by a physician in answer to a question calling for that information, but the answer to another question revealed the illness for which the physician treated the applicant, and the answer to a third question calling for the names of two physicians who knew the applicant named the physician who gave the treatment, the insurer had notice of the correct answer to the question concerning prior attendance by physicians since the information given would have enabled the insurer to learn the truth.

In at least one case in which there was a breach of warranty of the truth of an answer to a question in the application for insurance it was held that the insurer lost the defense because its soliciting agent knew the true facts when he delivered the policy. State Mut. Ins. Co. v. Latourette, 71 Ark. 242, 74 S.W. 300 (1903). In cases where the insurer's defense was based on a delivery in good health clause, the defense was sometimes lost because an agent of the insurer with authority to deliver the policy knew when he made delivery that the insured was not in good health. Sovereign Camp Woodmen of the World v. Cole, 192 Ark. 326, 91 S.W.2d 250 (1936); Kansas City Life Ins. Co. v. Ridout, 147 Ark. 326, 91 S.W.2d 250 (1936); Kansas City Life Ins. Co. v. Ridout, 147 Ark. 326, 91 S.W.2d 250 (1936).


60. In other jurisdictions a breach of warranty might fail to give the insurer the protection it sought because the policy would be treated as "divisible" or "severable," the breach of warranty being treated as exempting the insurer from responsibility as to only a portion of the total coverage of the policy. See E. Patterson, supra note 59, at § 70. Only one Arkansas case discussing this possibility with regard to an affirmative warranty has been found, and there the court declined to find the policy divisible. In Phoenix Ins. Co. v. Public Parks Amusement Co., 63 Ark. 187, 37 S.W. 959 (1896), a judgment for the plaintiff in an action to enforce a policy of fire insurance was reversed and a new trial ordered because of error in instructions. The jury had been told that if the insured held a few items of property covered by the policy under contracts of conditional sale, he nevertheless had an insurable interest in such property, and if the insured, in applying for the policy, had represented himself as owner of the property, that would not defeat recovery on the policy. The policy provided that it should be void if the interest of the insured in the property be other than sole and unconditional ownership. The supreme court held that the insured was not the "sole and unconditional owner" of property held on conditional sale, and that even if that were true of only a portion of the property covered, the violation of the policy condition would render the policy entirely void. "The contract was entire and indivisible . . . . It was all exposed
cused on here because it was against the background of this elabo-
rate body of case law that the mandates of the 1959 Insurance Code
were enacted.

B. Misrepresentation

Where mere representations were involved, the doctrine was
that a representation by an applicant for insurance would not be
grounds for avoidance of a policy unless it was substantially untrue,
material, and fraudulent. Given these limitations on the misrepre-
sentation defense, one might expect that the courts would feel little
need to employ the devices found in warranty cases as means of
mitigating the rigors of the formal doctrine. However, the Arkansas
misrepresentation cases generally followed the precedents involving
to one risk, and the consideration for the policy was a specified sum. The fact that separate
amounts of insurance were apportioned to separate items or classes of property did not make
the policy divisible." Id. at 202, 37 S.W. at 963. The court relied on McQueeny v. Phoenix
Ins. Co., 52 Ark. 257, 12 S.W. 498 (1889), a case involving breach of a promissory warranty,
or continuing condition, in a policy of fire insurance to the effect that the policy should be
suspended during any period when "the above mentioned premises shall become vacant or
unoccupied." The policy covered two buildings 30 feet apart within the same enclosure,
both owned by the insured, one of which he occupied as his residence, the other being held
for rent. A single premium was charged for the policy, which was in the amount of $1,000,
apportioned 60% on the residence and 40% on the rental house. Both houses were destroyed
by fire at a time when the rental property was unoccupied. The insurer paid the loss on the
residence only, and the insured brought suit on the policy for the remainder of the loss. The
trial court denied recovery, apparently holding that each house was a separate "premises"
within the meaning of the policy and that if either building became unoccupied that sus-
pended the insurance on that building. The supreme court considered the lower court's
holding to rest on a finding that the policy, "though entire in form is divisible in substance,"
which it held to be erroneous, invoking what it considered to be the general contract rule
that if a single consideration is paid, the contract is entire, even though its subject be several
distinct items, and the court saw no reason why that rule should not apply to insurance
contracts. The court then held that, treating the contract as entire, the "premises" referred to
in the policy would not be unoccupied as long as either building was occupied. The single-
consideration test of divisibility was rejected, however, in Fireman's Ins. Co. v. Larey, 125
Ark. 93, 188 S.W. 7 (1916), also involving a promissory warranty, which held that a fire
insurance policy covering store buildings owned by two persons as tenants in common, and
issued in the names of both owners, was not avoided as to the interest of one of the named
insureds by reason of the sale of the other's interest to a third person, despite a policy term
that "[i]f any change, other than by the death of an insured, take place in the interest, title, or
possession of the subject of insurance . . . the entire policy shall be void." The reasoning by
which the contract was found divisible is not clear, but the opinion suggests that since the
insurer would have no liability to the insured who sold his interest in the property, nor to the
third person who had acquired that interest, and there was, apparently, no change in the
possession of the property, the insurer would not be prejudiced by treating the policy as still
in force as to the other insured. Chief Justice McCullough dissented, pointing to the Mc-
Queeny and Public Parks Amusement Co. cases as settling the Arkansas rule, and also argu-
ing that the language of the policy clause itself made the contract indivisible.
warranties in fixing the meaning of representations\textsuperscript{61} and in applying doctrines of waiver and estoppel.\textsuperscript{62}

The requirement that a representation be substantially false if it were to give the insurer a defense did not come into sharp focus in the decisions as a distinct issue.\textsuperscript{63} It was likely to be finessed

\textsuperscript{61} Doubts regarding meaning of insurers' questions were resolved against the insurers. Woodmen of the World Life Ins. Soc'y v. Reese, 206 Ark. 530, 176 S.W.2d 708 (1943). See also Almond v. Countryside Cas. Co., 329 F. Supp. 137 (W.D. Ark. 1971), aff'd mem., 455 F.2d 503 (8th Cir. 1972) (a case decided after the Insurance Code became effective but involving a policy of a type that seems not to be affected by the Code insofar as misrepresentation is concerned). General questions concerning health and freedom from particular diseases were construed as calling for statements of opinion. Bankers' Reserve Life Co. v. Crowley, 171 Ark. 135, 284 S.W. 4 (1926). See also Title Guar. & Sur. Co. v. Bank of Fulton, 89 Ark. 471, 117 S.W. 537 (1909) (representations in Employer's Declaration accompanying application for fidelity bond read as representations of the condition of the employee's accounts "as it was then understood" and the character of the employee "as then known to the employer"). General questions about prior illnesses or medical treatments were taken to refer to serious illnesses or treatment for serious illnesses. Woodmen of the World Life Ins. Soc'y v. Reese, 206 Ark. 530, 176 S.W.2d 708 (1943); Federal Life Ins. Co. v. Hase, 193 Ark. 816, 102 S.W.2d 841 (1937). See also Mutual Reserve Fund Life Ass'n v. Cotter, 72 Ark. 620, 83 S.W. 321 (1904). Questions regarding prior use of alcohol or drugs would be construed as referring to habitual use. Mutual Reserve Fund Life Ass'n v. Cotter, 81 Ark. 205, 99 S.W. 67 (1906). See also John Hancock Mut. Life Ins. Co. v. Ramey, 200 Ark. 635, 140 S.W.2d 701 (1940) (representation that female applicant for nonmedical life insurance policy had not been treated for any disease or disorder within the past five years not grounds for avoidance because applicant had been in a hospital for the birth of a child during that period; opinion not clear whether ruling is based on interpretation of representation or finding that fact not revealed was immaterial).

\textsuperscript{62} Pyramid Life Ins. Co. v. Trantham, 214 Ark. 791, 217 S.W.2d 924 (1949); Washington Nat'l Ins. Co. v. Martin, 188 Ark. 306, 65 S.W.2d 551 (1933); Maccabees v. Gann, 182 Ark. 1141, 34 S.W.2d 456 (1931); Mid-Continent Life Ins. Co. v. Parker, 181 Ark. 213, 25 S.W.2d 10 (1930); Old Colony Life Ins. Co. v. Julian, 175 Ark. 359, 299 S.W. 366 (1927); Home Mut. Benefit Ass'n v. Mayfield, 142 Ark. 240, 218 S.W. 371 (1920); American Life & Accident Ass'n v. Walton, 133 Ark. 348, 202 S.W. 20 (1918); Mutual Reserve Fund Life Ass'n v. Cotter, 81 Ark. 205, 99 S.W. 67 (1906). See also Reliable Life Ins. Co. v. Elby, 247 Ark. 514, 446 S.W.2d 215 (1969), and Interstate Fire Ins. Co. v. Ingram, 256 Ark. 986, 511 S.W.2d 471 (1974); both of these cases involved policies issued after the effective date of the 1959 Insurance Code, but they were decided on the apparent assumption that the Code had no relevance to the misrepresentation issues and were reasoned along the lines of pre-Code cases.

In view of the rule that misrepresentation would not be grounds for avoidance unless the applicant made it with knowledge of its falsity and intent to deceive, it might be expected that there would be caution in the application of waiver or estoppel to cut off such a defense lest fraud be encouraged, but such concern is not evident in the cases. It may be said, however, that in most of the cases applying these cut-off doctrines, it was not clearly established that the applicant had been guilty of deliberate fraud.

\textsuperscript{63} The case of Old American Life Ins. Co. v. McKenzie, 240 Ark. 984, 403 S.W.2d 94 (1966), in discussing Missouri State Life Ins. Co. v. Witt, 161 Ark. 148, 256 S.W. 46 (1923), suggests that the Witt case was one in which the representation was found not to be substantially false. In Witt an applicant for life insurance, answering a question about prior illness, revealed that he had had an operation for appendicitis in 1917 with no complications and
good results, giving also the name and address of the doctor who attended him. When action was brought to enforce the policy issued on that application, the insurer asserted that the policy had been obtained by misrepresentation, in that the applicant had not revealed the fact that he was confined to his house by sickness for more than thirteen weeks in 1918. The evidence was that the 1918 illness was "the result of a malarial condition followed by an operation for appendicitis and adhesions," the operation being the 1917 appendectomy revealed in the application for the insurance. Judgment for the plaintiff was upheld, the court observing that since the 1917 operation and the identity of the attending physician had been shown on the application, "the company had an opportunity to investigate and satisfy itself whether the operation and the illness incident thereto had materially affected his health and longevity." 161 Ark. at 152, 256 S.W. at 48. If this case does illustrate a meaning of substantial falsity, the concept involved is difficult to distinguish from waiver or estoppel, as those concepts have been developed in the Arkansas cases.

There has been a statutory rule since 1899, applicable only to policies of fire insurance on personal property, that substantial compliance with the terms of the policy, including warranties, suffices. Ark. Stat. Ann. § 66-3237 (1980). One might expect cases decided under this statute to throw some light on the meaning of "substantial". Unfortunately, the cases applying the statute, with one possible exception, involved compliance with promissory warranties, and their relevance to the question whether a misrepresentation is "substantially" untrue is conjectural. The case coming closest to this question is National Liberty Ins. Co. v. Spharler, 172 Ark. 715, 290 S.W. 594 (1927), where the insurer defended an action on the policy by asserting breach of a sole and unconditional ownership clause. The policy covered a stock of merchandise and the fixtures of a store, and it was shown that some of the items covered were held by the insured under a contract of conditional sale on which a small balance remained unpaid at the time of the fire. The opinion of the court asserts that the insured did not know that the vendor retained title to these items. It had previously been held that a conditional vendee of personal property was not the sole and unconditional owner of such property. See note 60 supra. The opinion in Spharler indicates dissatisfaction with that ruling, pointing out that the purpose of a sole and unconditional ownership clause is to confine protection to those on whom the loss would inevitably fall but for the insurance, but the case holds that even if the clause was violated, the policy provision was substantially complied with in this case:

[It] would be unreasonable to hold that when an insurance company writes a policy insuring a stock of merchandise and fixtures, the policy would be void because there might be one or two articles in the store which the assured had bought on conditional sale, the vendor retaining title, and especially in view of the fact that the assured did not know that the seller retained title. The insurance agent inspected all the stock and had an opportunity to know about it. 172 Ark. at 720, 290 S.W. at 596-97. Although the basis of this decision is obscured by the references to the insured's ignorance of the facts constituting breach and the agent's opportunity to learn of the breach, the case is consistent with other substantial compliance cases in treating certain breaches of warranty as too trivial to provide the insurer with a defense, though where the line should be drawn was not clarified. See Royal Ins. Co. v. Morgan, 122 Ark. 243, 183 S.W. 198 (1916); Arkansas Mut. Fire Ins. Co. v. Woolverton, 82 Ark. 476, 102 S.W. 226 (1907). Another consistent theme of the substantial compliance cases was that if the acts of the insured gave the insurer the protection it sought to gain by inclusion of the policy provision in question, there was substantial compliance with the policy requirement, even though not literal compliance. See, e.g., National Union Fire Ins. Co. v. Avant, 167 Ark. 307, 268 S.W. 20 (1925); Queen of Arkansas Ins. Co. v. Forlines, 94 Ark. 227, 126 S.W. 719 (1910); Security Mut. Ins. Co. v. Woodson, 79 Ark. 266, 95 S.W. 481 (1906); People's Fire Ins. Ass'n v. Gorham, 79 Ark. 160, 95 S.W. 152 (1906). The confinement of insurers' defenses to breaches which defeated the assumed purposes of the contract clauses involved could just as easily be accomplished, without the aid of the statute, by interpretation of the
through the process of interpretation of the representation.\textsuperscript{64} A further reason for little attention to the substantiality element probably was that it is difficult to separate from the materiality requirement.\textsuperscript{65}

There was surprisingly little exploration of the meaning of the term material. The term was often used as if its meaning was self-evident,\textsuperscript{66} and the cases that did afford some guidance lacked precision.

Professor Edwin Patterson's studies of English and American cases led him to conclude that the test of materiality centered on the question of the relevance of the fact or facts misrepresented to the insurer's action on the application for insurance, but that the cases varied in their test of relevance.\textsuperscript{67} Most significantly, he found a division of authority with regard to whether the relevance was to be tested by reference to the usual practices of the insurer that actually issued the policy (an individual insurer standard) or on the basis of the usual practices of insurers as a class (a prudent insurer standard). While he favored the individual insurer standard (and the New York legislature was persuaded to adopt it),\textsuperscript{68} Professor Patterson conceded that the prudent insurer standard appeared to be favored by the greater number of courts. Secondly, he found a variation in regard to the degree of relevance of the facts misrepresented. Some cases asked, in effect, what the insurer might have done if it had known the truth, rather than what the insurer would have done. The "might" test obviously could lead to the conclusion that a fact was material even though the insurer probably would have made the very same contract even if it had known the truth, but it appeared to be adopted to dispose of cases where knowledge of a fact concealed by a misrepresentation would have led to investigation by the insurer (or a prudent insurer) but final action on the application would have depended on the results of the investigation.

\begin{footnotesize}
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\item policy language, see Central Sur. & Ins. Corp. v. Jordan, 234 Ark. 627, 353 S.W.2d 536 (1962) (involving record-keeping requirements of a burglary policy on a merchant's stock of goods), so the real impact of the statute appears to have been to call for tolerance of small breaches, even if they could be seen to be somewhat prejudicial to the insurers.
\item Indeed, Professor Patterson contended that, "The doctrine of substantial compliance is . . . another way of saying that an immaterial misrepresentation does not avoid the contract." E. Patterson, supra note 59, at 402.
\item This summary of Professor Patterson's analysis is drawn from E. Patterson, supra note 59, at § 82.
\item N.Y. Ins. Law § 149(2) (McKinney 1966).
\end{enumerate}
\end{footnotesize}
as where a representation is made in an application for life insurance which conceals prior medical treatment or hospitalization. Professor Patterson advocated as preferable the adaptation of the "would" test to this situation by assuming that the insurer, by its investigation, would have discovered what the insured's medical attendants discovered (and this adaptation was, in effect, adopted in New York).69

Still further refinement of the materiality concept is needed, for there is also a question of what action the insurer (or a prudent insurer) would (or might) have taken. Is it essential to a finding of materiality that it appear that knowledge of the truth would (or might) have led to total refusal to insure, or is it enough that the insurer would (or might) have offered a policy on different terms than that actually issued or have demanded a higher premium than the one actually charged? The latter appears to be the sounder test.70

Another problem that has arisen in connection with the materiality requirement in other states has been whether, where the question arises after a loss giving rise to a claim on the policy has occurred, it is pertinent to inquire whether the facts concealed by the misrepresentation were a cause of the loss. A causal connection requirement was rejected by the majority of jurisdictions at common law.71

The Arkansas cases provided the merest hints as to how most of these questions were to be answered. It is evident from the frequent use of the phrase "material to the risk"72 that the concern was with the question whether the misrepresentation made the risk to be assumed by the insurer appear to be smaller than it was,73 but it was not entirely clear that the matter was to be determined on the basis of the reality of the situation and could not be controlled by agreement between insurer and applicant.74 Whether an individual in-

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69. Id. § 149(4).
70. See id. § 149(2).
71. See E. Patterson, supra note 59, at §§ 72, 83.
74. In Inter-Ocean Cas. Co. v. Huddleston, 184 Ark. 1129, 45 S.W.2d 24 (1932), the applicant agreed, by signing the application, that the representations she made in it were "material representations," yet the court ruled, on the basis of testimony given at the trial, that some of those representations were not material. Some doubt as to the authority of that
surer or a prudent insurer standard was to be used was not directly addressed, though occasional passages in the opinions seemed to lean toward an individual insurer test. The would or might distinction was also left unexplored, though occasional statements were suggestive of a "would" test, adapted to take care of the problem arising from representations which would not themselves control the insurer's decision but could lead to investigation. The cases af-

case on the point under discussion is raised, however, by McBath v. American Republic Ins. Co., 208 Ark. 764, 187 S.W.2d 954 (1945). There a trial court, sitting without a jury, gave judgment in favor of the insurer in an action to enforce a disability policy, on the ground that the insured had procured the policy by fraudulent representations that he was then in "sound health" and had not been "sick or hurt" within the past three years. The evidence showed that the insured was suffering from hypertension when he applied for the insurance and had been in a hospital for treatment of that condition within the three year period preceding his application for the insurance. On appeal, the plaintiff argued that the court should take judicial notice that high blood pressure is neither a disease, nor a "grave ailment" as the trial court had found, but the judgment was affirmed. The court was willing to concede that hypertension was "seemingly" not regarded by medical authorities as a disease in itself, but pointed to a provision in the policy excluding coverage for certain diseases, including hypertension, unless they had their origin six months after the contract was made or, in case of reinstatement, six months after reinstatement. "It follows," said the court, "that McBath concealed from the Company facts material to his insurability." 208 Ark. at 768, 187 S.W.2d at 956. The case can be read as meaning that if the policy (or, presumably, the application) treats a fact as material, no independent inquiry into materiality is in order. Another possible interpretation, however, is that the policy provision was treated as circum-

stantial evidence of the insurer's attitude toward the relevance of hypertension to insurabil-

ity, which the trial court could accept as establishing materiality in a situation where it could not be declared as a matter of law that the fact was not material.

75. See Royal Neighbors of America v. Tate, 186 Ark. 1138, 1142, 57 S.W.2d 1055, 1056 (1933) ("The policy would not have been issued if the true disclosures had been made to the questions asked . . . "); Brotherhood of Am. Yeomen v. Fordham, 120 Ark. 605, 609, 180 S.W. 206, 208 (1915) ("If the association had known that the insured had had a severe attack of typhoid fever in . . . 1905 . . . it probably would have made a more searching inquiry as to his condition at the time he made the application for the insurance. At least it could have done so."); Fidelity Mut. Life Ins. Co. v. Beck, 84 Ark. 57, 104 S.W. 533 (1907) ("Where the matter inquired of would affect the question of the assumption by the company of the risk, then the warranty is material . . . "). These three cases were warranty cases, in which materiality was not, according to the black-letter law, an essential element of the insurer's defense. It is remarkable that the cases involving warranties offer more guidance to the meaning of material than those involving pure misrepresentation.

76. See Woodmen of the World v. Brown, 194 Ark. 219, 106 S.W.2d 591 (1937) (also a warranty case, where the court appeared to attach significance to testimony by the secretary of the insurer that the policy would not have been issued if correct information had been given); Royal Neighbors of America v. Tate, 186 Ark. 1138, 57 S.W.2d 1055 (1933).

77. In Mutual Life Ins. Co. v. Owen, 111 Ark. 554, 164 S.W. 720 (1914), there was evidence that an applicant for insurance on his own life made a representation that he had not been treated by any physician other than a Dr. Mount within the preceding five years. There was also evidence that a Dr. Brown had treated the applicant during that time. The insurer contended that even if Dr. Brown's treatments had been only for temporary disturbances the insurer had a right to know of them, in order that it might make such further investigation as it saw fit, and that the concealment of these treatments was a material mis-
forded little insight into the precise reaction of the insurer to misrepresented facts that would stamp them as material. And the precedents were ambiguous with regard to the necessity of causal connection between facts concealed by misrepresentation and actual loss.

Reliance by the insurer on the misrepresentation is also usually said to be essential to a successful defense, in accordance with the representation, which should defeat recovery on the policy. The court ruled that even if it were conceded that the representation was made and was false, it could not be said that the undisputed evidence established that if the truth had been told, the company would have learned that the applicant suffered from heart trouble. Judgment on a verdict for the plaintiff for recovery on the policy was affirmed. The test employed appears to be the one advocated by Professor Patterson. See text at note 69 supra. (The ruling on the materiality point in the Owen case is somewhat obscured by emphasis in the opinion on the additional point that a misrepresentation must be made with intent to deceive if it is to give the insurer a defense.)

78. As has been indicated, there was one case, involving breach of warranty, which declared, in apparent reference to materiality, that the policy would not have been issued if true answers to the insurer's questions had been given. Royal Neighbors of America v. Tate, 186 Ark. 1138, 57 S.W.2d 1055 (1933). And in another case the court appeared to attach significance to testimony by an officer of the insurance company that the policy would not have been issued if correct information had been given. Woodmen of the World v. Brown, 194 Ark. 219, 106 S.W.2d 591 (1937). However, the court did not say that materiality depended on such a finding and could not be established by proof that if the insurer had known the truth it would have issued a policy on different terms from the one actually issued.

79. In Fidelity Mut. Life Ins. Co. v. Beck, 84 Ark. 57, 104 S.W. 533 (1907), an action on a life insurance policy, it was firmly declared that if "the matter inquired into would affect the question of the assumption by the company of the risk, then the warranty is material, notwithstanding the death may have been from the accident or other cause totally disconnected with the question inquired of." 84 Ark. at 59, 104 S.W. at 533. The statement was made regarding a warranty based on statements made in the application for the policy, and it would seem that the court had in mind the same concept of materiality as would apply to a misrepresentation not warranted to be true. Royal Neighbors v. Tate, 186 Ark. 1138, 57 S.W.2d 1055 (1933), was equally positive on the point. However, the only misrepresentation case to discuss the matter pointed the other way. Inter-Ocean Cas. Co. v. Huddleston, 184 Ark. 1129, 45 S.W.2d 24 (1932). There suit was brought on a health insurance policy to recover benefits for sickness from malaria occurring after the policy was issued. In the application for the policy the insured had represented that she had never had "any . . . disease or infirmity," and had not had medical treatment during the preceding three years. At trial the insured admitted, and her physician testified, that she had been treated for malaria in the year preceding the application, though the physician also testified that the insured had been cured of that infection and that the malaria attack which gave rise to the claim on the policy was a new infection. Affirming a judgment for the plaintiff, the supreme court found the misrepresentation not to be material, on the basis of the physician's testimony. "There was no relation whatever between the two attacks of malaria, but they were due to separate bites of mosquitoes, so the first was not material to the second." 184 Ark. at 1132, 45 S.W.2d at 25.

80. R. Keeton, Basic Text on Insurance Law § 5.7(b) (1971); E. Patterson, Essentials of Insurance Law § 75 (2d ed. 1957).
general contract law applicable to misrepresentation.\textsuperscript{81} It might be thought inherent in the concept of materiality, at least where materiality is tested by considering what the actual insurer would have done if the truth had been known, but that is not necessarily so, for an insurer might enter into a contract under misapprehension of material fact but be misled, not by the applicant's misrepresentation, but by the results of its own investigation or by information supplied by a third party for whose conduct the applicant is not responsible.\textsuperscript{82} The Arkansas cases recognized a requirement of reliance,\textsuperscript{83} but no case has been found in which it was a crucial issue.\textsuperscript{84} The sort of fact situation which would raise the issue probably did not often occur.

It is likely that the reason for the sparseness of Arkansas authority on the meaning of material was that this element of a misrepresentation defense was overshadowed by the requirement that the representation have been made with knowledge of its falsity and intent to deceive the insurer. If such knowledge and intent were absent, the question of materiality was moot, and if such fraudulent intent were shown, it would probably be a rare case in which the misrepresentation was immaterial. The intent-to-deceive requirement may also help to explain the lack of emphasis on the rule that a representation must be substantially untrue to be grounds for

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\item \textsuperscript{81} Restatement of Contracts § 476(1), Comment c (1932); Restatement (Second) of Contracts § 306(1), Comment c (Tent. Draft No. 11, 1976).
\item \textsuperscript{82} See R. Keeton, supra note 80.
\item \textsuperscript{83} National Life & Accident Ins. Co. v. Threlkeld, 189 Ark. 165, 70 S.W.2d 851 (1934); Bankers Reserve Life Co. v. Crowley, 171 Ark. 135, 284 S.W. 4 (1926). See Missouri State Life Ins. Co. v. Witt, 161 Ark. 148, 256 S.W. 46 (1923).
\item \textsuperscript{84} In American Republic Life Ins. Co. v. Edenfield, 228 Ark. 93, 306 S.W.2d 321 (1957), there is a passage in the opinion for the court which suggests that the insurer's misrepresentation defense was being rejected for lack of reliance. The insurer contended that the applicant for insurance on his own life had made a misrepresentation that he was free of heart disease to induce issuance of the policy. The applicant had submitted to a physical examination by the insurer's physician at the time of the application. The court observed that the examining physician's signed report indicated no murmurs or enlargement of the heart and advised the risk without qualification. The insurer's underwriter testified, "If it is a medical policy we rely on what our physician says about a man." \textit{Id.} at 96, 306 S.W.2d at 323. This falls well short of establishing that the disposition of the appeal adverse to the insurer was on the ground of lack of reliance by the insurer on the representation. The court did not discuss the significance of the underwriter's testimony. Even though it did indicate reliance on the medical examiner's report, there may have been reliance on the applicant's representation as well. See R. Keeton, supra note 80. Moreover, the disposition of the case, judging from the opinion as a whole, appears to have been on the ground that the insurer's evidence was insufficient to establish that the applicant for insurance had knowingly misrepresented his heart condition.
\end{itemize}
avoidance and the relative insignificance of the reliance requirement.

Certainly the most formidable obstacle to a successful misrepresentation defense was the insistence on actual fraud on the part of the applicant. Though a probable majority of American cases rejected such a requirement in insurance cases,\(^8^5\) and it may not have been essential in Arkansas to justify rescission of other contracts for misrepresentation,\(^8^6\) the Arkansas insurance cases unyieldingly required that knowledge of falsity of the representation and intent to deceive be established by the insurer by a preponderance of the evidence.\(^8^7\) The burden was heavy because of the need to prove the actual state of mind of the applicant for the insurance, who might no longer be living at the time of the trial,\(^8^8\) and it was increased in some cases by the legal prohibition of disclosure by medical attendants of information obtained in their professional capacities.\(^8^9\) In any case at law where the evidence was not conclusive the question was settled by the trier of fact and most often adversely to the insurer.\(^9^0\) It is scarcely surprising that the reported cases in which in-


\(^8^7\). See Woodmen of the World Life Ins. Soc'y v. Reese, 206 Ark. 530, 176 S.W.2d 708 (1943); Old Colony Life Ins. Co. v. Julian, 175 Ark. 359, 299 S.W. 366 (1927); Mutual Life Ins. Co. v. Owen, 111 Ark. 554, 164 S.W. 720 (1914). Indeed, the insurer had the burden of proof on all elements of the misrepresentation defense. See Missouri State Life Ins. Co. v. Witt, 161 Ark. 148, 256 S.W. 46 (1923) (approving instruction that burden was on insurer, in action on a life policy, to show that false, material representations, which induced issuance of the policy, were made to it by the insured knowingly, willfully, and with intent to defraud the company); American Republic Life Ins. Co. v. Edenfield, 228 Ark. 93, 306 S.W.2d 321 (1957); National Life & Accident Co. v. Threlkeld, 189 Ark. 165, 70 S.W.2d 851 (1934).

\(^8^8\). Most notably in cases of life insurance, of course.

\(^8^9\). See cases cited notes 42 & 43 supra.

\(^9^0\). Of 33 Arkansas Supreme Court decisions prior to 1959 in which the opinions indicate that the question of fraudulent intent on the part of the applicant for insurance was considered by the trier of fact, findings of fraud were made at the trial level in only three. McBath v. American Republic Ins. Co., 208 Ark. 764, 187 S.W.2d 954 (1945) (judgment for insurer by court sitting without jury affirmed); Hohenschutz v. Knights of Columbus, 208 Ark. 358, 186 S.W.2d 177 (1945) (judgment on verdict for insurer affirmed); Wilbon v. Washington Fidelity Nat'l Ins. Co., 181 Ark. 1127, 182 Ark. 57, 29 S.W.2d 680 (1930) (judgment reversed for error in instructions). In two of the cases decided adversely to the insurer
surers escaped liability by reason of misrepresentation were rare.

C. Concealment

Closely related to the misrepresentation defense, but distinguishable from it because it does not involve affirmative deceptive action by the applicant for insurance, is what has been referred to as the defense of concealment, based on the applicant’s failure to volunteer material information even though the insurer has made no inquiry calling for such information. The generally accepted doctrine in the United States has been that such failure to make voluntary disclosure can be grounds for avoidance of the insurance contract; but, where marine insurance is not involved, only if the insurer is ignorant of the facts and the applicant knows the facts, realizes that they are material and believes the insurer to be ignorant of them. In other words, the insurer has a defense if the information is fraudulently withheld from it and the insurer is prejudiced. The rare Arkansas cases involving such facts seemed consistent with this view.
A somewhat specialized type of concealment problem is presented by a case where the applicant for insurance makes a truthful representation to the insurer at the time he applies, but before the policy is issued he becomes aware of facts which would render his prior statement false if it were repeated. Here, the majority of American courts have held (where marine insurance is not involved) that the applicant's failure to inform the insurer of the new developments is governed by the same rule as is applied in other cases of concealment. The minority position allows the insurer to avoid the contract if the facts are material and unknown to the insurer, even though the applicant does not realize their materiality, his silence being treated as misrepresentation. No Arkansas case exactly on point has been found, but in view of the Arkansas requirement of fraudulent intent to justify avoidance even for an affirmative misrepresentation, it seems a foregone conclusion that the Arkansas Supreme Court would not have endorsed the minority rule.

D. Limiting Effect of Contract Clauses

The provisions of the insurance policy may operate to limit the

later of Bright's disease. When action was brought to enforce the policy the jury was instructed to determine whether Peak had obtained the policy by fraud, either by failing to reveal to the insurer that he had Bright's disease after he learned of it, or by furnishing the defendant's physician with a specimen of urine that was not his own. The verdict was for the plaintiff and judgment was rendered accordingly. The supreme court reversed, in part because of error in admission of certain evidence, but also because the undisputed evidence showed that Peak knew he had Bright's disease, "and the failure to disclose his knowledge that he had chronic Bright's disease was an intentional concealment on his part of a material fact, and his failure to communicate it to the company avoided the policy." 122 Ark. at 67, 182 S.W. at 567. The cause was not dismissed, however, but remanded for new trial. Retrial again produced a verdict and judgment for plaintiff, and this time the judgment was affirmed, on the ground that the evidence in the second trial permitted the inference that Peak did not believe he had Bright's disease. United States Annuity & Life Ins. Co. v. Peak, 129 Ark. 43, 195 S.W. 392 (1917). Cf. Great Southern Fire Ins. Co. v. Burns & Billington, 118 Ark. 22, 175 S.W. 1161 (1915). But see Williams v. Farmers & Merchants Ins. Co., 327 F. Supp. 1109 (W.D. Ark. 1971), apparently taking the position by dictum, that an applicant for a policy of fire insurance, making oral application to the insurer's agent, has no duty to volunteer information when the agent has asked no question calling for it. (The case arose from facts which occurred after the effective date of the 1959 Insurance Code, but the decision appears not to have been influenced by the Code. The judgment was partially reversed on other grounds in 457 F.2d 37 (8th Cir. 1972).) No Arkansas case presenting a concealment issue with respect to marine insurance has been found.

94. See E. Patterson, supra note 85, §§ 81, 89; Harnett, supra note 92 at 406-07.
95. See E. Patterson, supra note 85, § 81; Harnett, supra note 92 at 404.
96. The Peak case, discussed in note 93 supra, does not appear to have involved an original representation by the applicant which would have been false if repeated.
effect of a breach of warranty or misrepresentation. Two types of policy clauses were of particular significance in the Arkansas cases prior to the 1959 Insurance Code, incontestability clauses and age adjustment clauses.

An incontestability clause (or incontestable clause) is a provision in an insurance policy, most commonly a policy of life insurance, that immediately or after a specified lapse of time, the policy is to be incontestable except for specified causes. Although the Arkansas cases were not numerous, and were concerned primarily with other questions raised by incontestability clauses, they seemed to assume that once the policy had become incontestable under such a clause, defenses of breach of affirmative warranty and misrepresentation in procurement of the policy were no longer available to the insurer.


99. Jefferson Standard Life Ins. Co. v. Smith, 157 Ark. 499, 248 S.W. 897 (1923), is ambiguous regarding whether the insurer's defense was breach of warranty or misrepresentation. The statement of facts refers to the defense as misrepresentation, but the opinion concludes with a statement that since the incontestability clause had not cut off the defense the trial court should have submitted to the jury the question of the "alleged breach of warranty." The case clearly assumes that the defense would have been cut off if the period of contestability had expired. American Nat'l Ins. Co. v. Stutchman, 208 Ark. 1023, 185 S.W.2d 284 (1945), carries an implied holding that a defense based on a delivery in good health clause, see note 33 supra, is cut off by expiration of the period of contestability.

100. The implied holding of Missouri State Life Ins. Co. v. Cranford, 161 Ark. 602, 257 S.W. 66 (1923), is that a misrepresentation defense is invalid when the policy has become incontestable. In Illinois Bankers' Life Ass'n v. Hamilton, 188 Ark. 887, 67 S.W.2d 741 (1934), the incontestability clause was treated as barring a misrepresentation defense, the court stating that such a clause is "effectual to waive all defenses" except those reserved in the clause. See also dissenting opinion in American Pioneer Life Ins. Co. v. Turman, 254 Ark. 456, 495 S.W.2d 866 (1973).

101. National Annuity Ass'n v. Carter, 96 Ark. 495, 132 S.W. 633 (1910), is difficult to decipher. In an action on a death benefit certificate which provided that benefits should be incontestable from the date of the certificate, the insurer set up a defense of misrepresentation. Affirming a judgment on a verdict for the plaintiff, the court noted that the insurer had not pleaded breach of warranty but added that, if it had, the defense would have been of no avail in view of the incontestability clause in the certificate, which, being the latest expression by the parties of the terms of their contract, would nullify any warranty provision in the application for the policy. The court then ruled that the lower court had correctly submitted to the jury the question whether the alleged misrepresentations were material to the risk. The case thus appears to treat the incontestability clause as effective to bar a breach of warranty defense but not a misrepresentation defense. As has been noted, see note 100 supra, there is more recent authority to the contrary with respect to the misrepresentation
An age adjustment clause, also typically found in life insurance policies, usually provides that if the age of the insured has been misstated, the amount of insurance is to be reduced to the amount which the premiums paid would have purchased at the insured's true age. It is probable, though no Arkansas case addressed the question, that such a clause would override a warranty based on a representation of age, on the ground that inconsistency between the two policy provisions would create an ambiguity which should be resolved against the insurer. On the other hand, the cases were in agreement that fraudulent misrepresentation of age could nullify an age adjustment clause, because such fraud would make the entire contract (including the age adjustment clause) voidable. The cases dealing with such clauses were more concerned with other questions of interpretation and estoppel.

II. THE ARKANSAS INSURANCE CODE

Act 148 of 1959 brought together a number of earlier statutes dealing with insurance and introduced much new law, in a comprehensive "Code." It was concerned with far more than misrepresentations in procurement of insurance, but only those features of it bearing fairly directly on misrepresentation are discussed here.

One advantage of statutory law is that it is much easier for the legislature to turn the law in a new direction than it is for precedent-conscious judges, who must, in any event, make changes in piecemeal fashion as appropriate cases come before them. To be successful, however, the legislature must mark out clearly the new path to be followed. The 1959 Insurance Code appears to have been intended to reform the law of misrepresentation, but the road signs, regrettably, leave much to be desired.

defense. If the Carter case has not been overruled sub silentio, it probably must be considered as limited to cases involving incontestability clauses which, by their terms, make the policy incontestable as soon as it is issued.


Of prime importance is section 275, which provides:

(1) All statements in any application for a life or disability insurance policy or annuity contract, or in negotiations therefor, by or in behalf of the insured or annuitant, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless either:

(a) Fraudulent; or

(b) Material either to the acceptance of the risk, or to the hazard assumed by the insurer; or

(c) The insurer in good faith would either not have issued the policy or contract, or would not have issued a policy or contract in as large an amount or at the same premium or rate, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise.

(2) If, in any action to rescind any policy or contract or to recover thereon, any misrepresentation with respect to a medical impairment is proved by the insurer, and the insured or any other person having or claiming a right under the contract, shall prevent full disclosure and proof of the nature of the medical impairment, the misrepresentation shall be presumed to have been material.

A. Effect of Section 275 on the Law of Warranties

The first sentence of subsection (1) may appear at first glance to consign to outer darkness the entire law of insurance warranties, and this impression is strengthened by the almost total disappearance of references to warranties from cases decided since the Insurance Code went into effect. A closer reading reveals, however, that the impact of the sentence is considerably more restricted.

First, it applies only where policies of life or disability insurance or annuity contracts are involved. That scope is substantial, for the terms "life insurance" and "disability insurance," par-

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109. "Life insurance" is defined as "insurance on human lives. The transaction of life insurance includes also the granting of endowment benefits, benefits for expenses incurred in connection with death, additional benefits in event of death or dismemberment by accident or accidental means, additional benefits in the event of the insured's disability, and optional modes of settlement of proceeds of life insurance. Transaction of life insurance does not
particularly the latter, are broadly defined in the Code. Still, the sentence leaves untouched a number of important types of insurance contracts. It does not affect property insurance of any sort, and a variety of types of insurance which may be thought of as falling between the traditional categories of personal and property insurance, such as liability insurance and fidelity bonds, are outside its scope. As to these forms of insurance, section 275 is irrelevant, and the pre-Code common law of warranties presumably continues to be applicable, except as modified by occasional provisions in other sections of the Insurance Code.

Second, the abolition of warranties is limited to warranties based on "statements in any application" for a contract within the scope of the sentence, "or in negotiations therefor." The word statements is somewhat ambiguous but probably means statements of fact. That appears to be assumed in the following sentence, preventing recovery under a policy, where subparagraph (c) provides a test based on what the insurer would have done "if the true

include workmen's compensation, as defined in section 76(1)(c) [§ 66-2405(1)(c)]." Ark. Stat. Ann. § 66-2402 (1980).

110. "Disability insurance" is defined as "insurance of human beings against bodily injury, disablement or death by accident or accidental means, or the expenses thereof, or against disablement and expense resulting from sickness, and every insurance appertaining thereto. Transaction of disability insurance does not include workmen's compensation, as defined in section 76(1)(c) [§ 66-2405(1)(c)]." Ark. Stat. Ann. § 66-2403 (1980).


112. See MFA Mut. Ins. Co. v. Dixon, 243 F. Supp. 806 (W.D. Ark. 1965) (finding that the truth of the applicant's representation was a condition of the validity of an automobile liability policy; Arkansas substantive law seemingly applicable, though conclusion reached without citation to Arkansas authority in circumstances where Arkansas case law would point to opposite conclusion).

113. It should be noted also that the definitions of "vehicle insurance," "liability insurance," "burglary insurance," and "malpractice insurance" in subsection (1) of § 76 of the Insurance Code, Ark. Stat. Ann. § 66-2405(1) (1980), include provision of benefits that would also come within the definitions of "life insurance" and "disability insurance," see notes 109, 110 supra. Section 76(2) provides: "Provision of medical, hospital, surgical and funeral benefits, and of coverage against accidental death or injury, as incidental to and part of other insurance as stated under subdivisions (a) (vehicle), (b) (liability), (d) (burglary), and (j) (malpractice) of subsection (1) shall for all purposes be deemed to be the same kind of insurance to which it is so incidental, and shall not be subject to provisions of this code applicable to life or disability insurances." Ark. Stat. Ann. § 66-2405(2) (1980) (emphasis added).


116. But see E. Patterson, Essentials of Insurance Law § 83 (2d ed. 1957).
facts had been made known to the insurer."117 If the word statements means statements of fact, the law of promissory warranties is not altered.118 Nor are affirmative warranties abolished unless they are warranties of the truth of statements made in the application for the policy or in negotiations for it. It would seem, for example, that a "delivery in good health" clause, a provision in the policy that the insurance is not to take effect unless the insured is in good health at the time the policy is delivered to him, whether termed a warranty or not,119 should not be affected by section 275.120

A third limitation on the scope of the first sentence of section 275 is that the statements which are not to be treated as warranties are statements made "by or in behalf of the insured or annuitant." Insured is not a defined term in the Insurance Code, and as generally used it could at times refer to either of two persons. If, for example, A were to apply for a policy of insurance, to be issued to him, covering the life of B, either A or B might be considered the insured.121 Does the first sentence of section 275 refer to statements made by or in behalf of A or B? From the standpoint of Arkansas' pre-Code law of warranties and misrepresentations, the focus has usually been on statements made by the applicant for the policy, and statements of others have been of significance only if such others could be regarded as agents of the applicant.122 A case could easily arise, however, where the applicant should, in principle, be held responsible for statements of one who was not his agent. If, for example, B, cooperating with A in his effort to obtain a policy, answered questions of the insurer as part of the application procedure, B's statements should be considered within the scope of the statute, since those statements would be understood by all parties to the

119. For the erratic history of delivery in good health clauses in Arkansas, see notes 33 and 40 supra.
120. Such a clause was involved in Reliable Life Ins. Co. v. Elby, 247 Ark. 514, 446 S.W.2d 215 (1969). Although the court held the clause to provide no defense in the circumstances of the case, affirming the chancellor's decision that the insurer had waived it, the court did declare that such a clause is "valid and enforceable," and no mention was made of § 275 of the Insurance Code. See also E. Patterson, supra note 116 at § 83. It has been earlier noted, supra note 33, that pre-Code cases in Arkansas sometimes simply ignored delivery in good health clauses; that continues to be true. See American Pioneer Life Ins. Co. v. Turman, 254 Ark. 456, 495 S.W.2d 866 (1973).
121. See E. Patterson, supra note 116, § 34 at 2, suggesting use of the term cestui que vie to designate the person whose life is the subject of the insurance.
122. See note 9 supra.
transaction as being made to induce the issuance of the policy. If insured means applicant, B's statements could readily be treated as being made in behalf of the insured, and thus within the statutory rule.

That this is the correct reading of insured is suspect, though, because of the way the word is used in other, related sections of the Insurance Code. Section 271,123 which deals with the requirement of an insurable interest to validate personal insurance, quite clearly employs the term insured with reference to the person whose life or body is the subject of the insurance, as distinguished from the person procuring the insurance,124 and the same is true of section 273,125 concerning the form of applications for life and disability insurance.126 In the case suggested above, if A is the moving party in procuring the insurance, and the application is made by him, even if it is done with B's consent, it would appear that if insured has the same meaning in section 275, no statement made by A would be one made by or in behalf of the insured. Yet it seems unlikely that the legislature meant to exclude statements made by the insurance applicant from the scope of the principal section of the

123. ARK. STAT. ANN. § 66-3204 (1980).
124. The statute provides in pertinent part:
   
   (1) Any individual of competent legal capacity may procure or effect an insurance contract upon his own life or body for the benefit of any person. But no person shall procure or cause to be procured any insurance contract upon the life or body of another individual unless the benefits under such contracts are payable to the individual insured or his personal representatives, or to a person having, at the time when such contract was made, an insurable interest in the individual insured.

   (2) If the beneficiary, assignee, or other payee under any contract made in violation of this section receives from the insurer any benefits thereunder accruing upon the death, disablement or injury of the individual insured, the individual insured or his executor or administrator, as the case may be, may maintain an action to recover such benefits from the person so receiving them.

   (3) "Insurable interest" with reference to personal insurance includes only interest as follows: . . .

   (b) . . . a lawful and substantial economic interest in having the life, health or bodily safety of the individual insured continue . . .

\(Id.\)

125. ARK. STAT. ANN. § 66-3206 (1980).
126. The statute provides in pertinent part:

No life or disability insurance contract upon an individual, except a contract of group life insurance or of group or blanket disability insurance, shall be made or effectuated unless at the time of the making of the contract the individual insured, being of competent legal capacity to contract, applies therefor or has consented thereto in writing, except in the following cases:

(1) A spouse may effectuate such insurance upon the other spouse.

\(Id.\)
Insurance Code dealing with the effect of false representations made to procure insurance. It may be significant that sections 271 and 273 consistently qualify the word insured by the use of the phrase individual insured, while section 275 speaks only of the insured; the difference in wording suggests a difference in substance, and the best guide to its meaning in section 275 would be the law forming the historical background for the section.\(^\text{127}\)

Notwithstanding these limitations, the effect of the first sentence of section 275 is to make unnecessary in a very significant number of cases the elaborate battery of court-developed devices to mitigate the harshness of the black-letter law of warranty (described in Part I.A., supra).\(^\text{128}\) Where misrepresentations are involved in those cases, the insurer cannot change the rules of the game as to their effect by policy provisions treating the representations as warranted true.\(^\text{129}\)

B. **Effect of Section 275(1) on the Law of Misrepresentation**

The second sentence of section 275 presents numerous problems.

1. **Scope: Policies and Contracts Affected**

   There is, first, the problem of what types of policies or contracts it applies to. The sentence begins: "Misrepresentations . . . shall not prevent a recovery under the policy or contract unless . . . ." The phrase "policy or contract" is most naturally read as referring

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\(^{127}\) Only one case has involved the problem thus far. In Dopson v. Metropolitan Life Ins. Co., 244 Ark. 659, 426 S.W.2d 410 (1968), a husband applied to the insurer for a rider to his hospitalization policy to extend coverage to his wife. The wife, in her husband's presence, answered questions of the agent taking the application for the rider, and the agent entered those answers on the application form. The court appeared to treat the husband as the "insured," but to regard him as guilty of making "incorrect statements" under § 275 of the Insurance Code.


\(^{129}\) A possible route to avoidance of the rule of this sentence of § 275(1) would be for the insurer to provide in the policy that its validity is conditioned on the truth of some or all statements made by or in behalf of the insured to procure the policy, and to argue that a condition is to be distinguished from a warranty, § 275 applying only to the latter. Such a distinction has sometimes been drawn by courts of other states. See, e.g., Ballard v. Globe & Rutgers Fire Ins. Co., 237 Mass. 34, 129 N.E. 290 (1921). This device would be a patent attempt at evasion, rather than legitimate avoidance, of the statutory rule, and it would be difficult to sustain in Arkansas, where the leading cases have identified warranties with conditions. See, e.g., Providence Life Assurance Soc'y v. Reutlinger, 58 Ark. 528, 532-33, 25 S.W. 835, 836 (1894) (quoted in text at note 8 supra).
to a policy or contract of a type referred to in the preceding sentence: a life or disability policy or an annuity contract. Policies of property insurance and other policies which are not policies of life or disability insurance appear to be outside its scope.\textsuperscript{130}

This question has been raised in the cases but not settled. \textit{Old Republic Insurance Co. v. Alexander}\textsuperscript{131} was an action for rescission of an accident insurance policy, in which the insured counterclaimed for policy benefits for loss of a foot as a result of an accidental gunshot wound. The action was brought on grounds of misrepresentation on the part of the insured in his application for the policy, and the counterclaim was resisted on the same basis. The opinion for the court by Justice Fogleman fairly clearly assumed that section 275(1) was applicable, as did the concurring opinion of Justice Smith.\textsuperscript{132}

In the subsequent case of \textit{Motors Insurance Corp. v. Tinkle}\textsuperscript{133} the action was brought by the named insured to enforce a physical damage automobile insurance policy, the plaintiff claiming benefits for accidental loss of a pick-up truck. On appeal from a judgment for the plaintiff, the principal issue was whether misrepresentations made in the application for the policy were material. The insurer relied on section 275(1) of the Insurance Code and was met with the argument that the section did not apply because the policy in suit was not one of life or disability insurance. The insurer pointed to the \textit{Alexander} case as one in which the court had treated the statute as applicable to an accident policy. Noting this dispute in a footnote, Chief Justice Harris dismissed it with a comment that, "It is not really necessary to discuss the apparent conflict in deciding the instant case."\textsuperscript{134} He then disposed of the materiality issue adversely to the insurer by drawing heavily on the reasoning of the majority opinion in \textit{Alexander}. It may be that it was thought unnecessary to decide whether section 275(1) applied because the reasoning in \textit{Alexander} was considered not to be based on the statute, or it may have been assumed that the \textit{Alexander} reasoning, even if based on the


\textsuperscript{131} 245 Ark. 1029, 436 S.W.2d 829 (1969).

\textsuperscript{132} \textit{Id.} at 1043, 436 S.W.2d at 837.

\textsuperscript{133} 253 Ark. 620, 488 S.W.2d 23 (1972).

\textsuperscript{134} \textit{Id.} at 625 n.5, 488 S.W.2d at 27 n.5.
statute, was equally appropriate for cases not governed by section 275.

While both Alexander and Tinkle involved contracts that could be described as accident insurance policies, the policies are readily distinguishable. The Alexander case was concerned with a policy of personal accident insurance and falls within the definition of "disability insurance" in section 74 of the Code;\(^\text{135}\) it would, therefore, be clearly within the scope of section 275(1). The policy in Tinkle, on the other hand, at least the portion of it involved in the litigation, was one of insurance against accidental damage to property, not within the definitions of life insurance and disability insurance\(^\text{136}\) of the Insurance Code, and thus not within the coverage of the second sentence of section 275(1) if the sentence is read as restricted to life and disability insurance.

To say that the second sentence of section 275(1) does not apply to insurance other than life or disability insurance is not to say that the statute is entirely irrelevant to other policies. Where no other provision of the Insurance Code deals with the same subject matter, the conditions under which misrepresentations will render other policies voidable continue to be governed by common law. There is no reason why the courts could not be guided by the rules of section 275(1), if they consider the statutory rules to reflect principles that are just as soundly applied to insurance policies not within the scope of the statute, or if they conclude that the statute amounts to a declaration of Arkansas public policy that goes beyond the limits of its stated rules. The Tinkle decision may have been reasoned along such lines.

2. **Scope: Application in Absence of Misrepresentation or Concealment**

The second sentence of section 275(1) probably also refers to misrepresentations made in any application for insurance or an annuity contract, or in negotiations therefor, by or in behalf of the insured or annuitant, as the first sentence expressly does. It seems the most natural reading, in view of the inclusion of both sentences in the same paragraph, and it seems to be assumed in the concluding words of subparagraph (c).

The propriety of this reading is cast into doubt, however, by the opinion for the court in *American Family Life Assurance Co. v.*

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135. See note 110 *supra*.
136. See notes 109 and 110 *supra*. See also note 113 *supra*. 
There an applicant for medical expense insurance covering both himself and his wife gave negative answers to the following questions: "1. To the best of your knowledge, does any member of the family group to be insured now have or ever had cancer? 2. To the best of your knowledge, has any member of the family group to be insured ever had: (a) lumps, growths or swellings; . . . ?" When the applicant's wife was found to be suffering from cancer ten months after the policy was issued, his claim for policy benefits was denied, and suit was brought on the policy. The insurer pleaded that the plaintiff had made misrepresentations in his application which were fraudulent and material to the risk, and that if the true facts had been known the certificate of insurance would not have been issued covering plaintiff's wife.

At trial the insurer introduced evidence that the plaintiff's wife had had her left eye removed because of a malignant tumor seven or eight years prior to the issuance of the policy. Plaintiff testified that neither he nor his wife had ever been told that the eye was removed because of a cancerous condition, and that, although he had been aware that the removal of the eye had been required by a growth, he had not seen the growth.

On appeal from a judgment for the plaintiff, the supreme court reversed and remanded. Justice Holt's opinion observed that the lower court's judgment necessarily involved a finding that the plaintiff had not been guilty of fraud and held that finding supported by the evidence. He also noted that the questions asked by the insurer were prefaced by the words, "to the best of your knowledge," and concluded from that language that the answers given could not be misrepresentations. But then Justice Holt held that the insurer could have a defense under section 275(1)(c) of the Insurance Code:

The appellant, however, pleaded at trial and asserts on appeal its affirmative defense, pursuant to subsection (c) of § 66-3208 that had the true facts been known, the certificate of insurance would not have been issued to insure Mrs. Reeves. As noted above, subsection (c) provides that recovery may be prevented if "[t]he insurer in good faith would . . . not have issued the policy . . . if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise." Logically, in the circumstances of the case at bar, this affirmative defense cannot be construed to be affected by the

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137. 248 Ark. 1303, 455 S.W.2d 932 (1970).
138. Id. at 1304, 455 S.W.2d at 934.
139. Id. at 1308, 455 S.W.2d at 935.
"[t]o the best of your knowledge" qualifying phrase in the questions of the application. The "true facts" referred to in subsection (c) relate to whether or not there was a pre-existing malignant growth, as contended by appellant, and not to whether the appellee had actual knowledge of this condition.\(^\text{140}\)

This passage is intriguing. The holding appears to be that if the insurer asks the applicant whether, to the best of his knowledge, any person to be insured has ever had cancer, lumps, growths or swellings, and he gives a negative answer which is true as far as he knows, though the applicant cannot be found guilty of either fraud or misrepresentation, section 275(1)(c) of the Insurance Code nevertheless provides the insurer with a defense, if the insurer can establish that one of the persons to be insured did in fact have a malignant growth and that it would have refused to issue a policy covering that person if it had known of the growth. The reasoning is not spelled out in the majority opinion, but it may be, as Justice Fogleman inferred, rooted in the words "or otherwise" in subparagraph (c). Justice Fogleman's dissenting opinion in *Reeves* pointed out that section 275(1)(c) "relates only to risks which would have been refused, or which would have been accepted only on a conditional or limited basis, or at a higher premium, if the true facts had been made known to the insurer 'as required either by the application for the policy or contract or otherwise.'"\(^\text{141}\)

Since the application for the policy required only an answer to the best of the applicant's knowledge, and since the majority opinion acknowledged that there was substantial evidence that plaintiff had answered to the best of his knowledge, Justice Fogleman inferred that the "premise of the majority opinion" was that the true facts referred to in subparagraph (c) were facts required otherwise than in the application for the policy, and he seemed to understand the majority opinion to mean that the insurer required facts to be true in any case where the existence of those facts would be regarded by the insurer as materially increasing the risk, regardless of whether the applicant had been asked to disclose such facts.\(^\text{142}\)

If Justice Fogleman's interpretation of the majority opinion (or the interpretation which this reviewer has attributed to him) is correct, the case holds that the scope of the second sentence of section 275(1) is considerably broader than the first, in that it can apply to

\(^{140}\) *Id.*

\(^{141}\) *Id.* at 1310, 455 S.W.2d at 937 (Fogleman, J., dissenting).

\(^{142}\) *Id.*
afford the insurer a defense in the absence of any misrepresentation made by the applicant for the insurance or in his behalf, either in the application for the policy or in negotiations for it.

It is difficult to believe that so broad a reading of the statute will prevail. It involves a drastic departure from prior law, with no indication of legislative intent to work such a change, other than the ambiguous "or otherwise" wording in section 275(1)(c) of the Insurance Code. That ambiguity can be quite satisfactorily resolved from the context in which the words appear. As Justice Fogleman demonstrated in his dissenting opinion in the Reeves case, the words "or otherwise" in paragraph (c) acquire a more restricted meaning when section 275(1) is read as a whole. The first sentence refers to statements of an insured or annuitant, or in his behalf, made in an application for a policy or annuity contract or in negotiations therefor. When paragraph (c) of the second sentence speaks of the "true facts . . . as required either by the application for the policy or contract or otherwise," the words "or otherwise" are seen to have been included with reference to the words "or in negotiations therefor" of the first sentence, and if there have been no negotiations, apart from the application, in which the insurer required information of the insured or annuitant, the insurer can have a defense under paragraph (c) only if false information is given which has been called for by the application. If, as in Reeves, the applicant is asked to state facts in the application to the best of his knowledge, and he does so, the fact that his knowledge is inconsistent with the objective facts should not make the policy or contract voidable.

3. Scope: Application to Failure to Volunteer Information

A closely related problem regarding the scope of the second sentence of section 275(1) is raised by the description of its subject-matter as "[m]isrepresentations, omissions, concealment of facts, and incorrect statements." The first sentence refers only to statements. The additional wording in the second sentence suggests that it is broader in scope.

Most challenging is the explicit inclusion of concealment of facts. As has been noted, Arkansas cases prior to the Insurance Code, in accord with American cases generally where marine insurance was not involved, did not appear to treat failure to volunteer information, commonly called concealment, as grounds for avoid-

143. Id.
144. See text at notes 92-96 supra.
ance of an insurance contract unless the information was withheld with awareness of its materiality and with intent to deceive the insurer. Yet under section 275(1) concealment of facts does not prevent recovery on a policy unless it is either fraudulent or material. It has already been held that the statute provides the insurer a defense on the basis of material misrepresentations even if they are not made with fraudulent intent, on the reasoning that the fraudulent and material requirements are stated in the alternative. 145 If concealment of facts in section 275(1) means simple failure to volunteer information, the statute makes a change in the law which can be highly prejudicial to insurance policyholders and their beneficiaries. No reason is apparent why the Arkansas General Assembly should have wished to adopt so harsh and novel a rule, but the statutory language must be accounted for.

The historical background of the section offers a clue to the meaning of concealment of facts and suggests that it is quite a different concept from the concealment of the pre-Code insurance law. As the discussion in Part I has shown, the Arkansas law prior to the Insurance Code was tortured by a desire of the courts to relieve against the harshness of the traditional law of insurance warranties, as well as an apparent feeling of a need to prevent the law of non-warranted misrepresentations from imposing undue burdens on insurance policyholders and their beneficiaries. With respect to misrepresentations, the Arkansas law was more protective than that of the majority of American states in its insistence that misrepresentations be fraudulent in order to make an insurance contract voidable, while the requirement of materiality remained ill-defined, quite likely because it was overshadowed by the requirement of fraudulent intent. Section 275(1) can be seen against this background to have as its probable purposes: (1) abolition of warranty doctrine as governing the effect of misrepresentations, (2) elimination of fraudulent intent as a prerequisite to avoidance for misrepresentation (thereby bringing Arkansas law into line with that of the majority of American jurisdictions), and (3) provision of a compensating clarification of the materiality requirement.

Since these purposes do not call for modification of the traditional law of concealment, it is not likely that that law was intended to be affected by the statute. Reading concealment of facts consistently with the inferable purposes of the statute would be that the phrase is used to refer to concealment in the nature of misrepresen-

145. See note 156 infra.
tation, a failure to give information which has the effect of actively misleading the insurer by implied misrepresentation. It could well be applied, for example, to a case where an insurer asked an applicant to list all surgical operations he had had within the past five years, and the applicant's leaving the space for an answer blank, when in fact he had had open-heart surgery within the five year period. The insurer could reasonably understand the answer to be none. Failure to answer here is not a simple failure to volunteer information; it is a failure to give required information, which implies that such information does not exist. As another example, an applicant for life insurance may be asked: "Have you, within the past five years, had medical treatment for any illness or injury? Describe all such treatments." If he answers only, "Broken leg, June 1978," he implies that the broken leg is the sole illness or injury for which he has been treated during that period, and if the truth is that he was also treated within the five years for a severe heart attack, his representation is false.

The text of the statute can be found to support this narrow reading of concealment of facts. As has been noted in the discussion of the Reeves decision, the first sentence of section 275(1) is expressly limited in scope to statements made in any application for a life or disability policy or annuity contract, or in negotiations therefor, and the probability is that the second sentence is intended to be similarly limited, an inference reinforced by the fact that subparagraph (c) provides the insurer a defense on a showing that it would not have issued the same policy on the same terms if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise. The assumption appears to be that the second sentence of section 275(1) applies only to cases where information was required by the insurer in the course of the negotiations leading to the issuance of the policy.

146. Such concealment may, however, not afford the insurer a defense, for it may be held that the insurer, by accepting the application without insisting that the blank be filled, assumes the risk of its ignorance of the matters to which the question relates. See Independent Fire Ins. Co. v. Horn, 343 So. 2d 862 (Fla. Dist. Ct. App. 1976).

147. See Roess v. St. Paul Fire & Marine Ins. Co., 383 F. Supp. 1231 (M.D. Fla. 1974), which employs similar reasoning to conclude that failure to inform the insurer of facts cannot afford the insurer a defense under a Florida statute very similar to Arkansas's, if the insurer did not raise the subject in the application for the policy or otherwise in negotiations preceding issuance of the policy, but asserts that the statute does not preclude a finding of fraudulent concealment under common-law principles. In Disposable Serv., Inc. v. ITT Life Ins. Co., 453 F.2d 218 (5th Cir. 1971) the court treated the Florida statute as applying to a case where a proposed insured's physical condition changed adversely between the time of application for the policy and the time of payment of the first premium, on which the pol-
It may be objected that if concealment of facts has so narrow a meaning the phrase is superfluous, for misrepresentations is adequate to cover the situations involved, as is the additional reference to omissions. The point must be conceded. It is to be noted, however, that incorrect statements seem no less redundant; it is difficult to imagine when an incorrect statement would not also be a misrepresentation. This overlapping terminology can probably best be accounted for as not uncommon drafting overkill, the objective being to emphasize the idea that misrepresentation, broadly conceived, is the subject of the sentence.

The Arkansas cases thus far have given little attention to the breadth of field described in section 275(1) by the words "[m]isrepresentations, omissions, concealment of facts, and incorrect statements" but are consistent with the reading suggested above as far as they go. They appear to treat the terms misrepresentations and incorrect statements as interchangeable, and to regard omissions as answers to insurers' questions which are either incomplete or false, the equivalent of misrepresentations. Concealment of

icy's effectiveness depended. The court considered the applicant's failure to inform the insurer of the material change within the statute, whether his silence be treated as "passive misrepresentation," "omission," or "concealment of facts," and asserted that his good faith and lack of knowledge of the seriousness of the change were immaterial. The two cases are not necessarily inconsistent, since the information withheld in Disposable Services did relate to facts of a kind that had been inquired about in the application for the insurance.

In Industrial Indem. Co. v. United States Fidelity & Guar. Cos., 93 Idaho 59, 454 P.2d 956 (1969), the Idaho Supreme Court appeared to assume that failure by an applicant to supply information not inquired about by the insurer was not within the coverage of Idaho's misrepresentation statute, which is worded much like § 275(1) of the Arkansas Insurance Code, and that common-law principles of concealment governed whether the insurer had a defense.

148. The only non-Arkansas case that has attempted a comprehensive examination of the meanings of these terms is Massachusetts Mut. Life Ins. Co. v. Allen, 416 P.2d 935 (Okla. 1965), applying an Oklahoma statute quite similar to Arkansas's. Unfortunately, the definitions adopted in that case are drawn largely from common-law definitions appearing in American Jurisprudence, and they are distorted by the insistence of the Oklahoma court that there can be no defense under the statute unless the applicant has knowledge or should have knowledge of the truth at the time of his "misrepresentation," "omission," "concealment of facts," or "incorrect statement." See note 156 infra.


facts has not been used in a way that sheds much light on its meaning, but no case has presented facts involving pure failure to volunteer information.

4. Determination of Falsity of Representation

That a representation is false is, of course, a necessary finding to make the rules of the second sentence of section 275(1) applicable, and the statute provides no instructions on how the finding is to be made. Pre-Code decisions remain viable precedents. Thus, it may be expected that questions asked by an insurer of an applicant for insurance will still be construed strictly against the insurer. It may be anticipated also that some representations will still be treated as merely statements of opinion or belief, false only if the persons making them do not honestly hold the opinions represented; to this extent, fraudulent intent continues to be a require-

“no” answers to questions about prior symptoms, ailments and treatments referred to as “omissions” or “incorrect statements”); Old American Life Ins. Co. v. McKenzie, 240 Ark. 984, 403 S.W.2d 94 (1966) (incomplete statement of medical history given by applicant for personal accident and hospitalization insurance said to involve “omissions”).


152. In Old Republic Ins. Co. v. Alexander, 245 Ark. 1029, 436 S.W.2d 829 (1969), an applicant for personal accident insurance answered “yes” to a question asking whether he had ever had an operation and gave details of two operations but failed to mention heart surgery he had undergone, although arguably the application form called for details of it. The insurer contended that the insured was guilty of “concealment or omission” under Insurance Code § 275. The court found it unnecessary to decide whether there was concealment or omission within the meaning of the statute, ruling that even if it were so, it could not be held as a matter of law that the information withheld was material to the risk. A chancellor's decree for recovery of policy benefits was affirmed. In National Old Line Ins. Co. v. People, 256 Ark. 137, 506 S.W.2d 128 (1974), the Alexander case is cited as dealing with misrepresentation.

153. See Reserve Life Ins. Co. v. Baker, 245 Ark. 853, 435 S.W.2d 780 (1968), where a negative answer to a question whether an applicant for hospital and surgical expense insurance had ever had, or been advised that he had, “[a]ny disease of the . . . urinary or gall bladder” was held not false, though it was shown that the applicant had had prostrate gland trouble. The insurer argued that the question referred to any disease of the urinary system, but the court held that the question asked only about the urinary bladder, adding that even if the question were treated as referring to the urinary system, persons not familiar with medical terminology “might well never connect this with trouble from the prostrate gland.” 245 Ark. at 857 n.3, 435 S.W.2d at 783 n.3.

154. See Union Life Ins. v. Davis, 247 Ark. 1054, 449 S.W.2d 192 (1970) (representation that one is in “good and sound health” not false if made in the justifiable belief that he is free of symptoms which should cause reasonable apprehension of disease materially affecting the risk, though chancellor's finding of falsity upheld). See also Old Republic Ins. Co. v. Alexander, 245 Ark. 1029, 436 S.W.2d 829 (1969) (representation of freedom from “heart trouble”; though application called for answer to the “best of your knowledge and belief,”
ment for voidability of an insurance contract on grounds of misrepresentation. It is probable as well that the courts will continue to look beyond the literal meanings of assertions of fact by applicants for insurance and will construe them in the light of the insurers' assumed purposes for seeking information. By these techniques, it is possible to conclude that misrepresentation defenses fail, without the necessity of wrestling with the complexities of section 275.

5. Abolition of Requirement of Fraudulent Intent

Assuming that there has been a misrepresentation, omission, concealment of fact, or incorrect statement within the scope of section 275(1) (the single term misrepresentation will hereafter be used for the sake of brevity), it "shall not prevent a recovery under the policy or contract unless either" of several conditions is met. Since one of these is that the misrepresentation be fraudulent and the other requirements, stated disjunctively, do not use the term fraudulent or any equivalent expression, it seems clear that section 275 does away with the major obstacle to a successful misrepresentation defense under pre-Code law, the requirement that any non-warranted misrepresentation have been made with awareness of its falsity and intent to deceive. And so it has been held.

opinion for court appears to take position that representation would be interpreted as statement of opinion even in absence of such language in the insurer's question. See National Old Line Ins. Co. v. People, 256 Ark. 137, 506 S.W.2d 12 (1974) (opportunity to so construe representation of "good health" passed up). American Family Life Ins. Co. v. Reeves, 248 Ark. 1303, 455 S.W.2d 932 (1970), discussed in text supra at note 137, is not contra, as it rules (erroneously, it is believed) that there need be no misrepresentation at all.

In other states with similar statutes this seemingly obvious proposition has not uniformly been accepted. See discussion of Florida, Georgia and Oklahoma cases, infra note 156. But see Dean v. Nationwide Life Ins. Co., 96 Idaho 772, 536 P.2d 1122 (1975); Lentz v. Prudential Ins. Co. of America, 164 Mont. 197, 520 P.2d 769 (1974); and later Florida cases discussed in note 156 infra.

155. See Interstate Life & Accident Ins. Co. v. Ellinberg, 242 Ark. 596, 414 S.W.2d 857 (1967), where the court accepted the argument of the plaintiff, in an action to enforce a policy of life insurance, that the insurer could not escape liability on the basis of answers given in the application to questions regarding prior ailments and medical treatments, if the ailment not disclosed was a "mere temporary, trifling or unimportant affliction," although judgment on a verdict for plaintiff was reversed, at least partly because the evidence showed treatments for ailments that were not merely temporary, trifling, or unimportant.

Logically, the converse appears equally clear: a fraudulent but

253 Ark. 127, 484 S.W.2d 892 (1972), suggests that fraudulent intent is required, but its meaning is difficult to pin down because the report of the case does not indicate what questions were asked by the insurer nor what statements the applicant and his wife made to the soliciting agent.

In most other states with similar statutes in which the question has been considered, it has been decided the same way, though sometimes with surprising effort.

In Florida a conflict of lower appellate court decisions was resolved by the supreme court in 1967 with a ruling that neither intent to deceive nor knowledge of the falsity of representations made in an application for insurance was essential to preclude recovery on the policy. Indeed, the court, by indicating approval of a Second District Court of Appeals decision, Douglas v. Mutual Life Ins. Co., 191 So. 2d 483 (Fla. Dist. Ct. App. 1966), appeared to say that its ruling would be applicable even to an answer to a question calling for an answer to the best of the applicant's knowledge. Life Ins. Co. v. Shifflet, 201 So. 2d 715 (Fla. 1967). However, the Florida court appears to have receded from the extreme position that a statement of opinion made in good faith can be ground for avoidance. National Standard Life Ins. Co. v. Permenter, 204 So. 2d 206 (Fla. 1967) (concurring opinion of Ervin, J., approved by a majority of the justices). See Hyman v. Life Ins. Co. of N. America, 481 F.2d 441 (5th Cir. 1973); Garwood v. Equitable Life Assurance Soc'y of United States, 299 So. 2d 163 (Fla. Dist. Ct. App. 1974).

In Georgia also, lower appellate court decisions requiring knowledge of falsity of representations to be shown in order to avoid a policy for misrepresentation by the applicant were repudiated by the supreme court, the court declaring that the statute renders material misrepresentations grounds for avoidance even if the representations are made in good faith. United Family Life Ins. Co. v. Shirley, 242 Ga. 235, 248 S.E.2d 635 (1978). The case involved representations which appear to have been statements of opinion only, and the case thus appears to take the position that such statements may be grounds for avoidance if the opinions are erroneous and the matters to which they relate are material, even though the opinions are expressed in good faith. See also Mercer v. Mutual Life Ins. Co., 283 F. Supp. 873 (M.D. Ga. 1967) (good faith and lack of knowledge of falsity immaterial even where applicant makes representations "to the best of my knowledge and belief").


The Oklahoma cases, on the other hand, appear to insist on knowledge of falsity, or at least reason to know of it. Brunson v. Mid-Western Life Ins. Co., 547 P.2d 970 (Okla. 1976); Massachusetts Mut. Life Ins. Co. v. Allen, 416 P.2d 935 (Okla. 1965). These cases seem to be influenced by an unexamined assumption that the statute precludes any distinction between statements of fact and expressions of opinion. The only Utah case to address the question is Brunham v. Bankers Life & Cas. Co., 24 Utah 2d 277, 470 P.2d 261 (1970), where it is flatly asserted that false representations do not provide a defense unless they were knowingly made with intent to deceive, but the statement is made on the basis of holdings under an earlier and differently worded statute.

Arizona cases also require that representations be fraudulent in order to be grounds for avoidance, but the Arizona statute, though superficially resembling those of Arkansas and the other states mentioned above, is significantly different, in that the three subparagraphs are not set forth disjunctively in Arizona; consequently they have, quite understandably, been construed as setting up cumulative requirements. Smith v. Republic Nat'l Life Ins. Co., 107 Ariz. 112, 483 P.2d 527 (1971). The requirement of fraud has been watered down,
non-material misrepresentation makes the contract voidable. The term fraudulent is not defined in the Insurance Code but seems likely to be construed as referring to the pre-Code idea of a representation made with knowledge of its falsity, or at least indifference to its truth, and with intent to deceive the insurer. It has been urged that statutes of other states using the terms fraudulent and material in the alternative should not be taken literally, the argument being that a misrepresentation that does the insurer no harm should not justify avoidance merely because it was made with deceptive intent. The force of this argument varies, however, with the test used to determine the materiality of the misrepresentation. If the test employs an individual insurer standard, asking what the actual insurer would have done if it had known the truth, it is difficult indeed to justify a rule that a misrepresentation which is not material by this test gives the insurer a defense if it was fraudulently made, for the insurer would presumably be unable to demonstrate reliance on the representation in these circumstances. On the other hand, the prudent insurer standard determines materiality on the basis of the prevailing practices of insurers generally, and it is conceivable that the actual insurer could be induced to issue a policy by a misrepresentation which was not material by this test. In such a case, if the false representation were made with intent to deceive the insurer, since it accomplished the desired result, it is not difficult to accept the conclusion that the party seeking to uphold the validity of the policy should not be heard to argue that the insurer's reliance was unreasonable because other insurers would not have relied. The light that these observations shed on the correct reading of section 275(1) of the Arkansas Insurance Code cannot be assessed, however, until the Code's treatment of materiality is explored.

6. Materiality of Misrepresentation

In the absence of fraud, section 275(1) provides that misrepresentation shall not prevent a recovery under the policy or contract unless it is either:

158. See E. Patterson, Essentials of Insurance Law § 84 (2d ed. 1957); R. Keeton, Basic Text on Insurance Law § 6.5(c)(1) (1971).
159. See text at notes 67-69 supra.
160. Id.
(b) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or (c) the insurer in good faith would either not have issued the policy or contract, or would not have issued a policy or contract in as large an amount or at the same premium or rate, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise.

It will be noted that paragraph (b) employs the word material without defining it, although it indicates that materiality may be tested by its relevance to acceptance of the risk or to the hazard assumed by the insurer. That different tests of materiality are contemplated is evident from the wording, "material either to . . . or . . . ." The difference between these two applications of material has been considered under similarly worded statutes of other states. A leading authority has suggested that materiality to the hazard assumed by the insurer involves an objective test of the bearing of the fact misrepresented on an insurer's decision to accept the risk, in other words a prudent insurer test of materiality, while materiality to the acceptance of the risk could imply either an individual insurer or a prudent insurer test, but that since the statutory wording contemplates different tests, the phrase material to the acceptance of the risk should be understood as adopting an individual insurer test as an alternative to the prudent insurer test, the insurer thereby being enabled to establish materiality either by reference to industry standards or by proof of its own higher standards.161

There is little need to wrestle with the question whether material to the acceptance of the risk in paragraph (b) of the Arkansas statute adopts an individual insurer standard of materiality, since paragraph (c) in effect spells out an individual insurer test of materiality. The more important question is whether paragraph (b) authorizes use of a prudent insurer test as an alternative to the individual insurer test, as it appears to do.162 Some support for this interpretation can be found in Arkansas cases, though there has been no dis-

161. See E. Patterson, supra note 158, § 73 at note 128, and § 83 at note 105.
discussion of the distinction. In *Union Life Insurance Co. v. Davis*, the court was reviewing a chancellor's decree for specific performance by the insurer of a contract of credit life insurance, and the decree was reversed, the court found that a representation of the insured in the application for the policy that he was in "good and sound health" was false, and, further, that the misrepresentation satisfied section 275(1)(b) as concealing facts which would "materially affect the hazard assumed by the insurer." The court appeared to take judicial notice of the materiality of the misrepresentation, which suggests that an objective test of materiality was being employed.

This reading of paragraph (b) does not resolve the problem of whether a fraudulent but non-material misrepresentation is sufficient to make a policy voidable. Where the individual insurer test of materiality is used, it seems that it should not, but it would be appropriate under a prudent insurer test, if the insurer can prove actual reliance on the misrepresentation. The answer most consistent with the statutory language would be that a fraudulent non-material misrepresentation can be grounds for avoidance, regardless of the test of materiality used, but that it is not grounds for avoidance unless the insurer proves actual reliance on the misrepresentation. Section 275 does not speak of reliance, but it should be regarded as silent on the necessity of reliance rather than as negating it by implication. The section does not purport to be a complete codification of the law of misrepresentation in procurement of insurance, even as to the types of insurance within its scope; it limits itself to laying down some rules to change or clarify specific features of the prior law. A requirement that the insurer prove reliance on the misrepresentation, in addition to its materiality, was recognized in prior Arkansas law, as well as in the law of other states, and there is

164. Id. at 1060, 449 S.W.2d at 195.
165. See also *American Pioneer Life Ins. Co. v. Turman*, 254 Ark. 456, 495 S.W.2d 866 (1973), and the cases dealing with the good faith requirement in paragraph (c), discussed in the text infra at notes 172-175.
168. See text at notes 80-84 supra.
nothing in section 275 to suggest legislative intention to abolish the reliance requirement. Retention of the requirement should prevent an insurer which has not been harmed by a fraudulent misrepresentation from using it as a defense to liability.

Paragraph (c) of section 275(1) is essentially a spelling out of an individual insurer, “would” test of materiality, though it is not free of problems of interpretation. The significance of the concluding words, “as required either by the application for the policy or contract or otherwise,” has already been discussed. A second problem is the meaning of the reference to good faith: “The insurer in good faith would either not have issued the policy or contract . . . .” Good faith is another undefined term in the Insurance Code, and its use in other statutes sometimes carries a meaning of purely subjective honesty, while at other times it includes an objective element of reasonableness. Its meaning in Insurance Code section 275(1)(c) is not obvious.

A probable explanation for the inclusion of the good faith qualification can be found in the nature of the test of materiality involved. The question to be answered is a hypothetical one: what would the insurer have done if it had known facts it did not actually know when it issued the policy in suit? The burden is on the insurer to prove that it would not have issued the policy, at least not on the same terms. Should it be enough to sustain this burden for the insurer to produce testimony of an underwriting official of the company that the policy would not have been issued or would have been issued on different terms, or should the insurer be required to prove that it has followed a consistent practice that would normally lead to rejection of the application or to offering a policy on terms varying from those of the policy applied for? The former would open the door to establishment of a misrepresentation defense by evidence that might well reflect capricious judgment on the part of the insurer and is hardly a satisfactory basis for answering a hypothetical question of such importance. What is needed is convincing evidence of

169. See text at notes 68-69 supra.
170. See text at notes 137 and 147 supra.
consistent practice by the insurer, to provide a solid basis for an inference as to what the insurer would have done in circumstances that did not exist. The Arkansas cases applying section 275 have clearly taken this attitude. Viewed in this light, the good faith requirement of paragraph (c) has an objective requirement of consistency of practice by the individual insurer.

However, the Arkansas Supreme Court has found more in the good faith requirement. In *Life & Casualty Insurance Co. v. Smith* Justice Brown noted that paragraph (c) does not use the word material but does require good faith on the part of the insurer, and commented, "If the matter omitted or incorrectly stated could logically have no bearing on the assumption of the risk then it could not be successfully argued that the insurer's 'good faith' defense should prevail." In that case it was held that the insurer had produced sufficient uncontradicted evidence to establish a defense under section 275(1)(c), and a judgment on a verdict for the plaintiff for recovery under the policy was reversed and the case dismissed.

In the subsequent case of *American Family Life Assurance Co. v. Reeves* Justice Brown's observation in *Smith* was picked up and treated as a requirement that the insurer, to establish a defense under section 275(1)(c), prove materiality to the risk. The action was one to recover on a group cancer policy covering the plaintiff and his wife, the wife having died of cancer after issuance of the policy, and it resulted in a judgment for the plaintiff. In the course of the trial the court refused to admit the testimony of a soliciting agent of the defendant who had the duty of explaining the group policy to the members of the group to be insured and of forwarding their applications to the insurer. The insurer (according to Justice Holt, writing for the supreme court) made an offer of proof by the

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173. See, e.g., Combined Ins. Co. of American v. Yates, 253 Ark. 963, 490 S.W.2d 134 (1973); Hartford Life Ins. Co. v. Catterton, 247 Ark. 263, 445 S.W.2d 109 (1969); Old Republic Ins. Co. v. Alexander, 245 Ark. 1029, 436 S.W.2d 829 (1969). This is not to say, however, that such proof will always be required; in some cases the materiality of a misrepresentation has appeared so clear that the court took judicial notice of it. See American Pioneer Life Ins. Co. v. Turman, 254 Ark. 456, 495 S.W.2d 866 (1973); Union Life Ins. Co. v. Davis, 247 Ark. 1054, 449 S.W.2d 192 (1970).


175. Id. at 937, 436 S.W.2d at 99.

176. Id. at 939, 436 S.W.2d at 100.

177. 248 Ark. 1303, 455 S.W.2d 932 (1970).

178. Justice Fogelman, dissenting, understood the offer of proof differently. Id. at 1312, 455 S.W.2d at 938.
agent that the agent had been directed not to send to the home office any application with an affirmative answer to either of two questions (which had been answered negatively, and arguably falsely, in the plaintiff's application). The court held that the proferred testimony was admissible, apparently as tending to show that the insurer would not have provided coverage for the plaintiff's wife if it had known the truth, and the exclusion of the evidence was held to be prejudicial error. However, the court observed that the offer of proof was "deficient as to materiality" with regard to one of the two questions to which the testimony related. The question was whether any member of the family group to be insured had ever had, to the knowledge of the applicant, "lumps, growths or swellings," and the insurer's evidence had been found sufficient to show that the wife had had a growth of which the applicant had knowledge. Justice Holt wrote, "In order to prevail in its subsection (c) defense, appellant must show that the growth was material to its risk," and then quoted Justice Brown's observation in the Smith case. The implication appears to be that in order to establish a defense under section 275(1)(c) the insurer must show, not only that if it had known the truth it would not have issued the same policy, but also that its decision would have been a reasonable one, and presumably reasonableness would be judged by application of a prudent insurer standard.

If that is the proposition for which Reeves stands, the third subparagraph in subsection (1) of section 275 is regarded by the Arkansas court as combining a prudent insurer test of materiality with an individual insurer test, the insurer being required to satisfy both tests to make out a defense. However, that reading is quite inconsistent with the second subparagraph of the same subsection, which, as has been shown, permits the insurer to defend by establishing materiality either way. A reading of good faith which limits its objective requirement to proof of consistent practice by the individual insurer supporting its contention that it would have behaved differently if the truth had been known does not nullify the law laid down in paragraph (b).

7. *Is a Causal Connection Test Incorporated?*

A question that has proved highly troublesome has been whether, after a loss within policy coverage has occurred, the insurer can avoid liability for benefits payable under the terms of the policy.
by proof of a material misrepresentation where the fact concealed by the misrepresentation was not a cause of the loss for which benefits are sought. Prior to the 1959 Insurance Code, the Arkansas law was not clear on this matter.\(^\text{180}\) Does section 275 clarify the law? The cases have vacillated in their response.

The first case to consider the issue was *Dopson v. Metropolitan Life Insurance Co.*\(^\text{181}\) This was an action against the insurer for specific performance of a hospitalization policy, in which the chancellor found that the insured, when he applied for extension of the coverage of the policy to include his wife, had made a misrepresentation concealing the fact that his wife had suffered from back trouble, and that the misrepresentation was material to the risk. On appeal the plaintiff argued that the decree in favor of the insurer was improper because no causal connection had been shown between the back trouble concealed and the back trouble that led to the hospitalization for which policy benefits were sought. The plaintiff relied on the pre-Code case of *Inter-Ocean Casualty Co. v. Huddleston*\(^\text{182}\) as holding that such causal connection was required. The court responded that “our holding in the *Huddleston* case has been modified to the extent that a recovery will be denied where the ‘omissions’ or ‘incorrect statements’ are such that the company would not have provided coverage with respect to the hazard resulting in the loss had it known the true facts.”\(^\text{183}\) (The insurer had introduced evidence that if it had known of the wife’s prior back trouble, it would not have extended coverage to her without an exclusion of benefits for back trouble.) The decree denying relief to the plaintiff was affirmed.\(^\text{184}\) The *Dobson* case thus definitely rejected a causal-connection requirement, and based its rejection on section 275(1)(c) of the Insurance Code.

In a case decided later the same year, *Reserve Life Insurance Co. v. Baker,\(^\text{185}\) the court appeared to reverse itself. An action to enforce a hospital and surgical expense policy resulted in a judgment for the plaintiff. The insurer contended on appeal that the policy was voidable because the insured had given a negative answer to a question asking whether he had, within the previous five years, received medical or surgical treatment. He had in fact been treated

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180. See text at note 79 supra and cases discussed in note 79.
181. 244 Ark. 659, 426 S.W.2d 410 (1968).
182. 184 Ark. 1129, 45 S.W.2d 24 (1932), discussed in note 79 supra.
183. 244 Ark. at 662, 426 S.W.2d at 411.
184. Id. at 858, 435 S.W.2d at 783.
185. 245 Ark. 853, 435 S.W.2d 780 (1968).
within that period for low back pain on one occasion and for dizziness, sore throat and nasal congestion on another. The court rejected the insurer's argument on the ground that the answer made by the applicant for the insurance, "though not correct, was not a material misrepresentation, because appellee had not, within the last five years, consulted the physician about the difficulty which occasioned the operation [for which policy benefits were sought]." No authority was cited.

In the following year Old Republic Insurance Co. v. Alexander was decided. Here an insurer brought suit in chancery for rescission of a contract of personal accident insurance on the ground that issuance of the policy had been induced by a misrepresentation in the application for the insurance that the would-be insured had never had heart trouble and a further misrepresentation which concealed the fact that he had undergone chest surgery. The insured counterclaimed for policy benefits for loss of a leg by reason of an accidental gunshot wound. The chancellor refused rescission of the policy and granted the relief sought by the counterclaim. The supreme court affirmed the decree, finding that the evidence did not establish a misrepresentation of freedom from heart trouble and, as to the alleged misrepresentation regarding prior operations, that even if misrepresentation were assumed to have occurred, the insurer had failed to prove either the materiality of the misrepresentation under section 275(1)(b) of the Insurance Code or that it would not in good faith have issued the policy if it had known the truth, under section 275(1)(c). (The insurer apparently did not contend that the misrepresentation was fraudulent.)

Justice Smith filed a concurring opinion (joined by Chief Justice Harris, the author of the opinion for the court in the Baker case), contending that even if the insurer had succeeded in proving a misrepresentation of freedom from heart trouble, the judgment on the counterclaim for policy benefits should be affirmed, because the evidence showed that there was no causal relation between the heart condition and the gunshot wound and ensuing loss of limb. He argued that section 275(1) of the Insurance Code prescribes only minimum requirements for a successful misrepresentation defense and should not be read as meaning that every fraudulent or material

186. Id.
188. Id. at 1042, 436 S.W.2d at 836.
189. Id. at 1043, 436 S.W.2d at 837.
misrepresentation prevents recovery, and that the court could add a requirement, where actual loss within policy coverage had occurred prior to the insurer's attempt to avoid the contract, of a demonstration that the fact misrepresented was a cause of the loss. He asserted, further, that such a requirement should be imposed, to avoid encouraging *ex post facto* litigation and unjust enrichment of insurers. If the insurer could avoid liability for a loss by showing a material misrepresentation having no connection with the loss, the insurer could "repudiate the policy whenever a loss occurred but... pocket the premiums with impunity when the policy proved to be of no value to the insured or his beneficiaries." Justice Smith could not believe the legislature intended such a result. He distinguished the *Dopson* case since in that case the claim was for hospitalization due to back trouble, and the misrepresentation had related to prior back trouble: "Hence the necessary causal connection between the misrepresentation and the loss was shown to exist."

The *Alexander* decision was followed by two cases in which a causal-connection requirement seemed to be assumed. In *Marshall v. Prudential Insurance Co. of America* a chancery court decreed rescission of a hospitalization insurance policy covering a husband and wife and rejected the insureds' claim for policy benefits, on a finding of material misrepresentation in procurement of the policy. Affirming the decree, Chief Justice Harris noted that the record showed that the application had failed to reveal that the wife had suffered "female disorders," but he considered that "further discussion of these ailments is not required since the hospitalization [for which policy benefits were sought] was occasioned by phlebitis."

In *American Pioneer Life Insurance Co. v. Smith* an applicant for credit life insurance represented that he was in good health, and undisputed evidence was produced at trial that the applicant/insured had suffered from and been hospitalized for diabetes mellitus and remained on medication for it until his death. The evidence established also that the insured had had a heart attack which resulted in his retirement, and that he continued to see his doctor regularly and to take three different medications for the heart condition until he died. Reversing a judgment for the plaintiff in an action on the policy, the court found misrepresentation and

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190. *Id.* at 1044, 436 S.W.2d at 838.
191. *Id.* at 1044-45, 436 S.W.2d at 838.
192. 253 Ark. 127, 484 S.W.2d 892 (1972).
193. *Id.* at 128, 484 S.W.2d at 893.
materiality as a matter of law, observing with regard to materiality: "Not only did the expert testify that the policy would not have been issued had the true facts been correctly stated but the autopsy reports [sic] shows the immediate cause of death as congestive heart failure."195

The causal connection requirement was finally given intensive consideration in 1974, in the case of National Old Line Insurance Co. v. People,196 and won the approval of the majority of the court. Justice Smith, the author of the concurring opinion advocating the requirement in the Alexander case,197 now spoke for the majority of the court in declaring it to be the law.

The case involved credit life insurance. Mr. and Mrs. People bought a car, promising to pay some $5,000 of the price in 36 installments, and the husband obtained, through the car dealer, a policy of insurance on his own life for the amount of the debt. The application and policy were combined in a single document, and the policy became effective at once, though by its terms it could be rejected by the insurer within 30 days. Although no specific question was asked of People about his health, he was required to sign the application, which contained a printed declaration that he was in good health.198

People died about nine months after the policy was issued, and his wife made no further payments on the installment purchase contract. When the finance company holding the contract brought suit against her for the unpaid balance of the debt, Mrs. People cross-complained against the credit life insurer to enforce the policy. The insurer denied liability on the ground that People had obtained the policy by a false and fraudulent statement that he was in good health. At trial there was undisputed evidence that People was not in good health when he applied for the insurance; he was being treated for diabetes and high blood pressure and both of these conditions had existed for at least four years. The evidence, however, did raise a question of fact whether these ailments were contributing causes of his death, which was attributed in the death certificate to kidney disorders, his doctor having testified that there was no indication of kidney ailments until well after the date of issuance of the policy.199 Judgment was rendered on a verdict in favor of Mrs. People, and the insurer appealed, contending that it was entitled to a

195. Id. at 950, 504 S.W.2d at 357.
197. 245 Ark. 1029, 436 S.W.2d 829 (1969).
198. 256 Ark. at 137-38, 506 S.W.2d at 128.
199. This, at any rate, was asserted to be so in the recital of the facts in the opinion for
directed verdict or judgment *n.o.v.* for want of any genuine issue of fact.200

The judgment was affirmed. Though the undisputed evidence showed that People was not in good health when he applied for the insurance, the jury might have found that People acted in good faith in signing the application, and the jury could have found that People's death was not caused by either the diabetes or the high blood pressure he had at the time of the application. In answer to the insurer's argument that under section 275 of the Insurance Code there need be no causal connection between a matter misrepresented in the application for the insurance and the ultimate cause of the death of the insured, Justice Smith wrote: "We do not so interpret the statute upon which the appellant relies."201 After reviewing nine prior cases decided under the Insurance Code, and finding that none of them had passed on the issue raised by the insurer, he concluded that the question of statutory construction was an open one, and further, that the common law authorities on the issue were rendered irrelevant by the Insurance Code, which "was a comprehensive revision of our law in that field and is to be interpreted according to the usual principles of statutory construction."202 Justice Smith then declared it to be "our conclusion that, under the Code, the insurer must show a causal relation between the applicant's misrepresentation and the eventual loss."203 He found that paragraph (c) of section 275(1) to some extent carries that implication:

"The insurer in good faith . . . would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known." Thus, it would be a defense to the insurer, in a back injury case, to show that if the applicant had disclosed a history of back trouble it would have excepted that hazard from the policy. In fact, that was precisely the insurer's proof in the *Dopson* case, . . . where the insurer prevailed by offering proof that "it would not have issued the rider without an exclusion relative to Mrs. Dopson's back." Yet if Mrs. Dopson's claim had been for a broken leg, an exclusion of coverage with respect to her back would not have afforded the insurer a defense to the claim.204

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200. 256 Ark. at 137-38, 506 S.W.2d at 128-29.
201. *Id.* at 140, 506 S.W.2d at 129.
202. *Id.* at 141, 506 S.W.2d at 130.
203. *Id.*
204. *Id.* at 141-42, 506 S.W.2d at 130-31.
The opinion also asserted that "[f]airness and reason support the view that a causal connection should be essential," since a contrary rule would make possible a successful denial of liability by an insurer on a showing that the insured was suffering from diabetes when he made his representation of good health, even though his death was caused by a stroke of lightning or by being run over by a car. And these considerations of fairness were considered "especially pertinent to a credit life insurance policy like the one before us."

This was a short-time policy, to remain in force for only three years. The company made no medical examination of the applicant, relying upon him either to refuse to sign the application if he was not in good health . . . or to “clip a note” to the application, explaining his health condition. The appellant had the burden of proving its affirmative defense, but it made no effort to show that the automobile salesman who took People’s application made any explanation of the printed form or of the significance of the representation of good health. If People had lived for three years the insurer would have sustained no loss. In the circumstances it is plainly unjust to permit the company to deny liability on the basis of a misrepresentation that had no connection with People’s death (or so the jury might have found) and that would have provided no defense to the insurer if the policy had excluded coverage for loss resulting from the undisclosed ailments.

Chief Justice Harris filed a concurring opinion in the People case, agreeing that under the Insurance Code the insurer must show a causal connection between misrepresentation and loss, and advising credit life insurers that if they want to avoid liability on policies procured by fraud, they would do well to ask specific questions of their applicants calling for information which could not be misrepresented without fraud.

Justice Byrd filed a strong dissent. He took issue with the majority’s interpretation of the law, arguing that, (1) the majority opinion cited no authority for its construction of Insurance Code section 275 as requiring a causal connection between misrepresentation and loss, (2) although in some states there are statutes expressly

205. *Id.* at 142, 506 S.W.2d at 131.
206. *Id.*
207. *Id.*
208. *Id.* at 143, 506 S.W.2d at 131.
209. *Id.* at 144, 506 S.W.2d at 132.
requiring such causal relation, every state with a statute similar to Arkansas' had construed it as not so requiring, (3) the textwriters were unanimous that materiality of a misrepresentation does not depend on causal connection between it and any loss that might occur, (4) section 275 of the Insurance Code had made it possible for life insurance to be economically written without the expense and delay of requiring a medical examination of the insured, a relatively short incontestable clause being required\(^{210}\) to "prevent the seeming injustice that would arise when an individual has paid premiums for a considerable time and during which time the insurer has had the benefit of the premiums,"\(^{211}\) (5) in most litigation it is debatable whether the fact misrepresented contributed to the loss, and "logic and reason would dictate that we should not be in the position of quibbling over whether a misstatement contributed to the loss involved in an insurance contract,"\(^{212}\) and (6) the majority's interpretation of the statute was not just "because it will increase the premium rate of life insurance to the honest insured to the bounty of those who misstate the facts in making their applications—for after all life insurance is an actuarial business based upon the business written not necessarily the life of every individual."\(^{213}\) Finally, Justice Byrd was of the opinion that even if the causal connection requirement were accepted, the testimony of the plaintiff's own witnesses established such causal relation.\(^{214}\)

The reasoning of the opinion for the court in the People case is interesting, especially since its author shifted from his reasoning in Alexander,\(^{215}\) that section 275 of the Insurance Code does not deal with the causal connection question but that such a requirement should be imposed as a matter of supplementary common law, to a finding that section 275 mandates the causal connection requirement. The only language pointed to in Justice Smith's opinion in People as supporting his conclusion is a portion of paragraph (c) of

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210. The statute provides in pertinent part:

There shall be a provision that the policy (exclusive of provisions relating to disability benefits or to additional benefits in the event of death by accident or accidental means) shall be incontestable, except for nonpayment of premiums, after it has been in force during the lifetime of the insured for a period of two (2) years from its date of issue.

ARK. STAT. ANN. § 66-3304 (1980).

211. 256 Ark. at 147, 506 S.W.2d at 133.

212. Id.

213. 256 Ark. at 148, 506 S.W.2d at 134.

214. Id.

section 275(1): "The insurer in good faith . . . would not have provided coverage with respect to the hazard resulting in the loss if the true facts had been made known . . . ." Even this he considered to carry that implication only to some extent.

Whatever tendency the language emphasized by Justice Smith in paragraph (c) of section 275(1) may have, when lifted out of context to suggest a requirement that a misrepresented fact has contributed to the loss for which policy benefits are sought, fades when the paragraph is read as a whole. The statute provides that misrepresentations shall not prevent a recovery under the policy or contract unless

(c) The insurer in good faith would either not have issued the policy or contract, or would not have issued a policy or contract in as large an amount or at the same premium or rate, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known . . . .

That the insurer would not have provided coverage for the hazard causing the loss is only one of four possible actions the insurer might have taken, if the truth had been known, that will satisfy the test of the paragraph, and it is difficult indeed to see that a causal connection is impliedly required by any of the others.

Moreover, the Arkansas Supreme Court stands alone in finding a causal connection requirement in this type of statute. In none of the seventeen other states that have enacted statutory rules governing misrepresentations in terms closely resembling section 275(1) of the Arkansas Insurance Code has the statute been construed as incorporating such a requirement, and cases in at least three of

216. 256 Ark. at 140, 506 S.W.2d at 130.
217. 256 Ark. at 141, 506 S.W.2d at 130.

220. A Puerto Rican statute closely resembles subsection (1) of § 275 of the Arkansas Insurance Code, but adds: "when the applicant incurs in [sic] any of the actions enumerated in paragraphs (1), (2) and (3) of this section, the recovery shall only be prevented if such
these jurisdictions have rejected that reading.\textsuperscript{221}

Viewing paragraph (c) as a whole, it appears\textsuperscript{222} to be a detailed statement of the individual insurer "would" test of materiality of misrepresentation, adding up to a general rule that a misrepresentation is material if the insurer, had it known the truth, would either have refused to insure at all or would have offered a policy on terms differing from the terms of the policy for which the insured applied. Yet the language singled out by Justice Smith in \textit{People} does suggest that something more is involved. For the insurer to establish a defense under this wording, when a claim on the policy has already arisen, the insurer must show not merely that knowledge of the truth would have led it to provide more restricted coverage, but also that the coverage provided would not have included "the hazard resulting in the loss." Justice Smith seems to have read the quoted phrase as meaning "the hazard causing the loss." Another possible reading, however, is "the type of hazard causing the loss." This reading would be consistent with such cases as \textit{Dopson},\textsuperscript{223} where the insurer established a defense under the statute by proof that if it had known the truth about Mrs. Dopson's back trouble, it would have excluded benefits for back trouble from the coverage of the policy, even though the insurer demonstrated no causal connection between Mrs. Dopson's prior back trouble and that which gave rise to the claim under the policy. If this reading is correct, it in effect calls for reformation of the policy, that is, enforcement of the obligation the insurer would have been willing to assume if it had not been misled as to material facts.

That inference suggests a legislative purpose which can be consistently applied to all the fact variations mentioned in paragraph (c), a purpose to modify the drastic pre-statutory effect of material misrepresentation (as making the contract voidable) by substituting a rule that the insurer should be held to the terms of the contract it would have been willing to make if it had known the truth. Thus, if the insurer shows that knowledge of the truth would have led it to actions or omissions contributed to the loss that gave rise to the action." P.R. LAWS ANN. tit. 26, § 1110 (1976).

\textsuperscript{222} See text at note 167 \textit{supra}.

\textsuperscript{223} 244 Ark. 659, 426 S.W.2d 410 (1968). See text at note 176 \textit{supra}.
insure in a smaller amount, its liability on the policy should be limited to that amount; and if the insurer shows that, had it known the truth, it would have charged a higher premium, recovery under the policy should be reduced by the amount of the additional premiums the insurer would have received. Only where the insurer proves that it would not have issued a policy at all if it had known the true facts should it have a complete defense to liability.

This reading of the statute serves to guard against the sort of injustice that advocates of the causal connection requirement fear, and it does so without going to the unnecessary extreme of requiring proof that a fact concealed by misrepresentation was an actual cause of loss to the insured. It cannot be regarded as unfair to the insurer, since it holds the insurer only to the terms of the contract it has shown that it would have been willing to make if it had had the correct information, and it prevents the person guilty of misrepresentation from gaining advantage from it. The contract is reformed to eliminate the distortion of its terms caused by the misrepresentation, without depriving the policyholder of protection he paid for and which the insurer would have been willing to provide for such payment.

It may be objected, of course, that this sort of reformation amounts to holding the applicant for the policy to a contract different from that for which he applied, and one he may not have been willing to accept if it had been offered to him. That is quite true, but the remedy here is used to accomplish a restitutionary purpose: prevention of the unjust enrichment of the insured or his beneficiaries as a result of the insurer having been induced by misrepresentation to enter into the contract that was actually made.

It may be objected also that provision of the remedy of reformation in this context is contrary to established principles of equity jurisprudence. It must be conceded that precedent is sparse, but if

224. The traditional use of reformation has been to correct mistakes in reducing oral agreements to writing. In cases of fraudulent misrepresentation regarding the contents or effect of a writing, reformation might be employed to give the defrauded party benefits as represented. Both the original and the revised Restatements of Contracts would limit reformation for misrepresentation to such cases. Restatement of Contracts §§ 491, 505 (1932); Restatement (Second) of Contracts § 308, Comment a (Tent. Draft No. 11, 1976). McClintock found authority for reformation of the terms of a written contract to correct distortions resulting from fraud in the inducement, H. McClintock, Handbook of the Principles of Equity § 100 (2d ed. 1948), but other writers have questioned the reliability of these precedents, see D. Dobbs, Handbook on the Law of Remedies § 9.5 (1973); J. Calamari & J. Perillo, Handbook of the Law of Contracts § 9-35 (2d ed. 1977), and even McClintock appeared to assume that the remedy was not appropriate for...
the remedy is called for by the statute no case law precedent is necessary.

The most serious criticism of this reading of the statute questions the reading's legitimacy as statutory construction. The courts of other states having statutes closely resembling section 275(1) of the Arkansas Insurance Code have been no more inclined to find a generalized reformation principle implied by the third paragraph than they have been to discern a causal connection requirement in its language. Moreover, if the paragraph incorporates a reformation principle, a problem is posed whether the insurer could avoid it by relying on the second paragraph, which requires only a finding that the misrepresentation be "[m]aterial either to the acceptance of the risk, or to the hazard assumed by the insurer." While a showing of materiality to the acceptance of the risk could be regarded as invoking the third paragraph as well as the second, proof of materiality to the hazard assumed could be made without invoking the third paragraph at all.

No reading of section 275(1) has been found that neatly reconcile all of its wording, but any sound reading must recognize the stubborn fact that an insurer seeking to establish a defense under the statute by showing that, if the truth had been known, it would have issued a policy with more restricted coverage than the one actually issued must show also that the restriction of coverage would have excluded the hazard resulting in the loss, if a loss has occurred. If this is not a causal connection requirement, it is essentially a direction to treat the contract as reformed to afford the coverage the insurer would have been willing to provide if it had not been misled. And if this treatment of material misrepresentation is appropriate where the misrepresentation led to issuance of a policy of broader coverage than otherwise would have been issued, it seems equally appropriate for cases where the insurer has been induced to issue a policy in a larger amount or at a lower premium. Certainly nothing in paragraph (c) forbids that course; if it does not imply that the reformation device is to be employed whenever the insurer bases its defense on paragraph (c), it is at least silent on the point, and such cases of innocent misrepresentation. H. McClintock, supra; see D. Dobbs, supra. The arguments for such sharp limitation of the reformation remedy appear to be based on an assumption that restoration of the status quo ante is possible through rescission and restitution, which is not true where a loss within insurance policy coverage has already occurred.

226. See text at notes 161-164 supra.
application of the statute would be in order, to achieve consistency of results.

Extension of the reformation device to cases where the insurer relies on paragraph (b)'s test of materiality to the hazard assumed is of more questionable propriety. However, the statute does not affirmatively provide that by demonstrating materiality to the hazard assumed the insurer necessarily establishes a complete defense. If the proof is that a prudent insurer, had it known the truth, would have issued a policy with narrower coverage than the one actually issued, there is nothing in the language of paragraph (b) to preclude the court from inquiring whether the narrowed coverage would have excluded liability for a loss that actually occurred before the misrepresentation defense was asserted, and denying recovery only if that loss would have been excluded. Application of paragraph (b) in parallel fashion to paragraph (c) would promote consistency in handling misrepresentation cases, and would be desirable for the same reasons of policy which apply to cases falling under paragraph (c).

It is not possible to determine the applicability of this reading of the statute to the facts of the People case, because the report of the case does not indicate what proof the insurer offered to establish the materiality of the misrepresentation. Presumably, this aspect of the evidence was considered irrelevant to the issues raised by the appeal. The case thus appears to hold that under section 275 a causal connection between misrepresentation and loss is required in every case in which an insurer seeks to avoid liability for a loss that has already occurred on grounds of misrepresentation (at least, if the misrepresentation is not fraudulent). Although the opinion for the court does indicate that the public policy arguments for the requirement are "especially pertinent" to credit life insurance issued without medical examination, with little practical opportunity afforded to the applicant to make full disclosure of his state of health, and without an explanation being given to him of the terms of the application and their significance, it would be a strained reading of the opinion to treat its holding as limited to a class of policies so narrowly defined, since the opinion asserts that section 275 imposes the requirement of causal connection, and no distinction is drawn in that section between credit life insurance and other forms of life insurance.

228. Id. at 141, 506 S.W.2d at 130. See also Southern Security Life Ins. Co. v. Smith, 259
While this writer finds it difficult to accept the conclusion that section 275 of the Insurance Code incorporates a causal connection requirement, there remains the possibility of such a requirement being imposed in some or all cases as a matter of supplementary common law. As Justice Smith originally argued in his concurring opinion in the *Alexander* case, the statute is not a complete codification of the law of misrepresentation in procurement of life and disability insurance and annuity contracts. There is some reason, however, to infer that the section impliedly rejects a causal connection rule. At the time the Insurance Code was adopted in Arkansas, there were a few states in which such a rule had been adopted explicitly by statute, one of them being the neighboring state of Missouri, whose statute dates back a century. The Arkansas General Assembly thus had available models of clear causal connection legislation which it could have followed if such a requirement had been desired. Its decision to employ a different formulation of the law, one which falls far short of giving clear approval to a causal connection rule, arguably implies rejection of such a rule.

If section 275 is considered to be entirely silent on the matter, however, the advisability of adding it by decision is debatable. Justice Smith's policy argument, in both *Alexander* and *People*, focuses on the need to prevent unjust enrichment of insurers, but the effectiveness of a causal connection requirement to achieve this purpose is dubious. As Justice Byrd suggested in *People*, the burden initially cast on insurers by the rule is not likely to remain with them, for premium rates will be adjusted to absorb the added cost; the

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Ark. 853, 537 S.W.2d 542 (1976), rejecting an argument that credit life insurance should be treated as a special category, not subject to Insurance Code § 275.

229. *See* text at notes 188-189 *supra*.


232. *See* text at note 213 *supra*. 
ultimate burden will thus probably be borne, in major part, by policyholders who have made no material misrepresentations at all. A concern to avoid unduly harsh treatment of those who have misled insurers without fraud is certainly legitimate, but the reformation device outlined above seems more likely to accomplish the objective without unjust enrichment of insurers and also without casting an additional burden on the policyholders in general.

C. Section 275(1)—Related Matters

That section 275(1) does not provide a complete body of substantive law governing representations made to procure insurance, even as to the types of insurance within its coverage, is evident from the foregoing discussion.

The pre-Code doctrine that a misrepresentation does not render the policy procured by it voidable unless the representation is substantially untrue\textsuperscript{233} does not appear to be repudiated by the statute. While, before the enactment of the Insurance Code, this doctrine appeared to have little real significance in Arkansas law,\textsuperscript{234} it may acquire a new importance now that the pre-Code requirement of fraudulent intent has been removed. A case or two decided under the Code may point in this direction.

In \textit{Old American Life Insurance Co. v. McKenzie}\textsuperscript{235} an applicant for medical expense insurance answered a question in the application about his medical history by revealing a disc operation, giving its date and the name of the surgeon, and asserting that there had been a complete recovery, but he failed to reveal that two subsequent spinal fusion operations had been performed. The court rejected the insurer's contention that the omissions made the policy voidable, reasoning that the application had provided the insurer with sufficient information to enable it to learn of the subsequent operations by inquiry of the insured's physician. The court declared that the insured had "substantially met all burdens imposed upon him in his relations with defendant under his contracts of insurance."\textsuperscript{236} The pre-Code case of \textit{Missouri State Life Insurance Co. v. Witte}\textsuperscript{237} was cited as precedent; that case was similar on its facts and the court there said simply that the applicant had supplied the in-

\textsuperscript{233} See note 14 \textit{supra}.
\textsuperscript{234} See text at note 63 \textit{supra}.
\textsuperscript{235} 240 Ark. 984, 403 S.W.2d 94 (1966).
\textsuperscript{236} \textit{Id.} at 987, 403 S.W.2d at 96.
\textsuperscript{237} 161 Ark. 148, 256 S.W. 46 (1923).
surer with enough evidence to give it the opportunity to investigate.  

_Pyramid Life Insurance Co. v. Garrison_ went beyond _McKenzie_. An applicant for a hospital, surgical and medical expense policy represented in 1963 that she had had no medical or surgical advice or treatment within the preceding five years, but she revealed that in August of 1949 she had had her left kidney removed by a doctor in Arizona with no complications. The insurer sought cancellation of the policy on the ground that the denial of medical treatment within the five years preceding the application was false, and it produced evidence that in 1957 the insured had been diagnosed as suffering from granular urethritis and that she had been treated for that condition by two Arkansas physicians in 1957, 1958, 1959, 1960, 1962, 1964 and 1965, the treatments in 1964 and 1965 being the basis of her claim for policy benefits. The chancellor ruled that the insured had made full disclosure, and the supreme court held the finding not against the preponderance of the evidence since the application for the policy had disclosed urinary problems and a kidney removal and had given the name and address of the physician who had attended her in 1949. _McKenzie_ was cited as presenting a similar situation, but one wonders if it could safely be assumed that inquiry of the Arizona physician would have led to the insurer's discovery of the subsequent treatments in Arkansas.

The scope of the insurer's duty to investigate, in order to learn facts not disclosed by the applicant for insurance, has never been given much exposition in the Arkansas cases, nor has the source of the duty. It may well be that the cases just described are better accounted for as involving the concepts of waiver and estoppel, the unexpressed rationale being that the insurer will be charged with knowledge of facts it could have learned before issuance of the policy by following leads given by the applicant or otherwise available to the insurer. The insurer's issuance of the policy with such imputed knowledge could lead to the conclusion that it waived any misrepresentation of those facts, or that the insurer is estopped from using such misrepresentation as a defense.

Section 275 of the Insurance Code does not appear to preclude resort to waiver and estoppel, and the pre-Code cases invoking

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238. _See_ note 63 _supra_.
240. _See_ text at notes 46, 47 and 62 _supra_.
241. This has been assumed in cases governed by statutes of other states closely resembling § 275(1) of the Arkansas Insurance Code. _See_ _Wardle v. International Health & Life_
these doctrines should remain viable precedents. *Continental Casu-
alty Co. v. Campbell* supports this view. The insured under a 
health and accident insurance policy testified that he told the 
insurer's soliciting agent that he had been hospitalized for a short time 
the previous year (1960) and had been told by his physician that he 
had Asian flu, but that the agent had replied that such hospitaliza-
tion was insignificant and the agent had filled in a "no" answer to an 
application question asking whether the applicant had been medi-
cally treated or hospitalized within the past five years. The insurer 
introduced evidence that the physician who treated the insured in 
1960 had diagnosed fibrocystic disease of the left lung and advised 
the insured of the diagnosis. Upholding a judgment in favor of 
the insured, the supreme court relied on *McKenzie* for the princi-
ple that the insurer cannot complain of the applicant's failure to re-
veal a prior ailment when the applicant has disclosed information 
which would enable the insurer to learn of the illness by its own 
investigation. The court cited *Southern National Insurance Co. v. 
Heggie*, a pre-Code case, as authority for treating the knowledge 
of the insurer's soliciting agent as the knowledge of the company 
and as a basis for estoppel against the insurer to set up the falsity of 
the answer in the application as a defense.

One of the most recent Arkansas decisions involving Insurance 
Code section 275 may be thought of as bypassing the section by 
resorting to waiver or estoppel, although the decision is not ex-
plained in those terms, and it raises more questions than it answers. 
In *Ford Life Insurance Co. v. Jones*, Lamar Jones, the buyer of a 
pick-up truck, purchased through the truck salesman a policy of 
credit life insurance from Ford Life Insurance Company. Jones told 
the salesman that he had suffered a heart attack three years previ-
ously and was still under a doctor's care, but he then signed the 
insurer's printed form, which served both as application for and cer-
tificate of insurance, his signature being made beneath a bold-face 
"Health Statement" which declared that he was, to the best of his 
knowledge and belief, in good health. A ruling against the insurer 
on its misrepresentation defense was upheld by the supreme
Noting that the printed form Jones signed provided no space for qualification of the statement of good health, the court, in an opinion by Justice Hickman, asserted that, "Such a statement on such a form should not be used as a defense when, in fact, it is undisputed that there was no misrepresentation or fraudulent statement." The company's argument that the salesman who sold the insurance was merely a soliciting agent whose knowledge could not be treated as the insurer's was answered with the observation that "[s]uch a situation places an unrealistic burden on an insured which can only result in a decided advantage enuring to the benefit of the company."

Finally, as to the application of Insurance Code section 275, the court said:

We limit our decision to the facts in this case. We are not unmindful that a strong argument can be made that we are making a decision that flies in the face of our previous decisions and Ark. Stat. Ann. § 66-3208 (Repl. 1966). However, in the final analysis it is our duty to see that the law enables people to have a fair decision after their day in court and undoubtedly our decision in this case cannot be characterized otherwise.

Three justices dissented, deploring the majority's failure to attempt to reconcile the decision with the statute and prior cases. Justice Smith, in an opinion joined by Justice Fogleman, argued that prior cases, holding that under section 275 a false statement of good health in an application for a policy, if material, provides the insurer with a defense within the period of contestability, governed the case under consideration. He insisted that Jones' explanation of the state of his health to the salesman was irrelevant, since the salesman was merely a soliciting agent for Ford Life and the knowledge of such an agent is not imputable to his principal, nor does such an

247. Judgment was given on a verdict in favor of Jones's widow against the insurer for the amount owed on the pick-up truck, statutory penalty and attorney's fees. The supreme court reversed the judgment for error in awarding the amount due under the policy to the insured's widow, rather than to the finance company to whom the debt had been assigned, and for error in assessing statutory penalty and attorney's fees, but the court rejected the insurer's argument that it was not liable on the policy at all because of misrepresentation in its procurement. 262 Ark. at 883-86, 563 S.W.2d at 400-02.

248. Id. at 886, 563 S.W.2d at 402.

249. Id.

250. Id. Chief Justice Harris filed a concurring opinion, calling attention to his opinion in National Old Line Ins. Co. v. People, discussed in text at notes 206-207 supra, and commenting: "I reiterate that specific questions which certainly called for specific answers would have prevented this situation." Id. at 888, 563 S.W.2d at 403.

251. Life & Cas. Ins. Co. v. Smith, 245 Ark. 934, 436 S.W.2d 97 (1969), and Dopson v. Metropolitan Life Ins. Co., 244 Ark. 659, 426 S.W.2d 410 (1968) were cited.
agent have authority to waive the insurer's requirement of a certificate of good health as a condition to issuance of the policy.\footnote{252} Justice Byrd, in a dissenting opinion of his own (also endorsed by Justice Fogleman) agreed with Justice Smith that the case was within section 275 of the Insurance Code and that the insurer could not be affected by the conduct of the truck salesman, a soliciting agent for the insurer, but he added the suggestion that even if the salesman had been a general agent, his knowledge should not be attributed to the insurer in a case such as this, where the applicant for the policy should realize that the insurer will be deceived by the application as completed.\footnote{253}

One can only guess at the effect this decision will have on future cases, since the opinion for the court expressly acknowledges that it may be inconsistent with the statute and the cases decided under it but offers no justification except that the court should see to it that people "have a fair decision after their day in court."\footnote{254} One can sense, in this case and others, a feeling that credit life insurers seek an unfair advantage in their dealings with applicants for such insurance but a frustrated inability to find doctrine in prior cases that can legitimately be drawn upon for the protection of the insureds.\footnote{255} The problem of finding appropriate legal doctrine to eliminate the perceived unfairness is rendered more intractable by the failure of the opinions to identify with precision the factual elements in the marketing of credit life insurance which produce the unfairness.\footnote{256}

\footnote{252. 262 Ark. at 889, 563 S.W.2d at 402.}
\footnote{253. Id. at 891, 563 S.W.2d at 405.}
\footnote{254. Id. at 886, 563 S.W.2d at 402.}
\footnote{255. Though Justice Smith dissented in Jones and he wrote for the court in rejecting a contention that credit life insurance should be treated as a special category in Southern Security Life Ins. Co. v. Smith, 259 Ark. 853, 537 S.W.2d 542 (1976), he too has shown impatience with credit life insurers.}
\footnote{256. Justice Smith's discussion in People, quoted in text at note 207 supra, points to: (1) the short-term character of the policy, (2) its nonmedical character, (3) the failure of the insurer to provide space on the application form for qualifications of the printed representation of good health, (4) the absence of proof that the salesman explained the application form, and in particular the representation of good health, to the applicant, (5) the absence, in the particular case, of causal connection between misrepresented fact and loss. Chief Justice Harris, in his concurring opinion in People emphasizes the ambiguity of the declaration of good health, the case with which it can be answered incorrectly in good faith, and the desirability of insurers asking specific questions calling for precise factual information. In the Jones case he found those observations pertinent to a case where it does not appear that the applicant even thought himself to be in good health. 256 Ark. at 143, 506 S.W.2d at 131.}
D. **Section 275(2)**

The second subsection of Insurance Code section 275 provides that in any action in which the insurer proves a misrepresentation with respect to a medical impairment, if the other party to the action "shall prevent full disclosure and proof of the nature of the medical impairment, the misrepresentation shall be presumed to have been material." The subsection is evidently intended to relieve the hardship on insurers that had resulted from the interaction of the traditional rule that the burden is on the insurer to prove all of the elements of a misrepresentation defense and the statute treating confidential communications between doctors and patients as privileged.

This portion of section 275 seems of minor significance, for it does not come into play until after the insurer has proved a misrepresentation, and for purposes of proof of misrepresentation the privileged communication rules are not relaxed by the statute. In the pre-Code cases in which insurers complained of being stymied by the privileged communication rules, those rules prevented the insurers from proving either the falsity or the fraudulent character of the insureds' representations. The greatest contribution made by the Insurance Code toward lightening the insurers' burden is probably the elimination, under subsection (1) of section 275, of a need to prove that misrepresentations were made with fraudulent intent.

E. **Other Insurance Code Provisions**

In addition to section 275, the Insurance Code contains a number of other sections which have, or may have, relevance to

258. See note 87 *supra*.
259. See note 42 *supra*.
261. Subsection (2) of Insurance Code § 275 has figured in only one decision to date. In American Pioneer Life Ins. Co. v. Turman, 254 Ark. 456, 495 S.W.2d 866 (1973), it was invoked in support of a holding that the insurer was not precluded from defending under paragraphs (b) and (c) of subsection (1) by the fact that it pleaded only the defense of fraudulent misrepresentation, the reasoning being that the misstatement became prima facie material when the plaintiff prevented medical proof of fraudulent intent by invoking the physician-patient privilege. This ruling was at best an alternative holding, since the court placed primary reliance on the proposition that it would take judicial notice that cancer of the stomach of 29 months duration is material to the risks involved in writing a nonmedical policy of life insurance for one-year term. It is unclear from the opinion why either of these findings made affirmative pleading of paragraphs (b) and (c) of § 275(1) unnecessary, except that an Alabama case had made an analogous holding. Two justices dissented.
cases involving misrepresentation in the procurement of insurance. For example, the incontestability and age adjustment clauses which operated, under pre-Code law, to limit misrepresentation defenses when the insurers included such clauses in their policies, assume increased importance under the Code because they are required terms in many policies. There are also a number of Code provisions which operate either as implied limitations of the rules of section 275 or to create procedural obstacles to a successful misrepresentation defense. Detailed treatment of most of these provisions does not seem called for, as none has figured prominently in litigation thus far, and most seem unlikely to do so in the future.

Age adjustment clauses, however, may pose new problems in view of the modification of misrepresentation law embodied in section 275. As has been indicated, the cases prior to the enactment of the Insurance Code, employing common law reasoning, treated fraudulent misrepresentation of age as grounds for avoidance of the policy if the misrepresentation was material, despite the inclusion in the policy of a provision for adjustment of the amount of insurance in the event that an insured's age had been misstated. The reason-

262. See text at notes 98-105 supra.

263. As to required incontestability clauses, see Ark. Stat. Ann. §§ 66-3304 (life insurance, other than group and industrial), 66-3317 (annuity contracts, other than group), 66-3406 (industrial life insurance), 66-3510 (group life insurance), 66-3605 (disability insurance, other than group) (1980). There are some variations in detail among these provisions. See also Ark. Stat. Ann. §§ 66-3324 (1980), dealing with incontestability of reinstated life policies and annuity contracts, other than group. (Forerunners of these sections were 1949 Ark. Acts 248, § 2(2), requiring two-year incontestability clauses in policies of group life insurance, and 1951 Ark. Acts 394, § 3(A)(2), prescribing three-year clauses for policies of individual accident and sickness insurance. See also 1951 Ark. Acts 394, § 7.)

Age adjustment clauses are required, in varying terms, by Ark. Stat. Ann. §§ 66-3306 (life insurance, other than industrial and group), 66-3319 (annuity contracts, other than group), 66-3407 (industrial life insurance), and 66-3513 (group life insurance) (1980). (Prior to the Insurance Code, 1949 Ark. Acts 248, § 2(5) had required an age adjustment clause in a policy of group life insurance.)

264. For example, §§ 374 and 420 of the Insurance Code applicable to group life and group disability insurance contracts respectively, reduce the scope of § 275 by making certain representations unavailable to the insurers by way of defense unless they are in writing and copies have been given to the persons making the representations or their beneficiaries, Ark. Stat. Ann. §§ 66-3511, -3702 (1980); the chapters dealing with individual policies have no comparable requirements. Insurance Code chs. 14, 15 & 17; Ark. Stat. Ann. tit. 66, chs. 33, 34 & 36 (1980).

265. See, e.g., Insurance Code § 274 which declares the application for any life or disability insurance policy or annuity contract (other than industrial life insurance) inadmissible as evidence "in any action relative to such policy or contract, unless a true copy of those portions of the application signed by the applicant were attached to or otherwise made a part of the policy or contract when issued." Ark. Stat. Ann. § 66-3207 (1980).

266. See text at note 102 supra.
ing was that the fraud made the whole contract voidable. Innocent misrepresentation, on the other hand, did not affect the validity of the policy (unless it was the subject of a warranty). The age adjustment clause, if the policy included one, therefore gave the insurer a partial defense where, except for the clause, it would have no defense at all. Now, under the Insurance Code section 275(1), a non-fraudulent but material misrepresentation can be grounds for avoidance of the policy by the insurer. Does it follow that a non-fraudulent but material misrepresentation of age can justify avoidance of a policy which is required by the Insurance Code to include an age adjustment clause? The question almost answers itself. To treat section 275 as authority for avoidance of the policy would be virtually to nullify the portion of the statute requiring the age adjustment clause by depriving the clause of nearly all practical effect; it would be operative only to the extent that the insurer chose to rely on it rather than on section 275. The probability is that the age adjustment clause requirements were designed at least as much for the benefit of policyholders and their beneficiaries as for the protection of insurers, and to give effect to that purpose the age adjustment provisions should be treated as creating implied exceptions to the more general rule of section 275.

A somewhat more difficult question is whether fraudulent misrepresentation of age can be treated under the Insurance Code as making a policy voidable if the policy is one required by the Code to include an age adjustment clause. It would not deprive the statutory requirement of virtually all effect to allow the insurer to avoid the policy in this case, for the age adjustment clause could still be applied in favor of the policyholder or beneficiary in cases of innocent misrepresentation. The question is whether the statutory prescriptions of age adjustment clauses should be treated as intended to overrule the common law doctrine permitting avoidance for fraudulent misrepresentation, whether or not the policy contained an age adjustment clause. There is much to be said for a reading that such overruling is intended. First, it is consistent with the wording of the statutory passages mandating inclusion of age adjustment clauses; they make no express distinction between fraudulent and non-fraudulent misstatements of age. Second, to treat such clauses as controlling would avert prejudice to insurers as a result of misrepresentations of age without imposing on policyholders or beneficiaries

267. See text at notes 17 and 87 supra.
268. See text at note 156 supra.
a forfeiture of all benefits. Third, the only purpose allowing avoidance of the contract could serve would be to punish perpetrators of fraud for their misconduct, but in cases of life insurance, to which most of the statutory requirements of age adjustment clauses apply, that punishment would be more likely to fall on innocent beneficiaries than on the guilty parties. Giving the age adjustment clause requirements literal effect substitutes a satisfactory reformation remedy for the more drastic remedy of rescission in cases of misrepresentation of age.

CONCLUSION

The purpose of this study is to assess the impact of the Arkansas Insurance Code of 1959 on the law of misrepresentation in procurement of insurance. Though the cases decided under the Code make it clear that the statute, particularly its section 275, has worked change, they do not present a neat and consistent picture of the dimensions of the change. To a substantial degree the uncertainty is attributable to the drafting of the statute; it is hardly a model of clarity, and Arkansas is not the only jurisdiction whose courts have had trouble with statutory language of the sort found in section 275. Nevertheless, the Code's language can be made to yield better guidance than has thus far emerged and, it is believed, produce more satisfying results, with increased attention to two familiar principles of statutory construction: (1) that particular words and phrases should be read in the light of the context in which they appear, and (2) that insight into legislative purpose and probable meaning can often be gained from a study of the history of the law with which the statutory language deals. This article has ventured to suggest some solutions to problems of interpretation and application that have surfaced in the cases, or seem likely to, primarily by reliance on these techniques.

269. See note 263 supra.
270. In all of the cases involving age adjustment clauses cited in notes 102-105 supra, the contests were between insurers and beneficiaries or assignees of policies, the persons who had made the alleged misrepresentations having died. Of course, where annuity contracts are involved, the weight of the penalty could more often be made to fall on the perpetrator of the fraud.