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Insurance Binders Revisited

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INSURANCE BINDERS REVISITED

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Temporary contracts of insurance—binders—protect the insured during the time between completion of the application and issuance of the policy. They are an accepted and necessary part of the insurance business, used in connection with a wide variety of insurance products. But when alleged coverage under a binder is the subject of litigation, the results are often inconsistent and, sometimes, indefensible.

This article provides a comprehensive discussion of binders, including the differences between standard form and manuscript binders, binding receipts in property and casualty insurance and conditional receipts in life insurance policies, the various kinds of conditional receipts, and otherwise. The author concludes with recommendations as to how to ensure greater consistency in binder coverage litigation.

"Some of the more vexing and inconsistent judicial decisions regarding coverage stem from cases where the insurer has not yet issued or delivered the actual policy and the policyholder claims coverage based on the conditional receipt or 'binder' it received at the time of applying for insurance."[1]

1. JEFFREY W. STEMPEL, LAW OF INSURANCE COVERAGE DISPUTES § 3.05[a] (2d ed. 1999).

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I. INTRODUCTION

Over the past three decades, there have been a number of judicial cases, articles,[2] and treatise commentaries[3] written on the law of insurance "binders" as constituting temporary contracts of insurance.[4] However, with an alarming growth of confusing and inconsistent judicial decisions involving property and casualty temporary insurance binders, and life and health insurance conditional receipt binders, it is appropriate to reassess the underlying law, theory, and practice of insurance binders involving both "standard form" and "manuscript form" policies. This article makes some modest recommendations to ensure greater understanding, predictability, and uniformity in resolving coverage disputes involving insurance binders.

2. *See, e.g.*, Alan J. Pierce, *2001–2002 Survey of New York Law: Insurance Law*, 53 SYRACUSE L. REV. 673, 698–704 (2003); John Dwight Ingram, *Life Insurance Conditional Binding Receipts*, 48 FED'N INS. & CORP. COUNSEL Q. 209 (1998); Maximilian A. Pock, *Insurance*, 47 MERCER L. REV. 153, 187–89 (1995); Alan I. Widiss, *Life Insurance Applications and Interim Coverage Disputes: Revisiting Controversies About Conditional Binding Receipts*, 75 IOWA L. REV. 1097 (1990); Arnold P. Anderson, *Life Insurance Conditional Receipts and Judicial Intervention*, 63 MARQ. L. REV. 593 (1980). *See also* Annotation, *Temporary life, accident, or health insurance pending approval of application or issuance of policy*, 2 A.L.R.2d 943 (1948) and later case service (1999 and Cum. Supp. 2003) [hereinafter *Temporary life, accident, or health insurance*]; Annotation, *Temporary automobile insurance pending issuance of policy*, 12 A.L.R.3d 1304 (1967 and Cum. Supp. 2003); Annotation, *Temporary fire, wind, or hail insurance pending issuance of policy*, 14 A.L.R.3d 568 (1967 and Cum. Supp. 2003). Most of these articles have analyzed life and health insurance conditional receipt binders rather than property and casualty insurance binders.

3. *See, e.g.*, ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW § 2.3 (1988); ROBERT H. JERRY II, UNDERSTANDING INSURANCE LAW § 33 (3d ed. 2002); STEMPEL, *supra* note 1, § 3.05; 1 ALLAN D. WINDT, INSURANCE CLAIMS AND DISPUTES: REPRESENTATION OF INSURANCE COMPANIES AND INSUREDS §§ 6:36–37 (4th rev. ed. 2002). *See also* 3 ERIC MILLS HOLMES, HOLMES' APPLEMAN ON INSURANCE 2d § 10.6 (2d ed. 1998) [hereinafter HOLMES' APPLEMAN ON INSURANCE]; and LEE R. RUSS & THOMAS F. SEGALLA, 1 COUCH ON INSURANCE §§ 13:1–5 (3d rev. ed. 1997) [hereinafter COUCH ON INSURANCE].

4. JERRY, *supra* note 3, § 33, at 241: "Ordinarily, a binder is a document given to the insured that obligates the insurer to pay insurance if a loss occurs before the insurer acts upon the application." According to Professor Stempel, "a binder is a short-form temporary contract of property or casualty insurance" and a "conditional receipt" form of insurance binder "is evidence of payment and prospective—but often contingent—insurance coverage in life and health insurance." STEMPEL, *supra* note 1, § 3.05, at 3–25, 26.

Professor Arthur Leff defined a binder in this manner:

> **binder.** When one applies for insurance, the policy itself is not ordinarily issued until the application is accepted at the insurer's home office. But selling agents of the company are usually authorized to issue a "binder" (also called "agreement of insurance," "binding slip," "interim receipt," "binding receipt," "conditional binding receipt"), which will give insurance protection to the applicant while the company is deciding on the application. This protection usually will apply unless the applicant has been guilty of fraud, material misrepresentation, or something similar, but in some instances [usually involving health and life insurance binders] the coverage is more extensively conditioned.

Arthur Allen Leff, *The Leff Dictionary of Law: A Fragment*, 94 YALE L.J. 1843, 2168 (1985).

II. INSURANCE BINDERS: AN OVERVIEW

A binder is a temporary contract of insurance, consisting of an insurer's acknowledgment that it will temporarily protect the insured against a specified loss at an agreed premium until a formal policy is issued.[5] Binders are for the convenience of the applicant, to protect the insured from a risk of loss during the period between the completion of the insurance application and the acceptance of risk by the underwriter, when the formal policy is issued[6] (or until the rejection of the risk by the insurer).[7] A binder can be sketchy, informal, and temporary, but it is nevertheless an enforceable insurance contract.[8]

Although the industry has not been consistent in determining the scope and validity of insurance binders, most courts, commentators, agents, brokers, underwriters, and insurance practitioners agree that effective binders, expressly or impliedly, must include at least the following six elements: (1) identification of the insured and the insurer; (2) if a binder for property insurance, a description of the property; (3) the policy limits payable upon loss; (4) the risks covered; (5) the time in which coverage attaches under the terms of the binder; and (6) an understanding that the formal policy

5. *See, e.g.*, N. Am. Specialty Ins. Co. v. Meyers, 111 F.3d 1273 (6th Cir. 1997) (Michigan law); Great Am. Ins. Co. v. Fireman's Fund Ins. Co., 481 F.2d 948 (2d Cir. 1973) (New York and Massachusetts law); Kellner v. Aetna Cas. & Sur. Co., 605 F. Supp. 331 (M.D. Pa. 1984); Smith v. Westland Life Ins. Co., 123 Cal. Rptr. 649 (Cal. 1975); Parks v. State Farm Ins. Co., 497 S.E.2d 575 (Ga. Ct. App. 1998); Flester v. Ohio Cas. Ins. Co., 307 A.2d 663 (Md. 1973).

6. Clark v. Smith, 690 N.E.2d 604 (Ohio Ct. App. 1997); Zander v. Cas. Ins. Co. of Cal., 66 Cal. Rptr. 561 (Ct. App. 1968).

7. *See, e.g.*, Turner v. Worth Ins. Co., 472 P.2d 1 (Ariz. 1970) (automobile insurance); Title Guar. Co. of Wyo. v. Midland Mortgage Co., 451 P.2d 798 (Wyo. 1969) (title insurance); Anetsberger v. Metro. Life Ins. Co., 14 F.3d 1226 (7th Cir. 1994) (Illinois law) (life insurance). *See generally* HOLMES' APPLEMAN ON INSURANCE, *supra* note 3, § 10–6, at 25–30. A binder may be rejected or rescinded for a material misrepresentation or concealment in the application. *See, e.g.*, Fed. Mut. Ins. Co. v. Deal, 239 F. Supp. 618 (S.D. W. Va. 1965); Klopp v. Keystone Ins. Co., 595 A.2d 1 (Pa. 1991). However, rescission may not be effective in those states where compulsory automobile insurance statutes only allow prospective termination of coverage. *E.g.*, State Farm Mut. Auto. Ins. Co. v. Crouch, 706 S.W.2d 203 (Ky. Ct. App. 1986). *See generally* COUCH ON INSURANCE, *supra* note 3, § 13:5.

8. *See, e.g.*, Dugan v. Mass. Mut. Life Ins. Co., 736 F. Supp. 1072 (D. Kan. 1990); Nichols v. Prudential Ins. Co., 851 S.W.2d 657 (Mo. Ct. App. 1993); Hornby v. Penn. Nat'l Mut. Cas. Ins. Co., 303 S.E.2d 332 (N.C. Ct. App. 1983), *appeal after remand*, 335 S.E.2d 335 (1985); Strickler v. Huffins, 618 A.2d 430 (Pa. Super. Ct. 1992). *See also* Turner v. Worth Ins. Co., 472 P.2d 1 (Ariz. 1970) (unless prohibited or regulated by statute, an insurance binder constitutes a valid contract of insurance). *See generally Crouch*, 706 S.W.2d at 203. *See generally* COUCH ON INSURANCE, *supra* note 3, §§ 13:2–7.

terms, conditions, and exclusions are incorporated into the binder.[9] Not surprisingly, the last is the source of most insurance binder litigation.[10]

Insurers, brokers, agents, policyholders, and legal practitioners also must be careful to distinguish between binding receipts in property and casualty insurance, which are almost always temporary contracts of insurance, and conditional receipts in life and health insurance, which are not always deemed temporary contracts unless certain conditions are met.

For example, property and casualty insurance agents normally are general agents who have the power to bind their principal insurance companies to temporary insurance binders, absent any express limitation to their agency powers. Life insurance agents, on the other hand, are only soliciting agents who normally do not have the power to create temporary insurance coverage with a life or health insurance policy, absent approval by the insurance company's home office.[11] So life and health insurance agents can give insurance applicants only conditional, rather than binding, receipts.[12]

There are other important underlying reasons for the differences between property and casualty insurance temporary binders and life and health insurance conditional receipt binders. In property and casualty coverages, a general agent normally is able to physically inspect the property and risk of loss, and most agents possess reasonably good field judgment

9. *See, e.g.*, JERRY, *supra* note 3, § 33, at 241–42; STEMPEL, *supra* note 1, § 3.05, at 3–30, 31; HOLMES' APPLEMAN ON INSURANCE, *supra* note 3, § 10.6, at 32–33; COUCH ON INSURANCE, *supra* note 3, §§ 13:10–12. If any of these necessary elements are missing, a binder may not be enforceable. *See, e.g.*, Brody v. Chenango Mut. Ins. Co., 686 N.Y.S.2d 488, 489 (App. Div. 1999) (because the parties did not specify the effective date of coverage for fire insurance, nor indicate the terms and duration of coverage, the insurance application did not constitute an enforceable binder). *See also* Lindsay Ins. Co. v. Mead, 508 N.W.2d 820 (Neb. 1993) (a mere application for insurance did not constitute a binder if the parties did not agree on the essential elements of the binder); Bowers v. Mut. Ins. Co., 670 N.Y.S.2d 274 (N.Y. 1998) (there was no enforceable binder because there was no meeting of the minds as to which insurance carrier was to insure the property in question).

10. *See, e.g.*, Westchester Resco Co. v. New England Reins. Corp., 648 F. Supp. 842, 843 (S.D.N.Y. 1986), *aff'd*, 818 F.2d 2 (2d Cir. 1987) (New York law):

> The facts in this case are an object lesson in how not to make a contract. Although all the parties involved were apparently acting according to the general practice in the insurance industry, the rounds of letters, telegrams, binders, and policy terms that were sent in various directions among the two parties and their brokers make it difficult indeed to determine whether or not minds ever met.

11. An insurance binder is not valid if the agent does not have actual or apparent authority to act on behalf of the principal insurance company. *See, e.g.*, N. Assurance Co. v. Lark, 845 F. Supp. 1301 (S.D. Ind. 1993), *aff'd*, 17 F.3d 956 (7th Cir. 1994) (applying Indiana law). *But see* Weaver v. Metro. Life Ins. Co., 545 F. Supp. 74 (E.D. Mo. 1982) (finding apparent authority of a life insurance agent based upon "sales aids" materials provided to the applicant by the principal insurer); Service v. Pyramid Life Ins. Co., 440 P.2d 944 (Kansas 1968) (finding implied or apparent authority of an agent to bind the company by an oral contract for life insurance).

12. *See generally* EMERIC FISCHER, PETER N. SWISHER & JEFFREY STEMPEL, PRINCIPLES OF INSURANCE LAW, § 4.2 (3d ed. 2004).

concerning possible hazards to the insurer. Much greater expertise and judgment are required to ascertain a life or health insurance risk. Moreover, property and casualty insurance policies generally are renewed on an annual basis, where life insurance coverage can last a lifetime.[13] Professor Stempel clarifies these important distinctions:

> The conditional receipt and binder are not only distinguished by language and intended use but also by the types of insurance and underwriting environments in which they appear. . . [T]he conditional receipt is most common in life and health insurance, particularly life. The contingent language of the receipt allows the insurer room to "back out" of the nearly completed transaction if the prospective policyholder does not pass the underwriting process due to flunking a physical, having inaccurate application answers, and so on. Because of the nature of life and health insurance, the underwriting process takes place away from the "point of sale" and requires a significant time period for researching medical history and arranging physical exams.
>
> By contrast, property and casualty insurance can often be underwritten in the field through visual inspections by the insurance agent. Even if further inquiry is required before the insurer will commit to a full-fledged insurance policy, it usually has enough confidence in property/casualty risks to offer the temporary insurance of a binder.[14]

III. PROPERTY AND CASUALTY INSURANCE BINDERS

Binders for property and casualty insurance such as fire insurance, automobile insurance, homeowners insurance, and commercial property insurance may be oral or written, and founded on the words or deeds of an agent. Statements made by a general agent such as "You're covered" or "I'll take care of it" have been held to constitute valid oral binders.[15] So long as the requisite six elements are present,[16] a binder can and will be found.

In one illustrative case, a building contractor telephoned a property and casualty insurance agent, who represented a number of insurance companies, to obtain a builder's risk insurance policy. The agent orally told the contractor over the telephone that "he was covered." After this telephone

13. *See* 5,6 HOLMES' APPLEMAN ON INSURANCE, *supra* note 3, §§ 25–26, 36–38.

14. STEMPEL, *supra* note 1, § 3:05[a], at 3–26.

15. *See, e.g.*, Am. Universal Ins. Co. v. Kruse, 306 F.2d 661 (9th Cir. 1962); State Auto. Ins. Co. v. Babcock, 220 N.W.2d 717 (Mich. Ct. App. 1974); Dixie Ins. Co. v. Joe Works Chevrolet, Inc., 766 S.W.2d 4 (Ark. 1989); Progressive Preferred Ins. Co. v. Davis, 405 S.E.2d 529 (Ga. Ct. App. 1991); Zanninni v. Reliance Ins. Co., 590 N.E.2d 457 (Ill. 1992).

16. *See* WINDT, *supra* note 3, § 6:36 (in the event a claim arises before the actual policy is issued, the general rule is that the binder provides only as much coverage as the policy would have provided; one who accepts a binder accepts all the terms of the underlying insurance contract).

conversation, the agent scribbled the words "Insure 7750 Van Buren [Street] same as 7730" on a piece of paper. The court held that this action constituted a valid and enforceable binder for temporary insurance coverage.[17]

Like any contract, property and casualty insurance contracts must be supported by consideration.[18] This general rule is somewhat altered when an insurance binder is involved, because a valid and enforceable binder can be issued prior to the first premium payment.[19]

For commercial policyholders, the practice of the industry in creating property and casualty binders is far from consistent. Sometimes policyholders rely on the oral representations of a broker or an agent. Sometimes commitment letters are sent. Sometimes agents or brokers create a binder over the telephone or via e-mail. In some cases, a policyholder will procure insurance through a broker, and the broker and the insured will agree on the immediate attachment of temporary insurance through an informal binder while the insured's request for a formal policy is being reviewed by the insurer or lead insurer. In other cases, the insurer will insist upon using a written confirmation for any property or casualty insurance application.[20]

This problem becomes complex, of course, when a loss is incurred before the formal policy is issued:

> The insured may, in that event, contend, if the policy was prepared before the loss, that the policy terms are unreasonable, and if the policy was still being prepared at the time of loss, that the insurer prepared it in a certain manner in order to exclude coverage.[21]

Under these circumstances, the validity of the binder, and the underlying policy terms and conditions, should be governed by whether they are customary to the insurance industry, as evidenced by reference to standard

17. *See* Julian v. Spring Lake Park Agency, Inc., 166 N.W.2d 355 (Minn. 1969). *See also* Granco Steel, Inc. v. Workmen's Comp. Appeals Bd., 65 Cal. Rptr. 287 (Cal. 1968). On the other hand, when an insurance agent represents only one insurer, the designation of such insurer becomes superfluous, and the insurer's liability commences on the date of the agent's oral binder. Zander v. Cas. Ins. Co. of Cal., 66 Cal. Rptr. 561 (Ct. App. 1968). *Compare* Bowers v. Merch. Mut. Ins. Co., 670 N.Y.S.2d 274 (N.Y. 1998) (no oral binder was established where there was no meeting of the minds as to which insurance carrier would insure the property in question).

18. *See, e.g.*, Am. Hardware Mut. Ins. Co. v. BIM Inc., 885 F.2d 132 (4th Cir. 1989) (applying W. Va. law); Statewide Ins. Co. v. Dewar, 694 P.2d 1164 (Ariz. 1984).

19. *See generally* HOLMES' APPLEMAN ON INSURANCE, *supra* note 3, § 10.6, at 30; COUCH ON INSURANCE, *supra* note 3, § 13:11 (both citing as authority *Joe Works Chevrolet*, 766 S.W.2d at 4). *See also* Kellner v. Aetna Cas. & Sur. Co., 605 F. Supp. 331 (D.C. Pa. 1984). The validity of a binder likewise is not dependent on the actual payment of a premium when the applicant agrees to pay the premium bill when later rendered by the insurer. *See, e.g.*, Strickler v. Huffins, 618 A.2d 430 (Pa. Super. Ct. 1992).

20. *See generally* STEMPEL, *supra* note 1, § 3.05, at 3–28 to 29.

21. WINDT, *supra* note 3, § 6:36, at 800.

policy terms, rate schedules, and expert testimony.[22] Thus, a temporary property and casualty insurance binder, although it may be sketchy, informal, and incomplete, will be merged into the terms and conditions of the formal insurance policy that is subsequently issued.[23] But how will the parties be able to identify exactly what terms and conditions are part of this underlying policy?

In the definitive case of *Westchester Resco Co. v. New England Reinsurance Corp.*,[24] the trial judge recognized that in New York, as in most American jurisdictions, the unique nature of insurance binders justifies a special approach:

> Daily, important affairs and rights in our society are made to depend upon [insurance binders]. It is a common and necessary practice in the world of insurance, where speed is often of the essence, for the agent to use this quick and informal device to record the giving of protection pending the execution and delivery of a more conventionally detailed policy of insurance.[25]

But although a binder alone is sufficient to establish coverage, "the deal is not completely done until the policy is issued."[26] So, if loss occurs after an incomplete and sketchy binder has been issued, but before a formal policy is issued, courts normally will infer the usual terms of contemplated coverage, on the assumption that "many policy clauses are either stereotypes or mandated by public regulation."[27] Thus, standard form policy terms, conditions, and limitations will be inferred to be part of the usual terms of the insurance binder that is later merged into an underlying in-

22. *Id. See also* Westchester Resco Co. v. New England Reins. Corp., 648 F. Supp. 842 (S.D.N.Y. 1986), *aff'd*, 818 F.2d 2 (2d Cir. 1987) (New York law); DiSanto v. Enstrom Helicopter Corp., 489 F. Supp. 1352 (E.D. Pa. 1980); Pine Ridge Realty Inc. v. Mass. Bay Ins. Co., 752 A.2d 595 (Maine 2000); Terry v. Mongin Ins. Agency, 306 N.W.2d 270 (Wis. Ct. App. 1981).

23. *See, e.g.*, King v. Allstate Ins. Co., 906 F.2d 1537 (11th Cir. 1990); Hartford Ins. Co. v. Shapiro, 117 So. 2d 348 (Ala. 1960); Chevron Oil Co. v. Indus. Comm'n of Colo., 456 P.2d 735 (Colo. 1969). *See also* Brister v. Gulf Cent. Pipeline Co., 618 F. Supp. 104, 110 (W.D. La. 1985), *aff'd*, 788 F.2d 1564 (5th Cir. 1986) ("it is hornbook insurance law that a binder merges into the subsequently issued policy so that the terms and conditions of the policy, in case of conflict or ambiguity, are controlling"); Kellner v. Aetna Cas. & Sur. Co., 605 F. Supp. 331, 333 (M.D. Pa. 1984) (a binder is a "complete, temporary, or preliminary contract" effective from the time it is issued until "issuance of the formal policy or until rejection of the risk"); COUCH ON INSURANCE, *supra* note 3, § 13:8.

24. 648 F. Supp. 842 (S.D.N.Y. 1986), *aff'd*, 818 F.2d 2 (2d Cir. 1987) (New York law) (involving completed operations insurance coverage).

25. *Id.* at 845 (quoting Employers Union Ins. Co. v. Firemen's Fund Ins. Co., 412 N.Y.S.2d 121, 124 (N.Y. 1978)).

26. *Id.*

27. *Id.*

surance policy, when such terms, conditions, or limitations have not been bargained over by the parties.[28]

There is a persuasive public policy rationale for inferring binder terms from standard form policies—that is, because such referrals bring with them the beneficial effects of uniformity and predictability:

> In the ambit of property and casualty insurance, there are reams of standardized forms that are used almost universally in the insurance industry. These forms are created and copyrighted by Insurance Services Offices, Inc. which seeks regulatory approval so that the ISO coverage forms may be used in the several states. The ISO forms are periodically revised to meet problems in the industry particularly regarding breaking issues. The policy forms so promulgated are, in reality, a set of forms to be assembled to create the entire contract of insurance. Thus, numerous endorsements are created to meet the particularities of each state's law. This provides for a high degree of uniformity among insurers with respect to a particular type of coverage.[29]

However, not all property and casualty binders are based on standardized policy forms. In the alternative, a property or casualty insurance binder and its underlying policy may be a manuscript form:

> Large corporate insureds . . . often have specific concerns and, coupled with their economic clout derived from the substantial amounts of premiums paid, often negotiate specific policy provisions with the insurer. When the standard contract forms are not used, the parties may have extensive discussions over the particulars of the language used and such policies are called "manuscript" policies. In these situations, there is no standardization and therefore the wealth of case law may be of limited utility in interpreting the manuscript policy language after disputes arise.[30]

This distinction between manuscript and standard form binders and policies is important. Although a number of courts have held that certain stereotypical standard form policy terms and provisions may be read into a property and casualty insurance binder, manuscript form policy terms and provisions may be an important exception to this general rule.[31]

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28. *See, e.g.*, Auto Owners Ins. Co. v. Jensen, 667 F.2d 714 (8th Cir. 1981) (Minnesota law) (although a binder did not contain a deductible and damage occurred before the formal policy was issued, the insured nevertheless was bound by a policy deductible provision because such a provision was "an ordinary term" in policies issued by similar insurance carriers for similar risks of loss); Hartford Fire Ins. Co. v. Bonsera, Inc., 675 N.Y.S.2d 827 (Sup. Ct. 1998) (a provision in a final insurance policy that was not bargained for in the binder would not be effective unless the evidence demonstrated that such a provision is standard in the industry or was standard in policies issued by the particular insurer). *See also* N. Am. Specialty Ins. Co. v. Meyers, 111 F.3d 1273 (6th Cir. 1997) (Michigan law); and Acadia Ins. Co. v. Allied Marine Transport LLC, 151 F. Supp. 2d 107 (D. Me. 2001).

29. 1 HOLMES' APPLEMAN ON INSURANCE, *supra* note 3, § 2.1, at 190–91.

30. *Id.* at 191.

31. *See, e.g.*, Westchester Resco Co. v. New England Reins. Corp., 648 F. Supp. 842, 845–46 (S.D.N.Y. 1986), *aff'd*, 818 F.2d 2 (2d Cir. 1987) (completed operations coverage

How should a court interpret a property or casualty insurance binder that contains a provision such as: "*Manuscript form to be agreed upon*," when loss occurs after the binder is issued but before the parties have negotiated the final terms of their manuscript form policy? This interpretative conundrum was an important part of the consolidated litigation arising out of several legal actions entitled *SR International Business Insurance Co. v. World Trade Center Properties LLC*,[32] involving the horrific attack on the World Trade Center in New York City on September 11, 2001, that "changed many aspects of insurance coverage forever."[33]

The World Trade Center complex was leased by the Port Authority of New York and New Jersey for ninety-nine years to various business entities controlled by Larry Silverstein and incorporated as the World Trade Center Properties LLC (also known as the Silverstein parties). The Silverstein parties secured property insurance coverage on the World Trade Center buildings from more than twenty insurers, excess insurers, reinsurers, and

dispute) ("In essence the [New York] Court of Appeals [in Employers Commercial Union Ins. Co. v. Fireman's Fund Insurance Co., 412 N.Y.S. 2d 121, 124 (N.Y.1978)] has determined that there are two distinct types of terms in an insurance contract: the terms unique to the deal, over which the parties bargain and memorialize in a binder; and the terms that are the 'usual' or 'stereotypical' conditions and limitations which are not bargained over and which are spelled out fully for the first time in the policy. Therefore, in trying to divine the meaning of the contract with regard to unique features of coverage, the first place to look is the binder."). *See also* Progressive Cas. Ins. Co. v. C.A. Feaseguradora Nacional de Venezuela, 802 F. Supp. 1069, 1076 (S.D.N.Y. 1992), *rev'd on other grounds*, 991 F.2d 42 (2d Cir. 1993) (reinsurance coverage dispute) ("I interpret [Employers Commercial Union] to mean that if terms may fairly be characterized as 'usual' or 'stereotypical,' they form a part of the policy even if not referred to in the binder; if not, not.").

See also N. Am. Specialty Ins. Co. v. Myers, 111 F.3d 1273, 1278 (6th Cir. 1997) (Michigan law) ("all ordinary provisions and exclusions of policies issued to cover similar risks will be read into the temporary binder unless there was an express agreement at the time of the issuance of the binder which would make such provisions and exclusions inconsistent with the intent of the binder agreement"); Acadia Ins. Co. v. Allied Marine Transport LLC, 151 F. Supp. 2d 107, 125 (D. Maine 2001) ("the general rule regarding the terms of an oral binder or contract of temporary insurance pending issuance of a written policy consists, in the absence of a special agreement, of the usual provisions of contracts employed to effect like insurance").

A manuscript form binder and policy would constitute such a special agreement between the parties, and thus is an exception to this general rule.

32. 222 F. Supp. 2d 385 (S.D.N.Y. 2002), *aff'd*, 345 F.3d 154 (2d Cir. 2003) (New York law).

33. *See generally* Jeffrey W. Stempel, *The Insurance Aftermath of September 11, 2001: Myriad Claims, Multiple Lines, Arguments over Occurrence Counting, War Risk Exclusions, the Future of Terrorism Coverage, and the New Issues of Government Role*, 37 TORT & INS. L.J. 817, 817 (2002).

The author served as an expert witness for one of the twenty-two insurance companies involved in this litigation. Many court documents, depositions, and other materials are still under a confidentiality order imposed by the trial court. Any information within this article concerning the World Trade Center property insurance coverage dispute has been gleaned from public sources and public records, not from confidential or sealed documents.

Lloyd's syndicates with a primary layer of coverage and eleven excess layers of coverage, totaling approximately $3.5 billion per occurrence.[34] By September 11, "over twenty individual insurance companies had signed binders which obligated them to provide property damage insurance, but, with minor exceptions, they had not issued formal insurance policies."[35]

A number of these property insurance binders stated that the underlying policy terms and conditions to be agreed upon by the parties would be a manuscript form, using such language as "Manuscript form to be submitted,"[36] "this authorization would be subject to review and acceptance of the finalized manuscript form,"[37] and "Manuscript form to be agreed."[38]

The underlying terms and conditions of these binders were therefore of crucial importance to both the Silverstein Parties and to the insurers, and particularly so the definition of "occurrence." The Silverstein Parties had argued that two different airplanes hitting two different World Trade Center towers, coming from two different airports, constituted two occurrences that would, in effect, raise the coverage from $3.5 billion (for one occurrence) to approximately $7 billion (for two). The insurance companies argued that the World Trade Center attack was a single, highly coordinated al Qaida terrorist attack, and therefore constituted only one occurrence.[39]

The court rejected the Silverstein parties' assertion that the property insurance binders on the World Trade Center were only a "binding preliminary commitment":

> An insurance binder is a unique type of contract. While not all the terms of the insurance contract are set forth in the binder, "[a] binder is a present contract of insurance.". . . The terms of a binder are not left to future negotiation. . . . The law of New York [and elsewhere] with respect to binders does not look to the negotiations of the parties to see what terms *might* ultimately have been incorporated into a formal policy. Nor does it suggest that the parties will not be bound if they fail to agree on important terms after negotiating in good faith. To the contrary, the New York Court of Appeals has

34. *See* Pierce, *supra* note 2, at 698–99; Stempel, *supra* note 33, at 832–43. The total value of insured losses due to the collapse of the World Trade Center, excluding life insurance, is estimated to total at least $35 billion, perhaps as high as $75 billion. *Id.* at 818.

35. *World Trade Ctr.*, 222 F. Supp. 2d at 387.

36. *Id.* at 392.

37. *Id.* at 393.

38. *Id.* at 396.

39. *See, e.g.*, Stempel, *supra* note 33, at 836:

> Where the cause of loss is part of a system or policy, courts have found but one occurrence. . . . These precedents provide some support to the WTC insurers that undoubtedly will argue that the September 11th terrorism emanates from but one al Qaida/bin Laden master plan. Although this appears to be true, the fact remains that the plan had two rather discrete and separate episodes: driving one plane into the North Tower and driving a completely separate plane, operated by another airline and crew, into the South Tower, both planes commandeered in separate hijackings rather than launched as parts of one fleet.

> made clear that when a binder is signed, "the contract of insurance is closed, and the binder [becomes] in effect the same as a regular insurance policy. . . ."[40]

But what was the underlying property insurance policy in the *World Trade Center* case? There were two possibilities: (1) a WilProp2000 insurance policy form, which was submitted by some brokers to some insurance companies as an initial model for their subsequent manuscript form policies, and that included a definition of occurrence; and (2) a Traveler's Insurance Company policy form, submitted by other brokers to other insurance companies as the probable lead policy that did not include a definition of occurrence.[41]

The Silverstein Parties argued that at the time the insurers signed the binders, they were

> well aware that they were committing themselves to participate in a process in which they would ultimately agree to be bound to the contract terms negotiated by the insureds and the lead underwriter, which in this case became the Travelers Insurance Company. Thus, the Silverstein Parties argue that as of September 11th, each of these insurers was bound to the terms to which Travelers and the insureds had agreed as of that date.[42]

Three insurance companies—Hartford Fire Insurance Company, Royal Indemnity Company, and St. Paul Fire & Marine Insurance Company—argued that at the time each insurer issued its binder, it agreed to be bound on the basis of an underlying draft insurance form—the WilProp2000 form—provided by Willis of New York, Inc., broker for the Silverstein parties, and that under the definition therein, the terrorist attack on the World Trade Center was unambiguously a single occurrence:[43]

> "Occurrence" shall mean all losses or damages that are attributable directly or indirectly to one cause or to one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one occurrence irrespective of the period of time or area over which such losses occur.[44]

The Silverstein parties further argued that the WilProp2000 definition of occurrence could be construed so that two planes hitting two World Trade Center Towers within sixteen minutes would not constitute "one series of similar occurrences,"[45] but Judge Martin rejected this argument as well:

40. SR Int'l Bus. Ins. Co. v. World Trade Ctr. Prop. LLC, 222 F. Supp. 2d 385, 388–89 (S.D.N.Y. 2002), *aff'd*, 345 F.3d 154 (2d Cir. 2003).

41. *See* Stempel, *supra* note 33, at 837–43; Pierce, *supra* note 2, at 698–704.

42. *World Trade Ctr.*, 222 F. Supp. 2d at 388.

43. *Id.* at 387.

44. *Id.* at 398.

45. *Id.* The Silverstein parties, quoting Professor Stempel, *supra* note 33, at 838–43, argued that even applying the Wilprop2000 definition, there may well have been more than one occurrence.

> Under New York law, the terms of an insurance policy are interpreted from the vantage point of the "average person on the street." When interpreting a "specialized business policy", however, "the average person is not the housewife purchasing flight insurance, but the average purchaser of broad business liability insurance.". . . complex comprehensive general liability policies issued to large corporate manufacturers . . . should be viewed as if by a reasonably intelligent business person who is familiar with the agreement and with the industry in question. Normally, the court can put itself in this position, so that expert evidence need not be submitted:"
>
> While an academic may be able to come up with a strained meaning for the definition of "occurrence" in the WilProp Form, "common speech" and the "reasonable expectation and purpose of the ordinary businessman" can not. The ordinary businessman would have no doubt that when two hijacked planes hit the Twin Towers in a sixteen minute period, the total destruction of the World Trade Center resulted from "one series of similar causes."[46]

The court also rejected St. Paul's claim that it had never been bound by a formal written binder, according to the insurer's usual custom and practice, "given the overwhelming evidence to the contrary, including the fact that St. Paul billed and collected the premium for the coverage."[47]

Thus, because these three insurance companies had bound themselves on the basis of the WilProp2000 policy form, and because the WilProp definition of occurrence was susceptible to only one meaning, each insurer was, as a matter of law, liable only for one payment in the face amount of its policy.[48]

The Second Circuit Court of Appeals affirmed:

> In deciding which terms are to be implied in a binder, reliance may be placed on the extrinsic evidence of the parties' particular negotiations. In particular, we believe that any policy form [such as the Wilprop2000 policy form] that was exchanged in the process of negotiating the binder, together with any express modifications to that form, is likely the most reliable manifestation of the terms by which the parties intended to be bound while the binder was in effect. In the absence of such a policy form underlying the negotiations or sufficient extrinsic evidence of the negotiations to determine the parties' intentions, the terms to be implied would likely be the customary terms of the insurer's own form . . . unless there is evidence indicating that an understand-

46. SR Int'l Bus. Ins. Co. v. World Trade Ctr. Prop. LLC, 222 F. Supp. 2d 385, 398–99 (S.D.N.Y. 2002), *aff'd*, 345 F.3d 154 (2d Cir. 2003) at 398–99.

47. *Id.* at 397 n.4. However, there is also authority in New York and elsewhere that the doctrines of waiver and estoppel ought not to be available to bring within coverage any risks that were not covered in the first place. *See, e.g.*, Annotation, *Doctrine of Estoppel or Waiver as Available to Bring Within Coverage of Insurance Policy Risks Not Covered by Its Terms or Expressly Excluded Therefrom*, 1 A.L.R.3d 1139, 1144, 1147–49 (1965) and 2003 Cumulative Supplement.

48. *World Trade Ctr.*, 222 F. Supp. 2d at 399.

ing existed between the parties that a different policy form would apply to the binder and that the insurer was aware of its terms.[49]

Thirteen other insurers, excess insurers, and reinsurers allegedly informed by their brokers that the Travelers' policy was the "follow form" lead policy, however, are experiencing much more complex insurance coverage issues, as "occurrence" was never defined within the Travelers' lead policy, and New York case law may embrace a view of "occurrence" and multiple "occurrences" that may be more favorable to the World Trade Center policyholders than under the WilProp2000 form, unless these insurers are able to successfully argue in court that the underlying WilProp2000 policy definition applied to them as well.[50]

In the World Trade Center coverage dispute, therefore, numerous manuscript form binders were found to be based on two different underlying policies: the WilProp2000 form and the Travelers' property insurance policy. What if a number of these same insurers had agreed to "manuscript form" binders, but the parties had not agreed on any underlying policy terms or conditions? What then? Should the court resort to other standardized or stereotypical property or casualty insurance provisions to infer the underlying terms and conditions to coverage for a final policy? Or should the court find that there was no "meeting of the minds" as to exactly what the "manuscript form" binder and policy should include in the first place? In this situation, "there is no standardization, and therefore the wealth of case law may be of limited utility in interpreting the manuscript policy language after disputes arise."[51]

49. World Trade Center Properties LLC v. Hartford Fire Ins. Co., 345 F.3d 154, 169–70 (2d Cir. 2003) (New York law).

50. *See, e.g.*, Stempel, *supra* note 33, at 835–38 (citing Arthur A. Johnson Corp. v. Indem. Ins. Co., 64 N.E.2d 704 (N.Y. 1959), and other illustrative cases, all finding multiple occurrences within a short period of time that triggered higher property and casualty insurance coverage than a single occurrence).

An Associated Press article, however, reported that Swiss Re attorney Barry Ostrager said in his opening statement in federal district court on February 9, 2004, that Larry Silverstein's risk manager, Robert Strachan, allegedly negotiated numerous policies in July of 2001 with Swiss Re and other insurers that used the WilProp2000 definition of "occurrence" under which the destruction of the World Trade Center twin towers constituted only a single occurrence. RICH. TIMES-DISPATCH, Feb. 10, 2004, at C-6.

Moreover, on September 12, 2001, Mr. Strachan allegedly faxed the WilProp definition of "occurrence" to a key governmental agency and stated that the World Trade Center was "underinsured." The Silverstein parties have argued that Mr. Strachan was "confused," was "acting under extreme stress," and was "out of the loop" with day-to-day involvement in the process. Swiss Re countered that Mr. Strachan in fact "was singularly responsible" for the World Trade Center insurance, and by his own testimony "spent 75% to 80%" of his time on the matter during the summer of 2001. Swiss Re has called Mr. Silverstein's two-occurrence argument "a self-motivated hoax," and Mr. Silverstein has accused Swiss Re of "cynical and manipulative tactics" and "scurrilous" personal attacks, and of "shirking its responsibilities to both the policyholders and lower Manhattan." *See, e.g.*, Dean Starkman, *Exec's Scribbles May Cut Amount of WTC Payout*, WALL ST. J., Feb. 4, 2004, at B-1, B-6, *available at* http://homes.wsj.com/regionalnews/northeast/20040213-starkman.html.

51. 1 HOLMES' APPLEMAN ON INSURANCE, *supra* note 3, § 2.1, at 191.

Accordingly, the better view is that if the parties contract through a manuscript form binder, but there is no underlying model or draft policy terms or conditions to support it, then there is no meeting of the minds and the binder is invalid and unenforceable. Therefore, whether the parties are negotiating a "standard form" or "manuscript form" type property or casualty insurance binder, they must agree upon some "draft" or "model" terms and conditions that may be inferred to be part of the policy.

In the absence of such underlying stereotypical policy terms and conditions for "standard form" binders, and in the absence of any underlying "draft" or "model" policy terms and conditions for "manuscript form" binders, insurance applicants, brokers, agents, and underwriters negotiate at their peril regarding the binders' validity and enforceability.

IV. LIFE INSURANCE CONDITIONAL RECEIPT BINDERS

Life and health insurance companies also issue binders. When the applicant for life insurance is informed by his agent that it may be weeks or months before his application is finally acted upon by the home office, that applicant may become too apprehensive or exasperated to complete and submit it. Thus, life and health insurance companies have responded in a variety of ways, and with a variety of binders, as sales aids to retain their applicants' business.[52]

Life and health insurance binders differ significantly from property and casualty binders. The latter often may be underwritten in the field through a visual inspection of the property by an experienced general agent; and even if further inquiry is required before the insurer will commit to a formal policy, the company usually has enough confidence in its agents, and in the specific property and casualty risks, to offer temporary binder coverage.[53] In addition, if the risk potential or the premium rate experiences significant change, most property and casualty companies can adjust their premium rate, their coverage, or their limitations to coverage accordingly, because property and casualty policies are generally renewed on an annual or a semiannual basis.

Life and health insurance binders, however, generally involve only conditional rather than binding temporary coverage, based upon the insurer's need for a comprehensive underwriting process involving research of medical history and often a physical examination. Moreover, assuming that the insured pays the premiums on time or within a statutory grace period,[54]

52. *See, e.g.*, Widiss, *supra* note 2, at 1097–98; Anderson, *supra* note 2, at 593.

53. STEMPEL, *supra* note 1, § 3.05, at 3–26.

54. Every modern life insurance policy, and many other kinds of personal insurance policies, normally have a thirty- or thirty-one-day grace period in which to pay an overdue premium. *See* JERRY, *supra* note 3, § 72, at 623–26.

and that the contestability period has passed,[55] a life insurance policy can literally last a lifetime. Consequently, a life and health insurance "binder" generally is only a conditional receipt binder, rather than a temporary binding contract of insurance.[56]

Conditional receipt binders fall within one of three categories: (1) approval-type conditional receipts, where no insurance coverage comes into effect until the application has actually been approved at the insurer's home office; (2) satisfaction-type conditional receipts, where insurance coverage takes effect only if, under the insurer's objective underwriting standards, and normally based upon a later physical examination, the prospective insured was an acceptable risk at the time of the application; and (3) unconditional temporary or interim insurance during the pendency of the application.[57]

A. *Approval-Type Conditional Receipts*

Approval-type conditional receipts generally provide that no coverage will come into effect until the application has been approved by an authorized official at the company's home office.[58] The traditional approval-type conditional receipt is based on a literal and formalistic[59] interpretation of the

55. Every life insurance contract, and most health insurance contracts, contain incontestability clauses. Such clauses, often required by state statute, provide that after the policy has been in force for two years, the policy's validity will become "incontestable." *Id.* § 104B, at 825–27.

56. *See generally* Comment, *Life Insurance Receipts: The Mystery of the Non-Binding Binder*, 63 YALE L.J. 523 (1954) [hereinafter *Life Insurance Receipts*]. *See also* JERRY, *supra* note 3, § 33, at 245 ("The main reason for this disparity [between property and casualty insurance binders and life and health insurance conditional receipts] is that less expertise is needed to inspect property adequately than to evaluate a person's health.").

57. *See* Anderson, *supra* note 2, at 593; *Life Insurance Receipts*, *supra* note 56, at 528; Peter N. Swisher, *Judicial Interpretations of Insurance Contract Disputes: Toward a Realistic Middle Ground Approach*, 57 OHIO ST. L.J. 543, 606–609 (1996). *See also* JERRY, *supra* note 3, § 33[c], at 243–45; *Temporary Life, Accident, or Health Insurance*, *supra* note 2.

A conditional receipt is not effective under any of these three approaches unless the first premium has been paid with the application. *See, e.g.*, Wright v. Pilot Life Ins. Co., 379 F.2d 409 (4th Cir. 1967).

58. *See, e.g.*, W. VANCE, HANDBOOK ON THE LAW OF INSURANCE, § 40, at 239 (3d Anderson ed. 1951); *Life Insurance Receipts*, *supra* note 56, at 532–34; *Temporary Life, Accident, or Health Insurance*, *supra* note 2, § 11, at 963–67.

59. Legal formalism is the traditional view that correct legal decisions are determined by preexisting judicial and legislative precedent, and the rule of law is viewed as a complete, autonomous system of logical, socially neutral principles and rules. Judging under this formalistic theory is thus a matter of logical necessity rather than a matter of choice. *See, e.g.*, Frederick Shauer, *Formalism*, 97 YALE L.J. 509 (1988) (discussing how legal formalism still serves a legitimate function in limiting judicial discretion and judicial activism).

In an insurance law context, legal formalism is exemplified by the seminal writings of Professor Samuel Williston on American contract law in general, and insurance law in particular. The bedrock principle underlying Williston's formalistic view is that an insurance application or policy must be construed and enforced according to general principles of contract law, and courts are not at liberty to reinterpret or modify the terms of a clearly written

contract language: that the insurance application represents a mere offer on the part of the applicant and that approval of this offer by the life or health insurance company is necessary to constitute a valid acceptance.[60]

For example, in *Bedgood v. Woodman of the World Life Insurance Co.*,[61] the Georgia Court of Appeals held that an application that stated "No insurance will be in force because of this application until it has been approved and at least one monthly premium has been paid" was unambiguously an approval-type conditional receipt that required approval from the insurer's home office, and not approval by the insurer's field representative, who was only a soliciting agent.[62]

Although approval-type conditional receipts were once the most common form of life and health insurance conditional receipts,[63] a growing number of functionalist[64] judges and commentators have criticized and re-

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and unambiguous insurance policy but must look at the plain meaning thereof. *See* 2 SAMUEL WILLISTON, THE LAW OF CONTRACTS, § 6:3 (4th ed. 1998). *See also* Peter Nash Swisher, *A Realistic Consensus Approach to the Insurance Law Doctrine of Reasonable Expectations*, 35 TORT & INS. L.J. 729, 748–52 (2000).

60. *See, e.g.*, Mut. Life Ins. Co. v. Young, 90 U.S. 85 (1875); Hill v. Life & Cas. Ins. Co., 181 S.E. 104 (Ga. Ct. App. 1935); Hyder v. Metro. Life Ins. Co., 190 S.E. 239 (S.C. 1937); Kronjaeger v. Travelers Ins. Co., 22 S.E.2d 689 (W. Va. 1942); Union Life Ins. Co. v. Rinehart, 315 S.W.2d 920 (Ark. 1958); Adolf v. Union Nat'l Life Ins. Co., 101 N.W.2d 504 (Neb. 1960); Great Southwest Life Ins. Co. v. Henson, 401 S.W.2d 89 (Tex. Ct. Civ. App. 1966).

61. 382 S.E.2d 421 (Ga. Ct. App. 1989).

62. *Id.* at 422.

63. *See Temporary Life, Accident, or Health Insurance*, *supra* note 2, at 963.

64. Legal functionalism, also known as legal realism, is based on the belief that the formalist jurisprudential theory of a logical and socially neutral legal framework is rarely attainable, and may be undesirable in a changing society, and that the paramount concern of the law should not be logical consistency, but socially desirable consequences. Thus, where legal formalism is more logically based and precedent-oriented, legal functionalism is more sociologically based and result-oriented. *See, e.g.*, WILIFRED RUMBLE JR., AMERICAN LEGAL REALISM (1968); GARY AICHELE, REALISM AND TWENTIETH CENTURY AMERICAN JURISPRUDENCE (1990).

In the insurance context, legal functionalism is exemplified by the writings and influence of Arthur Corbin. Professor Corbin was a major critic of Professor Williston's "plain meaning" analysis of insurance contract interpretation. According to Professor Corbin, "[t]he main purpose of contract law is the realization of the reasonable expectations" of the contracting parties, and there is "no single rule of interpretation of language, and there are no rules of interpretation taken all together, that will infallibly lead to the one correct understanding and meaning." 1 CORBIN ON CONTRACTS § 1:1, at 535 (1993 rev. ed.). *See also* Swisher, *supra* note 59, at 753–58.

This continuing jurisprudential battle has been described by Professor Robert Jerry in this way:

> On one side are the formalists or classicists, whose champions are Professor Williston and the first *Restatement of Contracts*. The formalists care mightily about texts and the four corners of documents. They believe that words often have a plain meaning that exists independently of any sense in which the speaker or writer may intend the words. They insist that a court or a party can discern the meaning of contractual language without asking about the intentions or expectations of the parties. They contend that interpretation is appropriate only if an ambiguity appears on the face of the document. . . . In the world of formalists, an insurer that drafts a clear form should be entitled to rely

jected approval-type conditional receipts as providing only illusory coverage, since a life or health insurance applicant would receive nothing of value on its issuance, while still having to tender an initial premium payment.[65] Moreover, approval-type conditional receipts do nothing to validate an applicant's reasonable expectation of coverage.[66]

Judge Learned Hand was an early critic of approval-type conditional receipts, arguing in the landmark *Gaunt v. John Hancock Mutual Life Insurance Co.*[67] that an approval-type application preyed on "persons utterly unacquainted with the niceties of life insurance" who would "read it colloquially" and reasonably expect coverage.[68] The facts in *Gaunt* were these: After two preliminary interviews, Gaunt signed an application for life insurance with John Hancock and paid his first premium. The application stated:

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on that form in writing rates without worrying that a court will disregard the finely tuned, clear language. . . .

The other contestants in the battle for the soul of contract law are the functionalists, who are sometimes also labeled as the progressives, the realists, or the post-classicists. The champions of this side are Professor Corbin and the *Restatement (Second) of Contracts.* The functionalists care less about the text of contracts, believing it to be most useful as an articulation of the objective manifestations of the contracting parties and as a means to understanding their intentions and [reasonable] expectations. . . . Text does not have an inherent meaning. . . . Where a form is standardized, the functionalists substitute objectively reasonable expectations for whatever the particular recipient of the form understood, given that the recipient has less reason to know what the drafter means, while the drafter has insights into what the ordinary, reasonable recipient of the form is likely to understand.

Robert Jerry II, *Insurance, Contract, and the Doctrine of Reasonable Expectations,* 5 CONN. INS. L.J. 21, 55–56. *See also* Peter Nash Swisher, *Judicial Rationales in Insurance Law: Dusting Off the Formal for the Function,* 52 OHIO ST. L.J. 1037, 1039–58 (1991).

65. *See* JERRY, *supra* note 3, § 33, at 243.

66. Professor Arthur Corbin's famous first maxim of contract law was: "The Main Purpose of Contract Law is the Realization of Reasonable Expectations Induced by Promises." 1 CORBIN ON CONTRACTS § 1.1 (1952). This reasonable expectations doctrine in insurance contract law arguably led to an increased utilization of important insurance law interpretive rules in order to determine the parties' intent, contractual duties and obligations, and the meaning of disputed terms in an insurance contract through a number of contractually based "reasonable expectations" rights and remedies, including (1) the doctrine of ambiguities; (2) insurance contract unconscionability and public policy issues; (3) equitable remedies such as waiver, estoppel, election, and contract reformation; and (4) a number of other interpretive rules applied to standardized insurance contracts as contracts of adhesion. *See generally* Swisher, *supra* note 59.

Subsequently, Professor (now Judge) Robert Keeton propounded a "rights at variance with the policy language" reasonable expectations doctrine. As propounded by Professor Keeton, this functionalistic "rights at variance with the policy language" doctrine is based upon a two-prong rationale: (1) an insurer should be denied any unconscionable advantage in an insurance contract and (2) the reasonable expectations of insurance applicants and intended beneficiaries regarding the terms of insurance coverage should be honored, even though a painstaking study of the policy provisions contractually would have negated those expectations. *See* Robert Keeton, *Insurance Law Rights at Variance with Policy Provisions,* 83 HARV. L. REV. 961, 963–64, and 83 HARV. L. REV. 1281 (1970).

67. 160 F.2d 599 (2d Cir. 1947), *cert. denied,* 331 U.S. 849 (1947).

68. *Id.* at 601.

> If the first premium . . . was paid when this application was signed, and if the Company is satisfied that on the date of the completion of Part B of this application [Gaunt's medical examination] [Gaunt] was insurable in accordance with the Company's [underwriting] rules . . . and if this application, including said Part B, is, prior to my death, approved by the Company at its Home Office, the insurance applied for shall be in force as of the date of completion of said Part B. . . .[69]

Gaunt successfully completed his required medical examination, but before John Hancock could approve his application, which it undoubtedly intended to do, his body was found dead beside a railroad track in South Dakota, with a bullet in his head. Thus, Gaunt's application was not approved prior to his death, even though Gaunt was an acceptable medical risk, and therefore the insurer's promise to make coverage retroactive to the date of Gaunt's medical examination was illusory.[70]

Judge Hand applied the doctrine of ambiguities, or *contra proferentem*,[71] to this approval-type conditional receipt, and he held that Gaunt's beneficiaries were entitled to coverage:

> the ordinary applicant who has paid his first premium and has successfully passed his physical examination, would not by the remotest chance understand the clause as leaving him uncovered until the insurer at its leisure approved the risk; he would assume that he was getting immediate coverage for his money. . . The canon *contra proferentem* is more rigorously applied in insurance than in other contracts, in recognition of the differences between the parties in their acquaintance with the subject matter. . . [I]nsurers who seek to impose upon words of common speech an esoteric significance intelligible only to their craft, must bear the burden of any resulting confusion.[72]

This modern trend that rejects approval-type conditional receipts as providing only illusory coverage has been followed by a number of courts.[73] Others, however, have resorted to more questionable interpretive tactics in order to validate the applicant's reasonable expectation of coverage by finding a "constructive ambiguity" in a life or health insurance conditional

69. *Id.* at 599 n.1.

70. *See generally* Kenneth S. Abraham, *Interpretation or Regulation?* 2 NEV. L. REV. 312, 312–14 (2002).

71. *Contra proferentem* generally holds that whenever an insurance contract is susceptible to two or more reasonable interpretations, it will be liberally construed in favor of the insurance applicant or policyholder who is the nondrafting party, and strictly construed against the insurer that drafted the language. *See generally* STEMPEL, *supra* note 1, § 4.08; KEETON & WIDISS, *supra* note 3, § 2.3; JERRY, *supra* note 3, § 25A(b).

72. Gaunt v. John Hancock Mut. Life Ins. Co., 160 F.2d 599, 602 (2d Cir. 1947), *cert. denied*, 331 U.S. 849 (1947).

73. *See, e.g.*, Puritan Life Ins. Co. v. Guess, 598 P.2d 900 (Alaska 1979); DeFoure v. MFA Life Ins. Co., 596 S.W.2d 7 (Ark. Ct. App. 1980); Simses v. N. Am. Co. for Life & Health Ins., 394 A.2d 710 (Conn. 1978); Prince v. W. Empire Life Ins. Co., 428 P.2d 163 (Utah 1967).

receipt, even though no such ambiguity exists in fact.[74] Many commentators, including Professor Keeton, have criticized this practice:

> To extend the principles of resolving ambiguities against the draftsman in this fictional way not only causes confusion and uncertainty about the effective scope of judicial regulation of contract terms, but also creates an impression of unprincipled judicial prejudice against insurers.[75]

The better reasoned approach, at least for modern functionalist courts, would be to openly adopt the reasonable expectations doctrine as a legitimate legal theory, rather than attempting to judicially justify some hidden agenda by espousing an intellectually unsound argument based upon the questionable legal doctrine of a constructive ambiguity. Accordingly, the majority of American courts decline to recognize this argument.

Gaunt definitively set the tone for a majority of American courts to expressly reject approval-type conditional receipts in favor of interim insurance coverage based upon (1) the application of various reasonable expectation interpretive principles;[76] (2) the application of the doctrine of ambiguities;[77] (3) judicial invoking of public policy and unconscionability objections to approval-type conditional receipts;[78] or (4) a combination of all these factors. In short, after the *Gault* decision, there has been substantial "judicial restructuring" of the traditional approval-type life and health insurance conditional receipt.[79]

B. *Satisfaction-Type Conditional Receipts*

A "satisfaction" or "condition precedent" conditional receipt constitutes a middle-ground doctrine that fairly balances the contractual language with the applicant's reasonable expectation of coverage. Under such a conditional receipt, if a life or health insurance company determines that the applicant is insurable as a standard risk—normally through a medical ex-

74. *See, e.g.*, Ransom v. Penn. Mut. Life Ins. Co., 274 P.2d 633 (Cal. 1954); Law v. Hawaiian Life Ins. Co., 459 P.2d 195 (Haw. 1969); Prudential Ins. Co. v. Lamme, 425 P.2d 346 (Nev. 1967); Allen v. Metro. Life Ins. Co., 208 A.2d 638 (N.J. 1965).

75. Keeton, *supra* note 66, at 972. *See also* Kenneth Abraham, *Judge-Made Law and Judge-Made Insurance: Honoring the Reasonable Expectations of the Insured*, 67 VA. L. REV. 1151, 1154 (1981) ("by sometimes finding ambiguities where none apparently existed, courts have avoided explaining why an insured's expectations, even though reasonable, should override the language of the policy"); Mark Rahdert, *Reasonable Expectations Reconsidered*, 18 CONN. L. REV. 323, 327–33 (1986); Swisher, *supra* note 64, at 1058–62.

76. *See, e.g.*, Collister v. Nationwide Life Ins. Co., 388 A.2d 1346 (Pa. 1978); Quindlen v. Prudential Life Ins. Co., 342 F. Supp. 9 (W.D. La. 1971).

77. *See, e.g.*, *Guess*, 598 P.2d at 900; Toevs v. W. Farm Bureau Life Ins. Co., 483 P.2d 682 (Idaho 1971).

78. *See, e.g.*, Powell v. Republic Nat'l Life Ins. Co., 337 So. 2d 1291 (Ala. 1976); Statewide Ins. Co. v. Dewar, 694 P.2d 1167 (Ariz. 1984); Hemenway v. MFA Life Ins. Co., 318 N.W.2d 70 (Neb. 1982).

79. *See generally* STEMPEL, *supra* note 1, § 3.05[c], at 3–37 to 38.

amination of the applicant—then the insurance coverage relates back to the date of the application, but if the applicant is deemed not to be a standard medical risk, then no contract of insurance ever arises.[80]

The rationale underlying this middle ground satisfaction-type conditional receipt was succinctly stated by the Illinois appellate court in *Hildebrand v. Franklin Life Insurance Co.*[81]

> Without expressing a view on approval receipts and interim coverage, we conclude that an insurance company's good faith rejection of an applicant under [a satisfaction-type conditional] receipt may have retroactive effect. This solution "fairly balances the applicant's interest in prompt protection, if available, against the insurer's interest in accepting only risks which are insurable under its underwriting standards, gives some effect to all the terms used in the binder, and does not conflict with past decisions of the Illinois courts."[82]

Other advantages that accrue to the applicant from a satisfaction-type conditional receipt analysis are that (1) the life insurance policy becomes incontestable sooner; (2) the policy reaches maturity earlier, with a corre-

80. *See, e.g.*, Smith v. N. Am. Co. for Life & Health Ins., 775 F.2d 777 (7th Cir. 1985) (applying Wisconsin law); Hildebrand v. Franklin Life Ins. Co., 455 N.E.2d 553 (Ill. Ct. App. 1983); Simpson v. Prudential Life Ins. Co., 177 A.2d 417 (Md. 1962); Damm v. Nat'l Ins. Co., 200 N.W.2d 616 (N.D. 1972); Anderson v. Cont'l Ins. Co., 666 P.2d 245 (Okla. Ct. App. 1983); Grandpre v. Northwestern Nat'l Life Ins. Co., 261 N.W.2d 804 (S.D. 1977); Williams v. First Colony Life Ins. Co., 593 P.2d 534 (Utah 1979).

See also JERRY, *supra* note 3, § 33[c], at 243:

> The *conditional* binder creates an immediate contract of coverage conditioned upon the applicant's insurability, meaning that the coverage does not exist until the insurer is satisfied that the risk is acceptable. In a life insurance transaction, for example, this satisfaction will ordinarily exist at the time the applicant passes a medical examination. . . . [t]he conditional binder is broader than the approval binder because losses prior to the insurer's expression of satisfaction with the insurability of the risk (that is, the "approval") are covered if it turns out that the insurer was satisfied with the insurability of the risk. Thus, to continue with the life insurance example, if the applicant passes the medical exam but dies before the paperwork is processed, the beneficiaries would receive coverage under the conditional binder. . .

See also Brown v. Equitable Life Ins. Co., 211 N.W.2d 431, 434–35 (Wis. 1973):

> A majority of jurisdictions have held that the language of the conditional receipt clearly expresses the intention of the contracting parties. Thus, by applying a strict contractual construction, these courts have held that insurability is a condition precedent to the affording of insurance coverage under a satisfaction-type conditional receipt. Thus, a contract of insurance is said to arise only upon the insurance company's good faith determination that the applicant was insurable as a standard risk at the time of the application. If the insurance company determines the applicant insurable as a standard risk, then the insurance relates back to the date of the application. If the applicant is deemed uninsurable as a standard risk, then no contract of insurance will be deemed to have ever arisen.

81. 455 N.E.2d 553 (Ill. Ct. App. 1983).

82. *Id.* at 563 (quoting Am. Nat'l Bank & Trust Co. v. Certain Underwriters at Lloyd's London, 44 F.2d 640, 644 (7th Cir. 1971)). *See also* Simpson v. Prudential Ins. Co., 177 A.2d 417, 425 (Md. 1962) (citing a similar rationale for recognizing satisfaction-type conditional receipts).

sponding acceleration of dividends and cash surrender value; and (3) if the insured's birthday falls between the date of the application and the date of approval, the premium is computed at the lower rate.[83]

Most important, however, a satisfaction-type conditional receipt is able to incorporate a traditional plain meaning, Williston approach to insurance contract interpretation with a more modern and functionalistic Corbin reasonable expectations approach. For example, a widely distributed sample whole life insurance policy, with a conditional receipt application, drafted by the American Council of Life Insurance,[84] is such a satisfaction-type conditional receipt, and reads, in relevant part:

> **CONDITIONAL LIFE INSURANCE AGREEMENT**
>
> **I. No Insurance Ever in Force.** No insurance shall be in force at any time if the proposed insured is not an acceptable risk on the Underwriting Date for the policy applied for according to [Council Life's] rules and standards. . . .
>
> **II. Conditional Life Insurance.** If the proposed insured is an acceptable risk on the Underwriting Date, this insurance shall be in force. . . .
>
> **Underwriting Date.** The Underwriting Date is the date . . . of the application, or the date of the medical examination, if required. . . . whichever is later . . .
>
> **. . . NOT A "BINDER"—NO INSURANCE WHERE SECTION I APPLIES—NO AGENT MAY MODIFY**[85]

The unambiguous plain meaning of this satisfaction-type conditional receipt is evident to the insurance applicant and to the court. On one hand, this is not a temporary unconditional binder, and it does not provide coverage under section I if the proposed insured is not an acceptable risk under Council Life's underwriting rules and standards. On the other hand, this satisfaction-type conditional receipt does provide conditional coverage under section II if the insured is an acceptable risk on the underwriting date, which is defined as the date of the application or the date of the applicant's medical examination, whichever occurs later. And there is no arbitrariness of the kind disapproved by Judge Hand in *Gaunt*. Moreover, the reasonable

83. *See* WINDT, *supra* note 3, at 289 n.248.

84. A sample "Council Life Insurance Whole Life Insurance Policy," distributed by the Education Services Department of the American Council of Life Insurance, 1850 K Street N.W., Washington, D.C. 20006, states the following caveat:

> There are no "standard" life insurance policies, and the contracts vary in wording and appearance from company to company. Sometimes there are also significant differences in policy provisions. [However] [t]his policy is generally representative of [life insurance] contracts issued in the United States.

Reprinted in EMERIC FISCHER & PETER SWISHER, PRINCIPLES OF INSURANCE LAW, Appendix C-1 to C-17 (2d ed. 1994).

85. *Id.* at C-15. In the absence of a medical examination, the applicant's medical history answers on the application would be determinative. *Id.*

expectations of the applicant to coverage would anticipate a favorable medical examination or a medical history report in order to determine the applicant's risk eligibility; this is a crucial underlying requirement for most life and health insurance coverages, and one that the average applicant would understand.

Indeed, Judge Hand had no problem with John Hancock's requirement that Gaunt satisfactorily complete a medical examination or, as it turned out, two medical examinations as required by the insurer. He took issue, not with the conditional medical examination requirement, but with the insurer's arbitrary failure to approve this conditional receipt once the medical examinations were successfully concluded. However, with a satisfaction-type conditional receipt, no such arbitrary withholding of approval by the insurer is possible.

Thus, a satisfaction-type conditional receipt readily incorporates and fairly balances Professor Williston's formalistic plain meaning approach to insurance contract interpretation with Professor Corbin's functionalistic reasonable expectations approach to coverage issues. But this should not be all that surprising to modern courts and commentators since

> [a] fair reading of both *Williston on Contracts* and *Corbin on Contracts* therefore suggest[s] that there are far more similarities than differences in their respective approaches to contract law in general, and insurance coverage disputes in particular.[86]

Consequently, a substantial number of life and health insurers continue to employ satisfaction-type conditional receipt language in their applications, a substantial majority of state insurance commissioners continue to approve their forms, and a substantial majority of courts continue to recognize their validity.[87]

C. *Unconditional Temporary or Interim Insurance*

A minority of courts recognize neither approval-type conditional receipts nor satisfaction-type conditional receipts. Instead, these courts have held that the insured is entitled to unconditional temporary or interim insurance until the insurer notifies the applicant that the application has been rejected.[88]

86. Swisher, *supra* note 59, at 755.

87. *See, e.g.*, Rohde v. Mass. Mut. Life Ins. Co., 632 F.2d 667 (6th Cir. 1980) (Ohio law); Cannon v. Southland Life Ins. Co., 283 A.2d 404 (Md. 1971). *See also* STEMPEL, *supra* note 1, § 3.05, at 3–36 n.126 ("Many jurisdictions continue to apply the literal language of the various insurability receipts, which appear to dominate today's market."). Professor Stempel adds: "Approval binders appear to be on the wane, perhaps because insurers have found them insufficiently attractive to consumers and also perhaps because state regulators are less inclined to approve their use."

88. *See generally* JERRY, *supra* note 3, § 33, at 244–45:

The rationale for recognizing unconditional temporary or interim coverage in life and health insurance conditional receipt controversies is based on one of three legal arguments: (1) the reasonable expectations of the applicant to immediate interim coverage should be honored, even though this may not be what the insurer actually intended;[89] (2) the insured applicant is covered because the terms of the conditional receipt arguably were ambiguous;[90] or (3) the terms of an approval- or satisfaction-type conditional receipt are unconscionable and against public policy.[91]

The different legal effect of the conditional binder and the unconditional temporary insurance binder devolves from the different kinds of conditions that the binders contain. In the conditional binder, the condition to coverage functions as a condition precedent: the insurer need not perform its duty (that is, pay proceeds for a loss) unless and until the condition is satisfied. In the unconditional temporary binder, the condition to coverage functions as a condition subsequent: the insurer has a duty to pay proceeds upon a loss, a duty subject to being discharged if the condition is not satisfied. Thus, with the unconditional temporary binder, if the insurer ultimately determines that it does not wish to undertake the risk, the insurer nevertheless has an obligation to pay proceeds until that determination is made. . . . In other words, coverage under this kind of binder ceases to exist only upon the insurer's communication to the applicant that the application is being rejected.

See also KEETON & WIDISS, *supra* note 3, at 58–62; STEMPEL, *supra* note 1, § 3.05, at 3–25 to 40.

89. *See, e.g.*, Sanchez v. Connecticut Gen. Life Ins. Co., 681 P.2d 974, 977 (Colo. Ct. App. 1984) (an insurer that wishes to avoid liability not only must use clear, unequivocal, and unambiguous language evidencing its intent to limit temporary coverage, but also must call such limiting conditions to the attention of the applicant such that an ordinary layman would understand). *But see* Grandpre v. Northwestern Nat'l Life Ins. Co., 261 N.W.2d 804, 808 (S.D. 1977) (when a conditional receipt stated in boldface letters: "IMPORTANT: This Receipt Does NOT Provide Any Insurance Until After Its Conditions are Met," "the ordinary meaning of these words . . . would alert any ordinary person to understand what had to be completed before the temporary or interim insurance would be effective"); Jacobson v. Kansas City Life Ins. Co., 652 P.2d 909, 911 (Utah 1982) (similar holding); Collister v. Nationwide Life Ins. Co., 388 A.2d 1346, 1353–54 (Pa. 1978) (though the terms of the life insurance application and conditional receipt unambiguously provided that no temporary contract of insurance was created, the terms of the contract would be ignored in favor of the insured's reasonable expectation of coverage); Gdovic v. Catholic Knights of St. George, 453 A.2d 1040, 1042 (Pa. Super. Ct.1982) (although the insurer might not have intended to provide temporary interim insurance under a conditional receipt application, nevertheless by accepting the applicant's premium, the insurer had the burden to show by clear and convincing evidence that the applicant did not have a reasonable expectation and basis for believing that he was purchasing immediate interim insurance coverage).

90. *See, e.g.*, DeFoure v. MFA Life Ins. Co., 596 S.W.2d 7, 9–10 (Ark. Ct. App. 1980) (conditional receipts are subject to liberal interpretation under the doctrine of ambiguities in favor of the insured applicant); Simses v. N. Am. Co. for Life & Health Ins., 394 A.2d 710, 714–15 (Conn. 1978) (a conditional receipt was ambiguous because the applicant could reasonably expect coverage to take effect on a certain date, and the insurer easily could have stated in exact language that the life insurance coverage would not take effect until the company actually determined that the applicant was a standard risk, but the insurer chose instead to use ambiguous language); Gaunt v. John Hancock Mut. Life Ins. Co., 160 F.2d 599, 602 (2d Cir. 1947) (Connecticut law), *cert. denied*, 331 U.S. 849 (1947) (holding that an approval-type conditional receipt was ambiguous).

91. *See, e.g.*, Glarner v. Time Ins. Co., 465 N.W.2d 591, 595–96 (Minn. Ct. App. 1991) (provisions in a conditional receipt were ambiguous as to whether it was an approval-type

Some scholars support this unconditional temporary or interim insurance rationale when applied to conditional receipt coverage disputes:

> [I]t is arguable that in order to achieve the advantages of a system where people are not misled about the coverage provided by the temporary [conditional] receipt, it is essential that [all] binders—regardless of their language—be treated as unconditional temporary binders. This, it could be argued, fairly balances the interests of insurer and applicant. Consumers, at the time they submit their applications, desire immediate, permanent coverage, but consumers do not receive this when the insurer uses the language of a [satisfaction] or approval binder to give itself the opportunity to investigate the risk before committing to permanent coverage. The insurer, on the other hand, desires the chance to investigate the risk. . . . If the insurer does not wish to be bound on the risk, in fairness, the insurer should not issue a binder and should forgo receipt of the premium until the policy is delivered. . . .[92]

It is not correct, however, to say that all binders, regardless of their language, should be treated as unconditional temporary binders since a further analysis of the three underlying rationales for recognizing unconditional temporary or interim insurance coverage in life and health conditional receipt controversies demonstrates that unconditional temporary insurance coverage in fact does not fairly balance the interests of the insurer and the applicant in the vast majority of life and health conditional receipt coverage disputes. Let us review these underlying arguments and rationales in more detail.

1. The Reasonable Expectations of the Applicant to Immediate Interim Coverage Should Be Honored, Even Though This May Not Be What the Insurer Actually Intended

The first rationale for recognizing unconditional temporary or interim insurance coverage in life and health conditional receipt controversies is that the reasonable expectations of the applicant to immediate interim coverage should be honored, even though this may not be what the insurer actually intended. This is largely based upon Professor (now Judge) Robert Keeton's two-prong insurance law doctrine of reasonable expectations: (1) an insurer should be denied any unconscionable advantage in an insurance contract and (2) the reasonable expectations of the insurance applicants

conditional receipt or a satisfaction-type conditional receipt, and even if the provisions were given the interpretation asserted by the insurer, the conditional receipt was still unconscionable and against Minnesota's strong public policy, which was to recognize the Keeton variant of the doctrine of reasonable expectations).

92. JERRY, *supra* note 3, § 33, at 248–49 (citing Collister v. Nationwide Life Ins. Co., 388 A.2d 1346 (Pa. 1978), and Damm v. Nat'l Ins. Co., 200 N.W.2d 616 (N.D. 1972)). *See also* STEMPEL, *supra* note 1, § 3.05, at 3–35.

should be honored, even though a painstaking study of the policy provisions contractually would have negated those expectations.[93]

That an insurer should be denied any unconscionable advantage in an insurance contract is an unremarkable proposition. A majority of contemporary courts and commentators, whether they be proponents of a formalistic or a functionalistic interpretive approach, recognize and apply it in resolving insurance coverage disputes.[94]

The second principle of Professor Keeton's doctrine of reasonable expectations has been more controversial: that "the reasonable expectations of the insured to coverage should be honored, even though a painstaking study of the policy provisions contractually would have negated those expectations." Severe criticism of Professor Keeton's "rights at variance with the policy language" principle has been threefold. First, under this principle, the insurance policy need not be interpreted according to its clear and unambiguous contractual language, which is anathema to a formalistic theory of contract interpretation.[95] Second, courts that apply this reasonable expectations principle have been unable to agree on what factors constitute such a reasonable expectation to coverage and what factors do not.[96] Third, a growing number of courts and commentators have questioned the underlying doctrinal justification supporting this interpretive approach.[97]

93. *See* Keeton, *supra* note 66, at 963–64.

94. Swisher, *supra* note 59, at 765.

95. *See, e.g.*, WINDT, *supra* note 3, at 376:

> The [Keeton] reasonable expectation rule, therefore, abandons the general contract principle that the insured's legitimate expectations are necessarily governed and limited by the terms of the policy. That principle will, instead, be applied only when it is fair to do so. As a result, in proper cases, an insured may be held to be entitled to coverage despite unambiguous language in the policy to the contrary.

Id.

96. *See, e.g.*, Rahdert, *supra* note 75, at 335:

> The Keeton formula gives no hint at what factors other than the policy provisions courts might use to define the "terms" of the insurance arrangement, or how the courts are to measure the force of these external factors against the force of the restrictive policy provisions to determine which should prevail in any given instance.

Id.

See also Abraham, *supra* note 75, at 1153:

> The courts have employed the expectation principle in cases where the insured's expectation of coverage was probably real and reasonable. They have also employed it where an expectation of coverage was less probable, but the policy's denial of coverage seemed unfair. Finally, they have relied on the principle even where an expectation of coverage was improbable and the denial of coverage would not appear unfair. In short, the [Keeton] judicial concept of an "expectation" of coverage is not a monolithic one.

Id.

97. *See, e.g.*, Jeffrey E. Thomas, *An Interdisciplinary Critique of the Reasonable Expectations Doctrine*, 5 CONN. INS. L.J. 295, 333 (1998–99) (concluding that the Keeton reasonable expectations doctrine "rests on dubious assumptions" because "consumer research and empirical data tends [sic] to show that the insureds do not rationally evaluate insurance information or arrive at specific expectations of coverage").

After more than thirty years of contentious debate, a majority of state courts still have neither adopted nor rejected Professor Keeton's doctrine of reasonable expectations, but rather have ignored this jurisprudential brouhaha.[98] Consequently, except for a handful of states,[99] the current judicial trend is to restrict, reject, or basically ignore Professor Keeton's "rights at variance" reasonable expectations doctrine. For all practical purposes, it is now a discarded legal doctrine.

2. The Insured Applicant Is Covered Because the Terms of the Conditional Receipt Arguably Were Ambiguous

A second rationale for recognizing unconditional temporary or interim coverage in life and health insurance conditional receipts is that the terms of a conditional receipt are ambiguous; they should be construed against the insurer and in favor of the insured applicant as the nondrafting party.[100] This contractually based doctrine of ambiguities, or *contra proferentem*, however, is not limited to interim conditional receipt coverage disputes, but it also applies to approval and satisfaction-type conditional receipts. Most courts widely recognize the doctrine.[101]

Yet an interpretive disparity still exists. Some courts, for example, will apply the doctrine of ambiguities strictly against the insurer, irrespective

98. *See* Swisher, *supra* note 59, at 776. As Professor Abraham observes:

> [E]ven in the states where it is in force, the expectations doctrine is static. It is not developing, evolving, or changing. There are very few if any decisions that apply the doctrine in a new way or uncover unrecognized implications of prior applications. On the contrary, the expectations doctrine is going nowhere.

Kenneth S. Abraham, *The Expectations Principle as a Regulative Ideal*, 5 CONN. INS. L.J. 59, 63 (1998–99).

99. *See* Jeffrey Stempel, *Unmet Expectations*, 5 CONN. INS. L.J. 181, 193–195 (1998–99) (listing states that have adopted the Keeton doctrine).

100. *See, e.g.*, Puritan Life Ins. Co. v. Guess, 598 P.2d 900 (Alaska 1979); De Foure v. MFA Life Ins. Co., 596 S.W.2d 7 (Ark. Ct. App. 1980); Simses v. N. Am. Co. for Life & Health Ins., 394 A.2d 710 (Conn. 1978); Toevs v. W. Farm Life Ins. Co., 483 P.2d 223 (Idaho 1971).

101. *See generally* STEMPEL, *supra* note 1, § 4.08; Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531 (1996). Some commentators would like to see the doctrine of ambiguities abolished as unfairly slanted in favor of the insured policyholder. *See, e.g.*, Michael B. Rappaport, *The Ambiguity Rule and Insurance Law: Why Insurance Contracts Should Not Be Construed Against the Drafter*, 30 GA. L. REV. 171 (1995); David S. Miller, Note, *Insurance as Contract: The Case Against the Ambiguity Rule*, 88 COLUM. L. REV. 1849 (1987). These critics argue that insurance law should be more symmetric and not disfavor the insurer as the drafter.

This criticism is misplaced. *Contra proferentem* is not peculiar to insurance law but is a well-accepted principle of general contract law. *See* ALLAN FARNSWORTH, CONTRACTS §§ 7.7–7.10 (3d ed. 1999); *Restatement (Second) of Contracts* § 206 (1981) (recognizing *contra proferentem*). It should continue to play a legitimate role in the resolution of insurance contract disputes. *See* FISCHER, SWISHER & STEMPEL, *supra* note 12, § 2.05, at 100–102.

of whether the insured is a sophisticated policyholder[102] or not.[103] Others hold that if the policy terms are ambiguous, then extrinsic evidence should be permitted to ascertain the parties' intent and *contra proferentem* should be relied upon only as a last resort interpretive tie-breaker.[104]

Regardless of how courts apply the doctrine of ambiguities, however, most continue to criticize the "constructive ambiguity" approach of finding ambiguities in a life or health insurance conditional receipt, even though no such ambiguity exists.[105]

Thus, the application of this doctrine is not limited to unconditional temporary or interim insurance binders; it also applies to approval-type conditional receipts, to satisfaction-type conditional receipts, and indeed to the entire panoply of insurance contract interpretive rules and doctrines. As Professor Stempel observes:

> *Contra proferentem* continues to have force when applied to many coverage questions because most policyholders are nondrafters who have nothing to say about the language of the contract. Consequently, if someone has to lose a contract dispute, one can make a good case [that] it should be the nondrafting policyholder. . .
>
> The complex nature of insurance, the information disparity between insurer and policyholder, the virtual necessity for insurance, and the industry's ability to collaborate on contract terms without legal liability (because of the McCarran-Ferguson Act's anti-trust exception for insurers) all make modern

102. A "sophisticated policyholder" is one whose business insurance policies are negotiated and drafted on its behalf by sophisticated insurance brokers, risk managers, and/or legal counsel. *See* BARRY OSTRAGER & THOMAS NEWMAN, HANDBOOK ON INSURANCE CONTRACT DISPUTES 26–36 (9th ed. 1998). *See also* Jeffrey Stempel, *Reassessing the "Sophisticated" Policyholder Defense in Insurance Coverage Litigation*, 42 DRAKE L. REV. 807 (1993); Hazel Glenn Beh, *Reassessing the Sophisticated Insured Exception*, 39 TORT TRIAL & INS. PRACTICE L.J. 85 (2003). Not all commercial policyholders are "sophisticated policyholders," however, especially those commercial policyholders that use standardized insurance contracts or terms. *Id.* at 118–119; Swisher, *supra* note 59, at 733–42.

103. *See, e.g.*, St. Paul Mercury Ins. Co. v. Grand Chapter of Phi Sigma Kappa, 651 F. Supp. 1042 (E.D. Pa. 1987) (applying the doctrine of ambiguities to commercial policyholders as well as to ordinary consumers unless the parties possessed equal bargaining power); Outboard Marine Corp. v. Liberty Mut. Ins. Co., 607 N.E.2d 1204 (Ill. 1992) (the sophistication of the insured is irrelevant when applying the doctrine of ambiguities). *But see* E. Associated Coal Corp. v. Aetna Cas. & Sur. Co., 632 F.2d 1068, 1080 (3d Cir. 1980) (Pennsylvania law) ("the principle that ambiguities in policies should be strictly construed against the insurer does not control the situation where large corporations, advised by counsel and having equal bargaining power, are the parties to a negotiated policy"); Eagle Leasing Corp. v. Hartford Fire Ins. Co., 540 F.2d 1257, 1261 (5th Cir. 1976) (Missouri law).

This "sophisticated policyholder" interpretive rule normally applies to commercial property and casualty business insurance, but it might arguably have application to group life and health insurance policies as well.

104. *See, e.g.*, Rainer Credit Co. v. W. Alliance Corp., 217 Cal. Rptr. 291 (Ct. App. 1985); Gen. Am. Life Ins. Co. v. Barrett, 847 S.W.2d 125 (Mo. Ct. App. 1993).

105. *E.g.*, Morgan v. State Farm Life Ins. Co., 400 P.2d 223 (Or. 1965); Comment, *Reasonable Expectations: Contract Ambiguity vs. Arbitrary Application*, 34 DRAKE L. REV. 1065 (1985–86).

> consumer insurance a stronger case for calling close questions in favor of the nondrafter than were presented in the customized land lease, sale of goods, and shipping contracts, from which the ambiguity doctrine sprang. Thus, the implicit rationale of *contra proferentem* continues with some vigor [in the interpretation of insurance coverage disputes].[106]

Accordingly, if *contra proferentem* is used responsibly, it will continue to play an important role in resolving coverage disputes and in interpreting life and health insurance conditional receipt coverage disputes in particular.[107]

3. The Terms of an Approval-Type or Satisfaction-Type Conditional Receipt Are Unconscionable and Against State Public Policy

A third rationale for recognizing life and health insurance conditional receipts as unconditional temporary or interim insurance is that the basic terms of approval-type conditional receipts and satisfaction-type conditional receipts are unconscionable and void as against public policy.[108]

The bedrock rule for unconscionability is found in *Restatement (Second) of Contracts*, section 208:

> If a contract or term thereof is unconscionable at the time the contract is made, a court may refuse to enforce the contract, or may enforce the remainder of the contract without the unconscionable term, or may so limit the application of an unconscionable term as to avoid any unconscionable result.[109]

The genesis of this rule is that most insurance contracts, rather than being the result of equal bargaining power, are often contracts of adhesion.[110] The unconscionability rule therefore states that (1) the insured's reasonable expectation to coverage on reading the insurance contract should guide that contract's construction and (2) these insurance contract provisions should not reach a result that is unconscionable.[111] This unconscionability rule is the outgrowth of general contract law, which has long

106. Stempel, *supra* note 33, at 810–11. *See also* Swisher, *supra* note 57, at 583–89.

107. *See, e.g.*, STEMPEL, *supra* note 1, § 4.08 (defending a restrained use of the insurance law doctrine of ambiguities and finding criticisms of *contra proferentem* to be greatly exaggerated); Swisher, *supra* note 57, at 583–89 (concluding that a continuing role for the doctrine of ambiguity in insurance contract disputes is reasonable and appropriate in determining insurance policy meaning).

108. *See, e.g.*, Anderson v. Country Life Ins. Corp., 886 P.2d 1381 (Ariz. Ct. App. 1994); Glarner v. Time Ins. Co., 465 N.W.2d 591 (Minn. Ct. App. 1991).

109. RESTATEMENT (SECOND) OF CONTRACTS § 208 (1981).

110. *See, e.g.*, Prudential Ins. Co. v. Lamme, 425 P.2d 346, 347 (Nev. 1967):

> An insurance policy is not an ordinary contract. It is a complex instrument, unilaterally prepared, and seldom understood by the assured. The same is equally true of the conditional receipt. The parties are not similarly situated. The company and its representatives are expert in the field; the applicant is not. A court should not be unaware of this reality and subordinate its significance to strict legal doctrine . . .

111. COUCH ON INSURANCE, *supra* note 3, § 22:11, at 22–23.

recognized that some terms in a contract of adhesion are so one-sided that they should not be enforced, even if the parties both were aware of the intended effect of these contractual provisions at the time of contracting.[112]

Moreover, as the insurance business is influenced by a strong public interest and is heavily regulated through state legislative statutes, judicial decisions, and administrative regulations,[113] it is appropriate that public policy should play a role. Thus, a determination of whether an insurance contract provision is in violation of state public policy is another important component found in the doctrine prohibiting unconscionable insurance contracts.[114]

A number of courts, therefore, have held that since approval-type conditional receipts provide only illusory coverage, they are unconscionable and against state public policy. But what about satisfaction-type conditional receipts? Are they similarly void?

In *Glarner v. Time Insurance Co.*,[115] the Minnesota Court of Appeals was presented with a health insurance conditional receipt binder that included the following provisions:

> *No insurance will become effective prior to policy delivery. Except, insurance may become effective prior to the policy delivery if and when each and every condition contained in this receipt is met. . .*
>
> 1. The Proposed Insured(s) must be, on the Effective Date . . . a risk acceptable to the Company under its rules, standards and practices for the exact policy and premium applied for, without modification.
>
> . . .
>
> 3. The policy is issued exactly as applied for within 60 days from the date of the application. If the policy is not issued within 60 days from the date of the application, then this condition has not been fulfilled and there will be no coverage provided under the terms of this conditional receipt . . .[116]

This was a unique hybrid situation, in that condition 1 was a satisfaction-type conditional receipt and condition 3 was an approval-type conditional receipt. The court could have found that an ambiguity existed between these two inconsistent provisions, or it could have voided condition 3 as

112. *Id.* at 22–27. *See also* HOLMES' APPLEMAN ON INSURANCE, *supra* note 3, § 8.6.

113. *See, e.g.*, Spencer Kimball & Werner Pfennigstorf, *Legislative and Judicial Control of the Terms of Insurance Contracts*, 39 IND. L.J. 675 (1964); Spencer Kimball & Werner Pfennigstorf, *Administrative Control of the Terms of Insurance Contracts*, 40 IND. L.J. 143 (1965).

114. *See generally* HOLMES' APPLEMAN ON INSURANCE, *supra* note 3, §§ 9.1–9.8; STEMPEL, *supra* note 3, § 4.10.

115. 465 N.W.2d 591 (Minn. Ct. App. 1991).

116. *Id.* at 593–94.

unconscionable,[117] which would have created coverage under the condition 1 language, because the applicant had taken his medical examination and was deemed an acceptable insurable risk under the company's underwriting guidelines. Instead, the Minnesota appellate court struck down both the approval and satisfaction conditional receipt provisions as being contrary to public policy:

> Conditional receipts can be categorized into three types. First, the approval type provides that the policy takes effect at a certain date, but with the added proviso that the application must be accepted by the company. There is no contract without company acceptance. Second, the condition precedent type of receipt creates an immediate contract, but coverage does not take effect until the company is satisfied that the risk is acceptable. The effect of these two types of receipts is to offer illusory coverage and to give the company a premium for a period of time during which the applicant remains more or less uninsured. . .
>
> . . .
>
> Even if the clause were given the interpretation asserted by the appellant, however, coverage would have to be found in favor of the respondent [applicant] because, as interpreted by the appellant [insurer], the clause is unconscionable.[118]

Consequently, *Glarner* found temporary interim health insurance coverage existed in favor of the insured applicant under the doctrine of reasonable expectations.[119]

Assuming that an approval-type conditional receipt does provide illusory coverage (and therefore has wisely been rejected in a large number of states), why did the Minnesota court also apparently apply this same unconscionability test to satisfaction-type conditional receipts that, to date, have been upheld as valid by a substantial number of state legislatures, insurance commissioners, and judicial decisions?

State public policy normally is expressed through the legislature and the duly authorized state insurance commissioner because a state possesses a valid right to regulate the business of insurance for the public good.[120] This

117. The *Glarner* court did find that condition 3 was an approval-type conditional receipt that provided illusory coverage, and also that there was ambiguous language in the conditional receipt application. *Id.* at 595.

118. *Id.* But then, paradoxically, the court implies that satisfaction-type conditional receipts *would* be upheld in Minnesota, citing Wallace v. Time Ins. Co., 387 N.W.2d 468, 470 (Minn. Ct. App. 1986), and stating that "a condition 1 case [a satisfaction-type conditional receipt] does not control in this condition 3 case [an approval-type conditional receipt]." *Id.* at 596.

119. *Id.* at 597.

120. *E.g.*, Cal. State Auto. Ass'n Inter-Ins. Bureau v. Maloney, 341 U.S. 105 (1951); Swanco Ins. Co. v. Hager, 879 F.2d 353 (8th Cir. 1989).

includes the state insurance commissioner's authority to approve policy forms and premium rates.[121]

It is true that a state court judge, as well as a state insurance commissioner, also can determine when an insurance policy is unconscionable.[122] But how far should this judicial discretionary power reach? Should a judge give due deference to the prior decisions made by a state insurance commissioner regarding whether or not to approve or disapprove certain insurance forms in general, and conditional receipt forms in particular, as legal formalists generally believe? Or should a judge overtly assert his or her co-equal power and authority to declare certain insurance policy forms, including conditional receipt forms, to be unconscionable, as legal functionalists generally believe?

A persuasive approach to this interpretive conundrum can be found *Kirk v. Financial Security Life Insurance Co.*,[123] where the Illinois Supreme Court stated:

> The Director of the Department of Insurance is required by statute to review policies of insurance in certain categories and approve or disapprove them, based on criteria including the established public policy of this State.
>
> . . .
>
> The approval of [certain language] in policies of insurance by the Department, although not conclusive upon the courts, is, however, entitled to great weight as against the contention that such a provision is against public policy.
>
> In our case, pursuant to the command of the legislature, we must assume that the Director has reviewed the provisions of the insurance policy in question to ascertain whether its provisions were "unjust, unfair, [etc.] or contrary to law or to the public policy of this State." The long-established approval of [particular provisions] in insurance policies similar to that contained in the policy in question, in the absence of any action by the legislature countermanding the approval by the Director of such provisions, is strong evidence that the General Assembly does not consider the use of such [provisions] violative of public policy.
>
> . . .
>
> The regulation of insurance has long been the prerogative of the legislature, and we should not usurp that authority . . .[124]

121. *See, e.g.*, Mut. Life Ins. Co. v. Daddy$ Money Inc., 646 S.W.2d 255 (Tex. Ct. Civ. App. 1982); Minnehoma Ins. Co. v. Okla. State Bd., 562 P.2d 1152 (1977).

122. *See, e.g.*, L'Orange v. Medical Protective Co., 394 F.2d 57 (6th Cir. 1968) (Ohio law); Sands v. Granite Mut. Ins. Co., 331 A.2d 711 (Pa. 1974). *See also* RESTATEMENT (SECOND) OF CONTRACTS § 208 (1981). *See generally* Kimball & Pfennigstorf, *supra* note 113.

123. 389 N.E.2d 144 (Ill. 1978) (involving time limitation periods for accidental death benefits).

124. *Id.* at 147–49.

Kirk therefore recognized the need to look at prior regulatory precedent from the state legislature and from the state insurance director or commissioner in approving or disapproving similar insurance forms over a long-established period of time, while at the same time recognizing that, although not conclusive, this approval or disapproval of insurance forms by the state insurance department was entitled to great weight in determining whether or not such policy provisions were unconscionable and void as against state public policy. This important interpretive factor, however, was basically ignored by the *Glarner* court, in a decision that effectively circumvented the legitimate power and authority of the Minnesota legislature, and the Minnesota insurance commissioner, to approve or disapprove insurance policy forms within that state.

Is there any viable way to provide a legitimate "unconditional" conditional receipt that unambiguously grants the applicant interim life or health insurance coverage without the unwelcome possibility that some state court judges may overtly extend—and perhaps abuse—their judicial discretion in an unwarranted manner while interpreting the validity of life and health insurance conditional receipts? Professor Alan Widiss suggests that

> [t]he interests of consumers would be . . . better served by offering those customers who want interim protection the option of buying a temporary life insurance policy that would provide protection until either the coverage sought by the applicant goes into effect or the individual is notified that the application has been rejected. Allowing applicants to decide whether to buy such coverage also will create marketing arrangements in which the insurer and the applicant have the same actual [or reasonable] expectations about whether interim coverage is provided.[125]

But in the absence of a clear and unambiguous conditional receipt providing interim or temporary coverage to an applicant, the better reasoned, and eminently more realistic, approach to life and health insurance conditional receipts is for state courts, state legislatures, and state insurance commissioners to disapprove and reject approval-type conditional receipts that provide only illusory coverage while continuing to recognize and validate clearly drafted and unambiguous satisfaction-type conditional receipts that fairly balance the contractual language of a conditional receipt with the applicant's reasonable expectation of coverage.

Thus, except in a relatively small number of states holding that life and health insurance conditional receipts constitute temporary interim insurance,[126] satisfaction-type conditional receipts in fact and in law are *not* un-

125. Widiss, *supra* note 2, at 1118.

126. Temporary or interim conditional insurance coverage is sold by various life and health insurance companies in selected states, including Alaska, California, Kansas, Nevada, Minnesota, New Jersey, and Pennsylvania. *See* FISCHER, SWISHER & STEMPEL, *supra* note 12, at 304.

conscionable or void as against public policy, and consequently satisfaction-type life and health insurance conditional receipts should continue to be recognized, validated, and legally upheld in the vast majority of American jurisdictions.

V. CONCLUSION

Insurance binders constitute temporary contracts of insurance until a formal insurance policy can be issued. Although an insurance binder may be sketchy, informal, and temporary, it is still an enforceable insurance contract. At a minimum, effective insurance binders expressly or impliedly must include the following six elements: (1) an identification of the insured and the insurer; (2) if a property insurance binder, a description of the property; (3) the policy limits payable on loss; (4) the risks covered; (5) the time in which coverage attaches under the terms of the binder; and (6) an understanding that subsequent formal policy terms, conditions, and exclusions are incorporated into the binder. Not surprisingly, requirement (6) is the source of most insurance binder litigation.

Property and casualty insurance binders, which are almost always temporary contracts of insurance, may be oral or written, and can be founded on the words or deeds of an agent. But although a binder alone is enough to establish coverage, "the deal is not completely done until the policy is issued." So if loss occurs after an incomplete binder has been issued, but before a formal insurance policy has been issued, courts normally will infer the "usual terms" of contemplated coverage from "standard form" or "stereotypical" policies utilized by a particular insurer, or by similar property or casualty insurance companies. A major problem arises, however, with "manuscript form" insurance policies and binders, which do not rely on "standard form" or "stereotypical" policy forms; accordingly, in these situations, there is no policy form standardization and, therefore, the wealth of case law may be or limited utility in interpreting manuscript policy language after such coverage disputes arise. Consequently, if the parties utilizing "manuscript form" binders have not agreed on some "draft" or "model" underlying policy language for their final manuscript policy, then arguably there has been no meeting of the minds, and no valid binder.

Life and health insurance companies also provide their prospective insureds with various types of binders. Life and health insurance binders, however, differ significantly from property and casualty insurance binders in that the life and health insurance binders generally only provide conditional coverage rather than binding temporary coverage. There are three types of life and health insurance conditional receipt binders: (1) "approval" type conditional receipts, (2) "satisfaction" type conditional receipts, and (3) unconditional temporary interim insurance coverage.

"Approval" type conditional receipts, once the most common form of life and health insurance conditional receipts, have been severely criticized by most modern commentators and courts for providing only illusory coverage, and therefore "approval" type conditional receipts have been widely rejected by a majority of state courts, legislatures, and state insurance commissioners based upon contract ambiguity, unconscionability, and public policy grounds. On the other hand, unconditional temporary or interim insurance coverage, which is currently recognized in only a small minority of states, also has been criticized for providing interim insurance through the use of questionable judicial tactics in order to provide interim insurance coverage that was never intended by the insurer in the first place.

The better reasoned majority approach today, however, is for state legislatures, state insurance commissioners, and state courts to recognize, validate, and uphold clearly drafted and unambiguous "satisfaction" type conditional receipts that fairly balance the contractual language of a life and health insurance conditional receipt with the insurance applicants reasonable expectation to coverage.