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IN THE SUPREME COURT OF THE STATE OF FLORIDA
CASE NO. 90,747
4TH DCA CASE NO. 96-01418

ALLEN GREEN,

Petitioner,

vs.

LIFE & HEALTH OF AMERICA,

Respondent.

REPLY BRIEF

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ARGUMENT

Life & Health of America's brief asks this Court to disregard an essential term of the insurance application which is an integral part of the insurance contract. The insurance company's attempt to explain away a term of the contract which it drafted is valiant but, nevertheless, futile. If a "knowledge and belief" standard was unimportant and immaterial, Life & Health of America should not have included it .

Based upon the terms and conditions of the insurance application, as drafted by Life & Health, this case should not be governed by Florida Statute 8627.409. Just as in the case of ***William Penn Life Ins. Co. of New York v. Sands,*** 912 F.2d 1359 (11th Cir. 1990), the insurance application sets forth a "knowledge and belief" standard which imposes a "different requirement of accuracy than that provided in $627.409. " ***Sands,*** *supra*, at 1364, Life & Health should not be able to hide behind the "strict accuracy" standard set by this statute when it itself voluntarily chose to impose a less restrictive "knowledge and belief" standard in its application. ***Carter v. United of Omaha,*** 685 So.2d 2 (Fla. 1st DCA 1996). Any contrary holding permits this insurance company to mislead or deceive an applicant as to the degree of accuracy (i.e., his own belief versus a medical corroboration) required on the application. ***National Union Fire Ins. Co. v. Sahlan, 999*** F.2d 1432 (11th Cir. 1993).

The case of ***Continental Assurance Co. v. Carroll, 485*** So.2d 406 (Fla. 1986) is not in conflict because it was decided on a different issue than what is now

before the Court. The *Carroll* case did not consider the effect of an insurance application that sets up only a knowledge and belief standard rather than a requirement of absolute accuracy when responding to questions on an insurance application. Nothing in Section 627.409 prevents an insurance carrier from utilizing this distinctly different standard of accuracy in its application. As the court noted in the *Carter* case, *supra,* "once the insurer sets its own standard by contract for judging misrepresentations and concealment, it cannot rely on a statute that imposes more stringent requirements on an insured. " *See, also: William Penn Life Ins. Co. v. Sands, supra; Hauser v. Life General Security Ins. Co., 56* F.3d 1330 (11th Cir 1995); *National Union Fire Ins. Co. of Pittsburgh, Pa. v. Sahlan, 999* F. 2d 1352 (11th Cir. 1993).

The *Carroll* case is distinguishable for the additional reason that the undisputed evidence establishes that Mr. Green (unlike the *Carroll* plaintiff) was completely unaware that he suffered from any of the specific medical conditions which were particularly described in the insurance application. Mr. Green's health care providers all testified that Mr. Green had no knowledge he suffered from kidney "failure" or "chronic obstructive pulmonary disease." Indeed, prior to the hearing on Life & Health's summary judgment motion, the parties stipulated on the record to the fact that Mr. Green was unaware that he suffered from any medical condition identified in the insurance application.' Under the plain provisions of the

'The insurance amicus brief asserts that Mr. Green knew his health was "impaired" to some extent because he had consulted physician(s). This is irrelevant

insurance contract, specific knowledge of these precise conditions was required to trigger "yes" answers on the application.

Life & Health continues to overlook the critical factual distinction between the instant case and the ***Carroll*** case, ***supra,*** where a plaintiff has specific knowledge of the existence of a heart defect, yet deliberately denied this fact on a GENERALLY worded insurance application which asked the mother if she knew whether her child was "in good health and free from deformity or defect. " Carroll, ***supra,*** at 407. The same facts that distinguish the ***Carroll*** case also prevent the foreign courts' decisions cited by Life & Health from having any persuasive value. In each of those decisions, clear evidence established that the plaintiff made knowing misrepresentations on the insurance application. ***Curtis v. American Community Mutual Ins. Co.,*** 610 N.E. 2d 871 (Ind. 4th DCA 1993) (plaintiff omitted 1987 doctor's exam and diagnosis on application); ***Hite v. American Family Mutual Ins.*** Co., 815 S.W. 2d 19 (MO. App. 1991) (plaintiff denied shortness of breath and chest pain within ten years on insurance application, yet told her doctor three months later that she had suffered such problems for more than one year); ***Methodist Medical Center of Illinois v. American Medical Security Inc., 38*** F.3d 316 (7th Cir. 1994) (plaintiff denied any "indication, diagnosis, consultation, treatment or taken medication for.. .heart" despite knowledge she suffered from

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in light of (1) the stipulation that Mr. Green had no knowledge of any requisite physical conditions identified in the insurance application, and (2) the application did not inquire whether he was generally aware of his health status.

silent myocardial ischemia, recurrent supraventricular tachycardia, hypertension, and was taking medication for an irregular heartbeat and high blood pressure); *Oakes v. Blue Cross Blue Shield of Columbus,* Inc., 317 S.E. 2d 315 (Ga. App. 1984) (identification of two rather than fifteen hospitalizations on insurance application); *Tharrington v. Sturdivant Life* Ins. Co., 443 S.E.2d 797 (N.C. App 1994) (no admission of treatment for persistent cough, discomfort in breathing, and occasional wheezing and asthmatic symptoms three months prior to an application which asked for information about any consultation or treatment during the last twelve months for "lungs"). The *Hite* and *Methodist* cases are distinguishable for the additional reason that both of those insurance applications included a statement by the applicant that the insurance company could rely and act on the representations when issuing the policy.

In attempting to justify the summary judgment in this case, Life & Health tries to convince this Court that its one-page insurance application should be read in a piecemeal, disjointed fashion rather than in its entirety as required by the case law.[2] The insurance company argues that yes/no responses to questions regarding precise medical conditions should be considered in a vacuum as unequivocal misrepresentations of fact that are unrelated to the acknowledgement on the application which states that information is accurately provided based upon the

[2]Life & Health asserts at pages 3 and 4 of its brief that questions regarding the applicant's physical condition did not contain any reference to the insured's "knowledge and belief" and that *later* in the application, there is a statement regarding completion of the application to the "best of my knowledge and belief".

applicant's "knowledge and belief." Life & Health would have this Court divide this short, one-page application into two unrelated parts by arguing that the question "have you or your spouse within the past 5 years had or been told you have the following conditions" should be read separately and independently from the certification which follows less than one inch further down the page which states that "the answers are full, true and complete to the best of my knowledge and belief. All statements made herein are deemed representations and not warranties.. . " Life & Health's interpretation of its own insurance application requires a violation of all rules of insurance policy construction.

Life & Health attempts to convince this Court that it should overlook the obvious differences between an insurance application which tells an applicant to provide "true" information and one which asks the applicant for information which is true "to the best of his knowledge and belief." Where an insurance carrier asks for information which is "true," it has imposed a standard of absolute factual accuracy. "True" answers are verifiable, precise, undisputed, and correct; the applicant's best efforts, personal know ledge, and intentions are irrelevant. A "true " standard advises the applicant that his own perceptions are not enough and that there is no margin for error or misunderstanding. On the other hand, a "knowledge and belief" standard asks only for a response based on the applicant's understanding of the facts. A "knowledge and belief" standard requires only that the applicant avoid misrepresentations; he cannot lie or inaccurately set forth his knowledge. Under a "knowledge and belief" standard, the applicant's "belief

cannot be clearly contradicted by the factual knowledge on which it is based. In such event, a court may properly find a statement false as a matter of law, however sincerely it may be believed. To conclude otherwise would be to place insurance companies at the mercy of those capable of the most invincible self-deception -- persons who having witnessed the Apollo landings, still believe the moon is made of cheese. " ***Sands, supra,*** at 1365,

There is yet another reason that there is no substance to Life & Health's assertion that "true" and "knowledge and belief" must be synonymous. The application in issue also states in its certification that " [a]ll statements made herein are deemed representations and not warranties.. . . " If an applicant was required by the application to give unequivocally true and correct responses to the inquiries, rather than his best knowledge and belief of the facts, he certainly would not be told that his responses were not warranties.

As Life & Health notes, the case law allows an insurance company to offer greater coverage than is statutorily required. ***Strickland Imports, Inc. v. Underwriters at Lloyds,*** 668 So.2d 251 (Fla. 1st DCA 1996); ***Travelers Ins. Cos. v.*** *Changler,* 569 So.2d 1337 (Fla. 1st DCA 1990). That is precisely what Life & Health has done in the instant case with the application language it drafted. An insurance company is not punished when it is held to the language it has selected for use in the insurance application. If the carrier wants absolute accuracy in its application, it need only delete the "knowledge and belief" qualifier in the certification.

The insurance amicus brief raises the specter of uncontrollable insurance costs if this Court holds that an insurance company is bound to the terms it chose for an insurance contract. This position ignores the fact that Life & Health could easily rewrite its contract application to (a) ask the applicant in a more general fashion about his physical condition (i.e. any kidney complaints or problems, rather than kidney failure; any breathing or lung difficulties, rather than chronic obstructive pulmonary disease, etc.); and/or (b) use a "true" rather than "knowledge and belief" standard in the applicant's certification of the contents of the application. It also ignores the fact that the insurance company application asks for the name and address of the applicant's health care provider so that the carrier can itself verify the accuracy of the information on the application.[3] Any "advantage" to the uninformed or ignorant individual is easily eradicated by a simple change in the wording of the application.

Each and every one of the remaining cases cited by the insurance company is inapplicable because none of those decisions involved an insurance application which contained a "knowledge and belief" standard. The cases which are cited in Green's initial brief are all indistinguishable and should control.

Life & Health arrogantly suggests that any decision by this Court would be "perverse" if it does not agree with the insurance company's position. Life &

[3]This ability to contact treating health care providers and/or obtain medical records obviates the need for an insurer to require an independent medical examination of an applicant; the "safety net" is already in place. This is also one reason for the incontestability clause in an insurance policy.

Health repeatedly asks this Court to ignore the insurance company's perverse practice of asking an eighty year old person to answer questions on an application only to the best of his knowledge and belief, then after he complies -- an only after the fact when a claim is made -- Life & Health first states that this is not enough. Life & Health should not respond to a claim by trying to get out of its contractual obligation by invoking a statutory privilege. No applicant could rationally be expected to know about any legislative statute that could differ from the wording of the contract. In the same vein, the insurance company amicus ludicrously suggests to the Court that Life & Health would have needed to conduct an expensive medical exam to obtain further, more accurate, information than was available from Mr. Green's knowledge and belief. This is untrue. For the price of a thirty-two cent stamp, Life & Health could have sent the identical insurance application to Mr. Green's primary physician (who was identified on Mr. Green's application) and asked him to either correct or verify the accuracy of Mr. Green's responses. With this simple procedure it is not even necessary to obtain the medical records before issuance of the policy. One cannot overlook the fact that when Mr. Green made his claim fourteen months after the policy was issued -- and only after this claim was made -- Life & Health found it easy enough to get precisely those answers from that doctor.

CONCLUSION

For the reasons set forth herein, it is respectfully submitted that the trial court erred in granting summary final judgment in this cause, and that the district court erred in affirming the lower court ruling based on the factually distinguishable case ***of Continental Assurance Co. v. Carroll,*** 485 So.2d 406 (Fla. 1986). It is respectfully suggested that this Honorable Court should resolve the certified conflict between the districts by adopting the reasoning as announced in the case of ***Carter v. United of Omaha Life Ins.,*** 685 So.2d 2 (Fla. 1st DCA 1996), reversing the ruling of the district court, and remanding this case for further proceedings.

Respectfully submitted,

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CERTIFICATE OF SERVICE

WE HEREBY CERTIFY that a true copy of the foregoing was mailed August 26, 1997, to: Nancy Gregoire, Esq., Bunnell, Woulfe, Keller & Gillespie, P.A., Suite 400, 888 East Las Olas Boulevard, Fort Lauderdale, Florida 33301, Attorney for Respondent; Howard Bashman, Montgomery, McCracken, Walker & Rhoads, 123 So. Broad Street, Philadelphia, PA 19109; Jerold Hart, P.A., 4000 Hollywood Boulevard, Hollywood, FL 33021; Jeff Tomberg, P.A., 626 S.E. 4th Street, P.O. Drawer EE, Boynton Beach, FL 33425; Rocco N. Covino, Esq., and Thomas C. Dearing, LeBoeuf, Lamb, Greene & MacRae, LLP, 50 N. Laura Street, Jacksonville, FL 32202; Rita M. Theisen, Esq., LeBoeuf, Lamb, Greene & MacRae, LLP, 1875 Connecticut Avenue, N.W., Suite 1200, Washington, D.C. 20009-5728; and Philip E. Stano, American Council of Life Insurance, 1001 Pennsylvania Avenue, N. W., Washington,D. C . 20004.

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