

Complaint

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IN THE MATTER OF
BENEFICIAL STANDARD LIFE INSURANCE COMPANY

CONSENT ORDER, ETC., IN REGARD TO THE ALLEGED VIOLATION OF THE
FEDERAL TRADE COMMISSION ACT

Docket 6309. Complaint, Mar. 11, 1955—Decision, Sept. 29, 1955

Consent order requiring a Los Angeles insurance company to cease misrepresenting the benefits and duration of its health and accident insurance policies.

Before *Mr. J. Earl Cox*, hearing examiner.

Mr. J. W. Brookfield, Jr. and *Mr. Donald K. King* for the Commission.

Hill & Attias, of Beverly Hills, Calif., for respondent.

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act, as that Act is applicable to the business of insurance under the provisions of Public Law 15, 79th Congress (Title 15, U. S. Code, Sections 1011 to 1015, inclusive), and by virtue of the authority vested in it by said Act, the Federal Trade Commission, having reason to believe that the Beneficial Standard Life Insurance Company, a corporation, hereinafter referred to as respondent, has violated the provisions of said Act, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues its complaint stating its charges in that respect as follows:

PARAGRAPH 1. Respondent, Beneficial Standard Life Insurance Company, is a corporation duly organized, existing and doing business under and by virtue of the laws of the State of California with its office and principal place of business located at 756 South Spring Street, Los Angeles 14, California.

PAR. 2. Respondent is now, and for more than two years last past has been, engaged as an insurer in the business of insurance in commerce, as "commerce" is defined in the Federal Trade Commission Act, by entering into insurance contracts with insureds located in various States of the United States other than the State of California, in which States the business of insurance is not regulated by State law to the extent of regulating the practices of respondent alleged in this complaint to be illegal. Respondent maintains, and at all times men-

tioned herein has maintained, a substantial course of trade in said insurance policies in commerce between and among the several States of the United States.

Respondent during the two years last past has issued a variety of policies providing indemnification for losses resulting from accidental injury and sickness, including those designated and identified by it as forms:

1. World-Wide Hospital and Surgical Expense Policies. Form 82, 83-B, 85, 86, 86-B, 90, 91, 96, 96-A, 97.
2. Paramount Sickness and Accident Policy Form 223-B.
3. Double Superior Sickness and Accident Policy Form 42-D, 42-E, 42-G, 42-M.
4. Superior Sickness and Accident Policy Form 41-H.
5. Champion Sickness and Accident Policy Form 23-G, 23-H.

Respondent is licensed as provided by state law to conduct an insurance business in the States of Alabama, Arizona, Arkansas, California, Colorado, Florida, Idaho, Illinois, Indiana, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Penna., South Carolina, Tennessee, Texas, Washington, Wyoming, and in the territories of Alaska and Hawaii. Respondent is not now, and for more than two years last past has not been, licensed as provided by state law to conduct an insurance business in any state other than those last above mentioned.

Respondent has sold a substantial number of its policies to insureds now residing in states other than those in which respondent has been duly licensed, as aforesaid, and respondent mails to such insureds or policyholders notices and receipts relating to the payment of renewal premiums and receives and accepts from such insureds or policyholders premiums mailed to it renewing the coverage purchased for the period of time covered by the premium submitted. The renewal of term insurance in this manner constitutes trade in commerce to the same extent as the original purchase of said insurance.

PAR. 3. In the course and conduct of said business and for the purpose of inducing the purchase of said insurance policies, respondent has made, and is now making numerous statements and representations concerning the benefits provided in said policies, by means of advertisements inserted in newspapers, and by circulars, folders, and other advertising material distributed throughout the United States. Typical, but not all inclusive of such statements and representations are the following:

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1.

PAYS 4 WAYS

SICKNESS :: HOSPITAL BENEFITS

ACCIDENT :: ACCIDENTAL DEATH

Regardless of Age to Limits of Policy

* * *

THESE BENEFITS NEVER GET LESS REGARDLESS OF
AGE TO POLICY LIMIT

***Just put the big end of the [premium] notice, together with your payment into the envelope and drop it in the mail box. This is all you ever have to do to retain for yourself and family the fine protection your policy affords. ***

AGE 3 MONTHS TO 70 YEARS ELIGIBLE

2. NO MEDICAL EXAMINATION is required, and you do not have to belong to any employee group to secure this valuable protection. ***

3. \$100.00 A MONTH will be paid you when you are sick and unable to work. It is payable (as long as you are disabled) after the third day and for as long as six months. You do not have to be confined in order to receive this benefit as long as you are under the care of a qualified doctor.

4. \$1,000.00 DEATH BENEFIT will be paid to your beneficiary if you are fatally injured as a result of ANY accident.

5. Beneficial PARAMOUNT SICKNESS AND ACCIDENT POLICY Benefits quoted below are for men under 55 paying monthly premiums of \$5.

* * *

\$1,000.00 DISMEMBERMENT BENEFIT will be paid for listed specific losses of limbs or eyesight from ANY accident.

* * *

\$100.00 A MONTH will be paid to you from the first day you are disabled as the result of *any injury*.

This benefit is payable from the first day you are disabled and as long as you are unable to work up to two full years. This benefit is paid whether you are injured on the job or off the job.

* * *

\$150.00 A MONTH will be paid you during the first month you are confined to a hospital whether by sickness or accident.

6a. Can YOU easily spare the \$500.00 to \$2,000.00 or more which may be required for Hospitals, Surgeons, and other expenses when YOU or a member of YOUR family have an operation.

CASH when YOU are SICK or INJURED for * * *

* * *

SURGEONS FEES

* * *

EVERY TIME YOU ARE HOSPITALIZED

6b. You'll like the BIG CASH PAYMENTS * * * up to \$20.00 a day for hospitals * * * up to \$300.00 for operations * * *

7. THE DOUBLE SUPERIOR SICKNESS & ACCIDENT POLICY Protects You From The First Day

* * *

SICKNESS BENEFITS START FROM FIRST DAY

PAR. 4. Through the use of such statements and representations and others of similar import and meaning not specifically set out herein respondent represents, and has represented, directly or by implication:

1. That the policies of insurance advertised in the manner set out in subparagraph 1, Paragraph 3, can be continued in effect indefinitely or to a specified age limit at the sole option of the insured so long as he makes the required premium payments within the time provided by said policies.

2. That in determining whether or not the cash benefits provided for in respondent's World-Wide Hospital and Surgical Expense Policies, the policies advertised in the manner set out in subparagraph 2 of Paragraph 3 will be paid for loss resulting from sickness or accident, the respondent will not take into consideration the physical condition of the insured prior to or at the time the policy is issued.

3. That the insured will be indemnified in the sum of \$100.00 per month for a period of 6 months starting with the third day for losses resulting in disability caused by any and all sickness, which renders the insured unable to engage in his regular work.

4. That the beneficiary of the insured will be indemnified in the sum of \$1,000.00 if insured should suffer loss of life due to a fatal injury as a result of any accident.

5. That respondent's Paramount Sickness & Accident policies provide for benefits for loss of a limb or eyesight due to any accident in addition to the regular accident benefits and hospital benefits provided. According to this representation such a policyholder who is under 55 years and has been paying a \$5 monthly premium and who has lost a limb or his eyesight as a result of any accident and has been unable to work due to this disability for a period of two years would be entitled to benefits totaling \$3,550.00 in all cases.

6a. That respondent's policies containing surgical benefits provide benefits which make paying surgery bills up to \$2,000.00 easy.

6b. That respondent's policies containing surgical benefits provide for full indemnification for the actual cost of surgery for all operations up to \$300.00.

7. That respondent's Double Superior policies completely cover the insured with respect to loss due to all sickness from the day said policies are issued.

PAR. 5. The aforesaid statements and representations are false, misleading and deceptive. In truth and in fact:

1. Respondent's said policies cannot be continued in effect indefinitely or until a specified age limit at the sole option of the insured as

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long as the required premiums are paid within the time provided. On the contrary respondent may cancel said policies at the end of any premium term by refusal to accept the renewal premium.

2. The respondent does take into consideration the physical condition of the insured prior to and at the time the policy was issued in determining whether or not the cash benefits provided by said insurance policies will be paid for loss resulting from sickness or accident after the effective date of the policy. The respondent's policies provide in effect that insured will not receive any benefits for loss caused by sickness, the cause of which is traceable to a condition existing prior to the effective date of said policies.

3. The indemnification contained in respondent's insurance policy 223-B, concerning which the representation set out in subparagraph 3, paragraph 4, was made, does not provide benefits to the insured in the sum of \$100.00 per month for a period of 6 months starting with the third day for losses resulting in disability caused by any and all sickness, but on the contrary said respondent's policy provides that:

(a) No cash benefits, disability or otherwise, are payable for any loss resulting from sickness, if the cause of such sickness is traceable to a condition existing prior to or within 15 days after the effective date of the policy.

(b) Such cash benefits, if payable at all, cover periods of disability caused by sickness only if during such period the insured is prevented from attending to any kind of work or business.

(c) No cash benefits will be paid for a period of over three months as indemnification for loss due to any type of hernia, apoplexy, tuberculosis, cancer or ulcers.

(d) No benefits are payable for a loss contracted or incurred outside the limits of the United States, Canada, Alaska or Hawaii.

(e) No cash benefits are payable for any loss to which a contributing cause is War (whether declared or undeclared) or any act of war; any attempt by the insured to commit suicide, while sane or insane; insanity or mental infirmity of the insured; intentionally self-inflicted injury; taking of poison or inhaling gas, whether voluntarily or involuntarily; the insured riding a motorcycle; a venereal disease or its complications, an injury to or disease or ailment of the genitourinary organs, not common to both sexes; or childbirth.

4. The beneficiary of insured will not be indemnified in the sum of \$1,000.00 if insured should suffer loss of life due to a fatal injury as a result of any accident; on the contrary respondent's policies so represented provide that cash benefits are payable for loss of life only if such loss results directly and independently of all other causes from accidental bodily injury and occurs within 30 days of

the date of the accident. In no event will cash benefits be payable for loss of life if a contributing cause of such loss is hernia or any of the causes listed above in subparagraph (e) of Paragraph Five, or if the loss was incurred outside of the United States, Canada or Hawaii.

Further, a cash benefit of \$1,000.00 is not payable for loss of life from accidental bodily injury, not otherwise excluded, if the insured shall carry with another company, corporation, association or society other insurance covering the same loss without giving written notice to the Company, then in that case the Company shall be liable only for such portion of the indemnity promised as the said indemnity bears to the total amount of like indemnity in all policies covering such loss, and for the return of such part of the premium paid as shall exceed the pro rata for the indemnity thus determined.

5. Respondent's Paramount Sickness and Accident policies do not provide for benefits for loss of a limb or eyesight due to any accident in addition to the regular accident benefits and hospital benefits provided. On the contrary these policies provide that no payment for dismemberment is due unless it occurred within thirty days of the accident and unless the loss is due to accidental bodily injury incurred directly and independently of any and all other causes.

The said policies also provide that the insured must make an election within 90 days of the accident whether to receive the benefits provided for loss of limbs or eyesight or the regular benefits for accident. In no case are both benefits payable.

A policyholder who is under 55 years and has been paying \$5 monthly premium who has lost one limb immediately as a result of an accident and who has been unable to work due to this disability for two years, if he is entitled to any benefits, could receive under the provisions of those policies as little as \$250.00 if he elected to take the dismemberment benefit, or \$2,550.00 if he elected to take the regular accident and hospital benefits. In no case would he be entitled to receive both dismemberment and accident and hospitalization benefits totaling \$3,550.00 as represented.

6. The policies referred to by the advertising claims set out in subparagraphs 6a and 6b of Paragraph Four (for example, Form No. 82) do not provide for full indemnification for the actual cost of surgery for all operations up to \$300.00. For example, Policy Form No. 82 lists 185 different types of operations and sets a maximum amount payable for each. Of these the policy provides that indemnification up to \$300.00 will be allowed only for one type of operation Appendectomy, and then only to policyholders paying the highest listed premium. This policy provides for a maximum payment of only \$75.00 or less for 113 of the 185 listed types of operations. Such

benefits certainly will not make paying surgery bills up to \$2,000.00 easy.

7. Respondent's Double Superior policies do not cover the insured with respect to loss due to all sickness and accidents from the day said policies are issued, but on the contrary respondent's policies provide that respondent assumes no liability for sickness or disease contracted or traceable to conditions existing before said policies have been in force for a period of 30 days, and assumes no liability for losses due to accident unless such loss results directly and independently of all other causes from accidental bodily injury.

PAR. 6. The use by the respondent of the aforesaid false and misleading statements and representations with respect to the terms and conditions of its said policies and its failure to reveal the limitations of said coverage found in said policies have had, and now have, the tendency and capacity to mislead and deceive, and have misled and deceived, a substantial portion of the purchasing public into the erroneous and mistaken belief that the aforesaid statements and representations were and are true and to induce said portion of the purchasing public to purchase insurance coverage from the respondent because of said erroneous and mistaken belief.

PAR. 7. The aforesaid acts and practices of respondent, as herein alleged, are all to the prejudice of the public and constitute unfair and deceptive acts and practices in commerce within the intent and meaning of the Federal Trade Commission Act.

INITIAL DECISION BY J. EARL COX, HEARING EXAMINER

The charges contained in the complaint in this proceeding are that Beneficial Standard Life Insurance Company, a California corporation with its office and principal place of business located at 756 South Spring Street, Los Angeles 14, California, has violated the Federal Trade Commission Act, as that Act is applicable to the business of insurance under the provisions of Public Law 15, 79th Congress (Title 15, U. S. Code, Section 1011 to 1015, inclusive), by falsely and deceptively advertising the indemnification for losses resulting from accidental injury and sickness, provided by insurance policies which it has offered for sale and sold in commerce.

Following issuance and service of the complaint and prior to the filing of an answer, respondent entered into a Stipulation For Consent Order with counsel supporting the complaint, which was approved by the Director, Bureau of Litigation, and transmitted to the hearing examiner.

This stipulation provides, among other things, that respondent admits all the jurisdictional allegations set forth in the complaint and

that the record herein may be taken as if findings of jurisdictional facts had been made in accordance with such allegations; that the stipulation, together with the complaint, shall constitute the entire record herein; that the complaint may be used in construing the order agreed upon, which may be altered, modified, or set aside in the manner provided by statute for orders of the Commission; that the signing of the stipulation is for settlement purposes only and does not constitute an admission by respondent that it has violated any law as alleged in the complaint; and that the order provided for in the stipulation and hereinafter included in this decision shall have the same force and effect as if made after a full hearing, presentation of evidence and findings and conclusions thereon.

All parties waive the filing of answer, hearing before a hearing examiner or the Commission, the making of findings of fact or conclusions of law by the hearing examiner or the Commission, the filing of exceptions and oral argument before the Commission, and all further and other procedure before the hearing examiner and the Commission to which respondent may be entitled under the Federal Trade Commission Act and the Rules of Practice of the Commission; and respondent specifically waives any and all right, power or privilege to challenge or contest the validity of the order entered in accordance with the stipulation.

The order agreed upon conforms to the order contained in the notice accompanying the complaint, except for the omission therefrom of the provision "(B) Misrepresenting in any other manner or by any other means the terms or provisions of said insurance policies," and disposes of all the issues raised in the complaint. The Stipulation For Consent Order is therefore accepted, this proceeding is found to be in the public interest and the following order is issued:

It is ordered, That the Beneficial Standard Life Insurance Company, a corporation, and its officers, agents, representatives, and employees, directly or through any corporate or other device, in connection with the offering for sale, sale and distribution in commerce, as "commerce" is defined in the Federal Trade Commission Act, of any accident, health, hospital or surgical insurance policy, do forthwith cease and desist from representing, directly or by implication:

1. That said insurance policy may be continued in effect indefinitely or for any period of time, when, in fact, said policy provides that it may be cancelled by respondent or terminated under any circumstances over which insured has no control, during the period of time represented;

2. That no medical examination is required or that applicant's health is not a factor in securing insurance, unless the representation

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is clearly and conspicuously limited in immediate connection therewith to insurance on claims not caused by previous conditions of health of the insured;

3. That said policy provides for indemnification to insured in cases of sickness or accident generally or in any or all cases of sickness or accident, when such is not the fact;

4. That said policy provides a monthly or other cash benefit to insured, when disabled by sickness or accident, for a longer period of time or in a larger amount than is in fact provided;

5. That said policy provides for the payment of certain benefits in addition to other benefits when such is not the fact;

6. That said policy will pay in full or in any specified amount or will pay up to any specified amount for any medical, surgical or hospital service unless the policy provides that the actual cost to the insured for that service will be paid in all cases up to the amount represented;

7. That said policy provides indemnification for losses caused by accident or sickness immediately upon the effective date of said policy when such is not the fact.

DECISION OF THE COMMISSION AND ORDER TO FILE REPORT OF COMPLIANCE

Pursuant to Section 3.21 of the Commission's Rules of Practice, the initial decision of the hearing examiner shall, on the 29th day of September, 1955, become the decision of the Commission; and, accordingly:

It is ordered, That respondent Beneficial Standard Life Insurance Company, a corporation, shall, within sixty (60) days after service upon it of this order, file with the Commission a report in writing setting forth in detail the manner and form in which it has complied with the order to cease and desist.

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IN THE MATTER OF

ILLINOIS COMMERCIAL MEN'S ASSOCIATION

CONSENT ORDER, ETC., IN REGARD TO THE ALLEGED VIOLATION OF THE
FEDERAL TRADE COMMISSION ACT*Docket 6245. Complaint, Oct. 14, 1954—Decision, Oct. 4, 1955*

Consent order requiring an insurance company in Chicago to cease misrepresenting the terms and benefits of its accident policies.

Before *Mr. Loren H. Laughlin*, hearing examiner.

Mr. Paul R. Dixon and *Mr. Robert R. Sills* for the Commission.

Mr. Richard K. Decker of *Lord, Bissell & Brook*, of Chicago, Ill., for respondent.

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Pursuant to the provisions of the Federal Trade Commission Act, as that Act is applicable to the business of insurance under the provisions of Public Law 15, 79th Congress (Title 15, U. S. Code, Sections 1011 to 1015, inclusive), and by virtue of the authority vested in it by said Act, the Federal Trade Commission, having reason to believe that Illinois Commercial Men's Association, a corporation, hereinafter referred to as respondent, has violated the provisions of said Act, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues its complaint, stating its charges in that respect as follows:

PARAGRAPH 1. Respondent, Illinois Commercial Men's Association, is a corporation organized, existing and doing business under and by virtue of the laws of the State of Illinois with its office and principal place of business located at 332 South Michigan Avenue, Chicago 90, Illinois.

PAR. 2. Respondent is now, and for more than two years last past has been, engaged as an insurer in the business of insurance in commerce, as "commerce" is defined in the Federal Trade Commission Act, by entering into insurance contracts with insureds located in various States of the United States other than the State of Illinois, in which States the business of insurance is not regulated by State law to the extent of regulating the practices of respondent alleged in this complaint to be illegal. Respondent maintains, and at all times mentioned herein has maintained, a substantial course of trade in said insurance policies in commerce between and among the several States of the United States.