

Complaint

IN THE MATTER OF

THE COMMERCIAL TRAVELERS MUTUAL ACCIDENT
ASSOCIATION OF AMERICA

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

Docket 6242. Complaint, Oct. 14, 1954—Decision, July 23, 1962

Order dismissing without prejudice—the evidence relating to practices too remote in point of time to support the recommended order—complaint charging a Utica, N.Y., insurance company with false advertising.

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 (U.S.C. Title 15, Secs. 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 Commercial Travelers Mutual Accident Association of America, 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, The Commercial Travelers Mutual Accident Association of America, is a corporation duly organized, existing and doing business under and by virtue of the laws of the State of New York with its office and principal place of business located at 70 Genesee Street in the city of Utica, New York.

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 New York, 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.

Respondent's said insurance policies, referred to by it as "certificates," are of the type known in the insurance trade as "accident and health policies" or "accident and sickness policies."

Generally, such a certificate provides that in consideration of a stated sum of money, sometimes referred to as a premium, and other considerations, respondent promises to indemnify the insured, or certificate holder, for losses resulting from accidental injury, disease or sickness, in accordance with the various terms and conditions of such certificates, by the payment of cash benefits.

Respondent during the two years last past has sold insurance coverage contained in a variety of certificates, among which were the following:

- (1) Accident Certificates identified by respondent as "01."
- (2) Accident Certificates identified by respondent as "02."
- (3) Accident and Hospital and Surgical Certificates identified by respondent as "05."
- (4) Accident and Hospital and Surgical Certificate identified by respondent as "06."
- (5) Accident and Hospital and Surgical Certificate identified by respondent as "07."
- (6) Accident and Hospital and Surgical Certificate identified by respondent as "08."
- (7) Accident and Health Certificate identified by respondent as "11."
- (8) Accident and Health Certificate identified by respondent as "22."
- (9) Accident and Health Certificate identified by respondent as "33."
- (10) Accident, Health and Hospital and Surgical Certificate identified by respondent as "44."
- (11) Accident, Health and Hospital and Surgical Certificate identified by respondent as "55."
- (12) Accident, Health and Hospital and Surgical Certificate identified by respondent as "66."
- (13) Accident, Health and Hospital and Surgical Certificate identified by respondent as "77."
- (14) Accident, Health and Hospital and Surgical Certificate identified by respondent as "88."

PAR. 3. Respondent is licensed, as provided by the respective State laws, to engage in the business of insurance as heretofore generally described in the States of New York and Virginia. Respondent is not now, and for more than two years last past has not been, licensed as provided by the respective State laws to engage in the business of insurance in any State of the United States other than New York and Virginia.

Respondent solicits business by mail in the various States of the United States in addition to the States of New York and Virginia. As a result thereof it has entered into insurance contracts with insureds located in many States in which it is not licensed to do business. Respondent's business practices are not regulated by any of these States as it is not subject to the jurisdiction of such States.

PAR. 4. In the course and conduct of its aforesaid business, respondent, during the two years last past, disseminated and caused to be disseminated in the form of circulars and other printed and written matter, false, misleading and deceptive advertisements concerning the terms and provisions of various of its contracts of insurance as reflected by said policies aforesaid. These advertisements were disseminated by the United States mails or through its agents in commerce between and among the various States of the United States. The purpose and effect of these advertisements was and is to induce members of the public to become insured by the respondent under the terms and provisions of the policies advertised.

PAR. 5. In the course and conduct of its said business in said commerce, as aforesaid, the respondent has disseminated, among others of similar import and meaning, not herein set out, advertisements relating to its said policies containing statements hereinafter set forth.

1. A man must be under 55 years of age to join, but once he becomes a member there is no age limit for the accident coverage, except for a reduction of the death benefit at age 70 * * *

Eligible members may continue their accident protection indefinitely with the death benefit reduced 80% at age 70.

Hospitalization may be continued to age 65 * * *

Sickness coverage reduces 40% at age 60, but it and hospital and surgical benefits may continue to age 65.

2. Accident benefits include \$50.00 weekly payable from the first day of total disability every 30 days for as many as 104 weeks for *each* mishap * * * \$25.00 weekly for as many as 26 weeks for partial disability * * * as much as \$5,200 for each accident, with no reduction on account of other insurance.

IF You Have an Accident

membership in The Commercial Travelers pays you \$50.00 a week while you are totally disabled from pursuing the regular duties of your occupation, from the very first day of disability for as many as 104 weeks—two whole years. There is no limit to the number of accidents covered.

3. All kinds of sickness are covered, excepting only venereal diseases and alcoholism. Even heart disease, cancer, tuberculosis and hernia, arising after first year's membership, are included.

4. In addition to all other benefits, you are paid for *each* injury or illness * * * plus as much as \$150 for a surgical operation * * *

PAR. 6. Through the use of said statements and representations, and others of similar import and meaning not specifically set out herein, the respondent represents and has represented, directly or by implication, with respect to said policies of insurance, as follows:

(1) That the indemnification provided by its said certificates against loss caused by accident or sickness may be continued to age 65 or 70

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or indefinitely at the option of the insured upon the continued payment of premiums.

(2) That the weekly benefits hereinabove described in paragraph 5(2) are payable for each mishap and each accident from the first day of total disability for as many as 104 weeks up to a maximum of \$5,200.

(3) That a member will be indemnified for a loss caused by any kind of sickness with the sole exception of those caused by an alcoholic or venereal condition, and after one year for such diseases or conditions as cancer, tuberculosis, heart trouble or hernia.

(4) That a member will be indemnified for each and every surgical operation in an amount up to \$150.

PAR. 7. The aforesaid statements and representations are false, misleading and deceptive. In truth and in fact:

(1) Each of the certificates described in paragraph 2 expressly provides that the respondent may cancel the certificate at any time; and that it is automatically terminated upon the payment of the maximum amount of losses set forth in Section A of said certificate, such termination varying in form with certain of the certificates; and each certificate of health, and hospitalization and surgical coverage contains a "change of occupation" clause requiring the consent of respondent as a condition precedent to the continuation of such coverage in the event an insured member engages in a new and different occupation.

(2) The weekly benefits described in paragraph 5(2) are not payable for each mishap or accident from the first day of total disability for as many as 104 weeks nor up to a maximum of \$5,200, for the certificates referred to expressly provide that:

(a) No weekly benefits are payable by respondent for Total Disability caused by "each mishap" or "each accident" unless "such injuries alone shall, within twenty days after the date of the accident causing them or immediately following a period of partial disability insured against and caused by said accident, wholly and continuously disable him from the prosecution of every duty pertaining to his occupation."

(b) No weekly benefits are payable by respondent for Partial Disability caused by "each mishap" or "each accident" unless "such injuries alone shall, within twenty days after the date of the accident causing them or immediately following a period of total disability insured against and caused by said accident, partially disable and prevent him from performing the important duties of his occupation."

(c) No accident benefits, weekly or otherwise, are payable, for any loss whenever occurring, if such loss was caused "directly, in-

directly, wholly or partially by or to which a contributing cause is:

- (a) medical, surgical or dental treatment; or
- (b) any kind of sickness, disease, or bodily or mental infirmity;
- (c) sunstroke, heatstroke, ptomaine poisoning or bacterial infection of any kind (except only septic infection of and through and external and visible wound caused solely and exclusively by external and accidental violence); or
- (d) hernia, however caused, except in a sum not to exceed One Hundred Dollars (\$100.00)."

(d) The exceptions contained in the certificate of accident coverage provide that no benefit shall be paid for any loss caused by suicide, or attempt to commit suicide, any loss caused by war or any act of war, any loss occurring or originating while a member is outside the continental limits of the United States and Canada unless a travel permit or a permit to reside elsewhere is first granted in writing by the respondent, or while engaged in military or naval service in time of war declared or undeclared, or while insane, or while intoxicated or under the influence of narcotics.

(e) No benefit is paid for a loss caused by an accident unless such loss occurs within 90 days of the date of such accident.

(3) No indemnification is provided for all losses caused by sickness aside from those caused by alcoholic or venereal conditions and after one year for such diseases as cancer, tuberculosis, heart trouble or hernia; on the contrary no benefits are payable for losses resulting from any disease or sickness if the cause of such disease or sickness is traceable to a condition that existed prior to or within 30 days of the effective date of the certificate.

(4) Members will not be indemnified for each and every surgical operation up to \$150, for under the terms of the certificates providing surgical benefits, some are limited to provide a maximum recovery of \$75; all other certificates providing surgical benefits do provide a maximum benefit of \$150 for 14 specified operations; with respect to 73 other specified operations the maximum benefit payable ranges from \$6 to \$100. All certificates provide a maximum benefit of not less than \$5 and not more than \$10 for any operation not listed in the Schedule of Operations. No surgical benefits are provided in connection with the extraction, filling or surgical or dental treatment of tooth or teeth. In the event two or more surgical operations are performed because of injuries resulting from the same accident or

because of the same disease or illness or during any one period of continuous hospitalization, the insured member will only be paid the largest sum scheduled for any one of the operations so performed. No benefits are provided for any surgical operation necessitated by any injuries received in an accident which accident is specifically excluded by the provisions of the policy. No benefits are provided for any surgical operation in connection with any disease or sickness the cause of which disease or sickness is traceable to a condition existing before or within 30 days after the effective date of the certificate providing surgical benefits.

PAR. 8. 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. 9. The aforesaid acts and practices of respondent, as herein alleged, are all to the prejudice and injury of the public and constitute unfair and deceptive acts and practices in commerce within the intent and meaning of the Federal Trade Commission Act.

Mr. John W. Brookfield, Jr., and Mr. William R. MaHanna for the Commission.

Mr. Moses G. Hubbard and Mr. Eugene B. Hubbard, of Hubbard, Felt & Fuller, of Utica, N.Y., for respondent.

INITIAL DECISION BY LOREN H. LAUGHLIN, HEARING EXAMINER

This proceeding is one brought under Section 5 of the Federal Trade Commission Act as that Act is amended by and made applicable to the business of insurance under the provisions of Public Law 15, 79th Congress (Title 15, U.S.C. Secs. 1011-1015, inclusive). It involves the advertising acts and practices in interstate commerce of the respondent insurance company as to its health and accident insurance policies. The respondent is a cooperative assessment accident and health association incorporated under the laws of New York, under the original title of The Commercial Travelers Mutual Accident Association of America, which title was shortened by amendment to its

present form of The Commercial Travelers Mutual Accident Association on May 22, 1953.

While the corporation under its charter is privileged to engage in the life insurance business, it has never availed itself of its authority to write life insurance and to date has confined itself to providing accident, health, and hospitalization coverage. (See Respondent's Exhibit No. 7, pages 3-4.)

The respondent company has engaged in the solicitation of accident, health, and hospitalization insurance business entirely by advertisements in newspapers having a widespread national circulation and by direct mail advertising to the consuming public. Some of respondent's direct mail advertising is by means of follow-up brochures, applications, and letters sent to those who have become leads by answering its newspaper advertisements, but in some cases such mail advertisements are sent direct to persons whose names have been furnished by members of the respondent company. Respondent has never employed any agents in the solicitation and sale of its said accident, health, and hospitalization insurance.

The complaint alleges, in substance, that during the period of two years prior to the filing of such complaint on October 14, 1954, the respondent had disseminated in interstate commerce certain advertising matter which contained some four general types or categories of alleged false, misleading, and deceptive statements and representations concerning its accident, health, and hospitalization policies, which are subsequently herein discussed in detail. It is further alleged in the complaint that all of such acts and practices were and are to the prejudice and injury of the public. A cease and desist order prohibiting such acts and practices is therefore prayed for. Respondent in its answer, in substance, for a first defense denies that the Federal Trade Commission has any jurisdiction over it or over the subject matter of the complaint. For its second defense, respondent denies that it is a "corporation" as defined in Section 4 of the Federal Trade Commission Act "which is organized to carry on business for its own profit or that of its members," and alleges that respondent is a nonprofit association operating on a cost basis and not for its own profit or that of its members and thereby the Commission has no jurisdiction over its person. For its third defense, respondent admits that it is incorporated and doing business under the laws of the State of New York, with its principal place of business in the city of Utica in said State. The respondent generally denies the other material allegations of the complaint, although admitting, in substance, that it has issued, and does issue, the

certificates of insurance referred to in paragraph 2 of the complaint. Its fourth defense, in substance, states respondent's alleged compliance with the Trade Practice Rules of the Commission promulgated in 1950, pertaining to the advertising of health and accident insurance. This defense was stricken by the hearing examiner as hereinafter more fully stated. For the fifth defense, respondent, in substance, pleads abandonment of the advertising practices referred to in the complaint, alleging that they have become entirely moot and academic because it has been required *pendente lite* to change all of its policies and certificates under a new statute of the State of New York and that its new advertising applies solely and exclusively to such new forms of certificates of insurance. For its sixth defense, respondent pleads, in substance, estoppel against the Commission to the same effect as in its fourth complete defense which likewise was stricken by the hearing examiner as hereinafter stated.

In this initial decision respondent corporation is found to be a corporation which is subject to the jurisdiction of this Commission and that it has disseminated in interstate commerce a substantial amount of false, misleading, and deceptive advertising matter relating to its accident, health, and hospitalization insurance policies. It is concluded therefrom that the Federal Trade Commission has jurisdiction over the respondent's person and also over the subject matter of this proceeding which is clearly and substantially maintainable in the public interest. A cease and desist order against respondent insurance company appropriate to the findings made and conclusions drawn is issued herewith.

This proceeding was instituted October 14, 1954, by the filing of the complaint against respondent. After lawful service of the complaint upon it, respondent, on November 12, 1954, filed its notice of motion to dismiss the complaint, which motion was extensively presented pro and con at an oral argument held December 28, 1954. On May 23, 1955, the hearing examiner issued his interlocutory order overruling said motion to dismiss for lack of jurisdiction, supplemented on June 9, 1955, because of an additional brief of respondent, by a further interlocutory order rejecting respondent's suggestion of its immunity from the Commission's jurisdiction because of its alleged nonprofit corporate character. These orders were appealed to the Commission, which, on September 23, 1955, denied such interlocutory appeal. The hearing examiner conducted a hearing whereat evidence was introduced on behalf of the Commission at Utica, New York, on October 25, 1955, and counsel rested the Commission's case-in-chief. Thereafter respondent filed a motion for the dismis-

sal of the complaint with a supporting brief to which an answer brief was filed by Commission's counsel. After oral arguments had been had, the hearing examiner denied said motion on April 24, 1956. Meanwhile, on January 25, 1956, the hearing examiner issued his order to show cause why respondent's fourth and sixth defenses should not be stricken from the answer as incompetent, irrelevant, and immaterial. The extensive showing of cause filed on February 9, 1956, in response to said order, was orally argued *in extenso* on March 2, 1956, following which, on April 3, 1956, the hearing examiner, upon authorities and reasons cited therein, ordered such allegations stricken from the answer. An appeal from this decision and its typographical amendment of April 16, 1956, was denied by the Commission on May 29, 1956, and since the basis and reasons for the examiner's ruling, and the Commission's order sustaining such ruling fully appear in the record and are immaterial to the issues now presented, no further comment respecting the same will be made in this initial decision except, in substance, to say that the stricken matter attempted to state an illegal defense or defenses in the nature of equitable estoppels arising against the Commission by reason of alleged compliance by respondent with Trade Practice Rules adopted by the Commission in 1950. It may be noted further, however, that respondent never did subscribe to the Rules or consent in any way to the Commission's jurisdiction and authority to issue and enforce such Rules.

On June 18, 1956, at Utica, New York, the respondent presented its defense under the answer as it remained following the striking of said matter above referred to. Both parties thereupon rested and in due course submitted their respective proposed findings, conclusions, and order.

The hearing examiner has given full, careful, and impartial consideration to all the testimony and other evidence presented and to the fair and reasonable inferences arising therefrom, as well as to any and all facts pleaded in the complaint which are admitted by the answer, and to all matters stipulated or admitted during the hearing on the record by counsel for the respective parties. All briefs and arguments of counsel have been carefully reviewed and have also been given full, careful, and impartial consideration. Upon the whole record thus considered, it is found that the complaint's material allegations are each and all established by a preponderance of the evidence, the hearing examiner specifically finding as follows:

Respondent, The Commercial Travelers Mutual Accident Association of America, is an insurance corporation duly organized, existing

and doing business under and by virtue of the laws of the State of New York, with its office and principal place of business located at 70 Genesee Street, Utica, New York. As before stated, during 1953 its name was shortened to The Commercial Travelers Mutual Accident Association. The respondent is not and never has been a fraternal beneficiary association with a ritual and lodge system but is incorporated as a cooperative life and accident insurance company under Article 9-B of the *New York Insurance Law* (Book 27, McKinney's Consolidated Laws of New York, Annotated, Sections 230-248, inclusive). During the period covered by the complaint, 1953-1954, respondent was engaged in the business of accident and health insurance, writing accident, health, and hospitalization certificates or policies upon its membership. While the form of its policies has been changed during this litigation to comply with new requirements of New York insurance law and regulation, respondent is still engaged in the same type of business. The history of the company and its various changes in charter under several amendments of the applicable law of New York are aptly set forth in Respondent's Exhibits Nos. 7, 7-B, 7-C, and 18. During the period in question, membership was "limited to any white man of good moral character and good general health, not over fifty-five or under eighteen years of age at entry, considered by the board of directors as a preferred insurance risk." Respondent is licensed to conduct its business in the State of New York and the Commonwealth of Virginia, as well as in the Dominion of Canada and its provinces of Ontario and Quebec. Its membership extends throughout the United States and Canada. It maintains, in addition to its home office, offices in New York City and Ottawa, Canada. Incorporated in 1883, it ranks as the second oldest and by far the largest of the mail order insurers whose business was originally premised upon the writing of "commercial travelers" as the corporate name of respondent clearly denotes. By subsequent amendments of the statute and the corporation's charter and bylaws, its authorized membership had been broadened during the period in question to include any white male risks considered to be in the preferred risk class by the management. Recent amendments permit it to write accident, health, and hospitalization insurance also upon female persons and racial discrimination has been removed.

The evidence does not disclose the nature of the Canadian office of respondent but does indicate that its licensing in the State of Virginia has not resulted in any activity in such state other than is usual in the other states of the Union. The existence of this Virginia license may be attributable to the fact that respondent's general

counsel was also counsel in *Travelers Association, et al. v. Virginia ex rel State Corporation Commission* (1950), 339 U.S. 643. But the reasons for such license are immaterial since the respondent admittedly has no agents selling its insurance anywhere. During the period in question it solicited its business entirely either through advertisements placed in newspapers of general circulation, such as *The New York Times Magazine*, *The New York Times* editorial section, *New York Herald-Tribune*, *New York Mirror*, *Richmond (Va.) News-Leader*, *Buffalo (N.Y.) Courier*, *Rochester (N.Y.) Democrat and Chronicle*, the *Washington (D.C.) Times-Herald*, *Chicago Tribune*, *Chicago Sun-Times*, *Washington (D.C.) News*, and *New York Post*, as well as in certain magazines of large national circulation—*Nation's Business*, *Esquire* and *Coronet*—or by various other methods, such as names of prospects given to respondent by its members, and the circulation of letters and other advertising material through mailing lists covering preferred risks on the basis of occupational classification.

The record is replete with indications that the respondent's business has been successful and well-managed. The issues herein in no way attack the corporation's financial and business standing or the propriety of the insurance certificates which it issues to its members, which, of course, have been fully approved by the New York Insurance Department. The basic issue which is to be determined in this proceeding is, "Do the statements and representations of respondent in its advertising matter, each read in the entirety of the advertisement of which it is a part, have the tendency and capacity to deceive the prospective purchasers of respondent's accident, health, and hospitalization certificates which are advertised thereby?" There is no evidence that any person has been deceived or defrauded by respondent nor under the many decisions of the courts is such evidence at all necessary to the maintenance of this proceeding. Furthermore, consumer or public "impression" evidence is not necessary and none was received in this case. It is true that the opinion evidence of several officials of the Insurance Department of the State of New York indicates that they believe the questioned advertising in this proceeding is not false, misleading, and deceptive, but each of the witnesses so called was a mature expert who had been dealing with insurance and insurance regulation practically throughout his entire adult lifetime, and quite naturally he was familiar with all of the exceptions, exclusions, and reductions which were to be expected in respondent's insurance certificates. Their evidence is not at all conclusive upon this examiner who has been obliged to view the evidence broadly and make his findings herein with respect to the several classes or categories of

alleged false, misleading and deceptive advertising from a consideration of each of respondent's advertisements in its full context, compared with the particular certificate or certificates advertised, thereby giving due consideration to what those members of the public who were qualified to purchase such insurance most reasonably, probably, and generally would be led to believe from such statements and representations. As stated by the court in *Zenith Radio Corp. v. Federal Trade Commission* (C.C.A. 7, 1944), 143 F. 2d 29, 30,

The Commission was not required to sample public opinion to determine what the petitioner was representing to the public. The Commission had a right to look at the advertisements in question, consider the relevant evidence in the record that would aid it in interpreting the advertisements, and then decide for itself whether the practices engaged in by the petitioner were unfair or deceptive, as charged in the complaint.

Respondent's several types of certificates used during the period in question are in evidence and identified as Commission's Exhibits Nos. 1 to 14, inclusive. They consist of accident certificates, accident and health certificates, accident and hospital and surgical certificates, and accident, health and hospital and surgical certificates, whereby respondent affords to its members a number of different plans which are summarized in Respondent's Exhibit 7-H. Respondent "requires each member to carry accident coverage, to which may be added sickness or hospital benefits or both. Currently (1955), 14 coverage combinations are offered. . . ." Each of the policies sets forth certain accident benefits and all certificates including hospital benefits have a schedule of operations. For brevity and in order not to repeat the exceptions, limitations, and reductions mentioned in the several certificates issued by respondent as to the several classes of alleged false, misleading and deceptive representations made in its advertising, the 1954 *Report on Examination* made by the Insurance Department of the State of New York (Respondent's Exhibits 7, 7-A to 7-Z-27, inclusive) is hereinafter appropriately quoted (7-I to 7-N, inclusive):

Accident Benefits

Indemnity benefits are provided for loss of life, limb and sight or loss of time. The loss must be caused directly, exclusively, independently of disease, bodily infirmity or any other cause, by accidental bodily injuries resulting solely from and caused solely by external and accidental violence.

A member becomes eligible for benefits immediately upon issuance of the certificate. There is no waiting period between the date of disability and the date on which benefits commence. The loss of life, limb or sight must occur, however, within 90 days after the accident; the loss of time must occur within 20 days after the date of accident.

The member is indemnified for total disability at the full rate provided in the contract and for partial disability at half rate. For total disability a member may receive benefits for periods up to 104 weeks; and for partial disability up to 26 weeks. The maximum period, however, within which benefits for total and partial disability may accrue is limited to two years and twenty days after the date of accident.

Excluded under the terms of the accident policy is any loss caused directly, indirectly, wholly or partially by or to which a contributing cause is any of the following:

- (1) medical, surgical or dental treatment
- (2) any kind of sickness, disease or bodily or mental infirmity
- (3) sunstroke, heatstroke, ptomaine poisoning or bacterial infection of any kind (except only septic infection of and through an external and visible wound caused solely and exclusively by external and accidental violence)

Benefits are further limited by the policy provision that in those instances where the Association is liable to a member (or his beneficiary) for indemnity because of loss of life, limb or sight it shall not be liable for loss of time arising out of the same accident. In the event that a single accident causes multiple losses in any combination of life, limb or sight the Association's liability is limited to the greatest single loss sustained.

Where an accident policy is written without provision for benefits under a health policy, hernia, however caused, is limited to an amount equal to two weeks' total benefits.

The benefits offered under provisions of the single benefit Accident policy are as follows: (Double benefit policies provide for twice the amounts shown).

Total disability per week.....	\$25.00
Partial disability per week.....	12.50
Loss of life:	
To age 70.....	5,000.00
Ages 70 and over.....	1,000.00
Loss of both hands, both feet, sight of both eyes, a hand and foot..	5,000.00
Loss of one hand or one foot.....	2,500.00
Loss of sight of one eye.....	1,250.00

Hospital, Surgical and Nursing Benefits

Under this category indemnity benefits are provided to members under age 65 when hospitalization and related services are recommended and approved by a licensed physician, other than the assured, and the expense therefor has actually been incurred by the member. In May 1954, the Association permitted members aged 60 or over to elect to retain their hospitalization benefits without age limitation upon payment of an additional premium commencing at age 60.

A member becomes eligible for benefits immediately upon issuance of a certificate provided such benefits are necessitated because of an accidental injury. Where sickness or disease causes the member to seek hospitalization, surgical or nursing benefits, the indemnity is also payable provided the onset of the sickness or disease occurs after the certificate has been in force more than 30 days.

A further limiting provision requires that the policy be in force one year before liability commences with respect to benefits due on account of hernia.

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A schedule of idemnity allowances for the various procedures and services is incorporated in the certificate. In the event the member requires more than one operation arising from the same accident or sickness, the liability of the Association is limited to the largest sum scheduled for any one operation performed.

The benefits offered under provisions of the single benefit Hospital policy are as follows: (Double benefit policy-holders receive twice the amount shown).

Room per day: \$3.00—maximum 60 days.

Registered nurse in home: per day \$3.00—maximum 30 days

Surgeon—up to \$75.00

Operating room—up to \$10.00

Anaesthesia—up to \$10.00

Xray examination—up to \$10.00

Laboratory—up to \$5.00

Sickness Benefits

Indemnity benefits are provided to members under 60 years of age (and at a 40% reduction from age 60 through 64 years) for loss of time when a member is totally disabled due to sickness or disease.

Benefits commence on the 11th day of disability measured from the date of first treatment by a physician, provided that the onset of the sickness or disease occurs after the certificate has been in force more than 30 days. A further limitation requires that the policy be in force one year before liability commences for disability due to cancer, tuberculosis, heart trouble or hernia.

The member is indemnified for either confining total disability at the full rate provided in the contract or non-confining total disability at half rate. For confining disability, a member may receive benefits up to 52 weeks; for non-confining disability up to 26 weeks. The maximum period, however, within which benefits for total confining or total non-confining disability may accrue is limited to 52 weeks from the date of the commencement of liability for payment.

Hernia is construed by terms of the policy as due solely to sickness and not to accident.

The benefits offered under the provisions of the single benefit sickness policy are as follows: (Double benefit policies pay twice the amount shown).

Confining total disability—up to age 60—\$25.00 a week

Non-confining total disability—up to age 60—\$12.50 a week

Confining total disability—age 60 and over—\$15.00 a week

Non-confining total disability—age 60 and over—\$7.50 a week

Exceptions

All certificates issued by the Association contain certain limitations under which benefits may be denied. In general terms these are:

- (1) Loss caused by suicide.
- (2) Loss caused by war.
- (3) Loss outside the United States or Canada unless a travel permit is issued by the Association.
- (4) Loss while member is in military service.
- (5) Loss while member is insane.
- (6) Loss while member is intoxicated or under influence of narcotics.
- (7) Loss due to aerial flights except as paying passenger on a scheduled air line.

(8) Loss while engaged in an illegal occupation or while committing a felony.

Sickness and Hospital certificates, in addition to the limitations listed above also contain the following exception:

Disability or claims resulting from or predicated upon, directly or indirectly, wholly or partially, venereal disease, syphilitic infection or alcoholism.

General Certificate Provisions

The general provisions as contained in all certificates are outlined below:

Specific time limits for filing proof of loss and instituting legal action against the Association.

Option of cancellation by the member or Association.

Procedures regarding reinstatement after lapse of membership.

The right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim.

Also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

Notification of Association of any change of members occupation.

The member shall pay such assessments as may be levied upon him and annual dues of \$1.00.

The complaint specifies some four different classes or categories of alleged false, misleading, and deceptive advertising disseminated in interstate commerce by the respondent during 1953 and 1954. Under each category in the complaint, certain quoted statements appear which are alleged to be "among others of similar import and meaning, not herein set out." The advertising pieces in evidence, although disseminated widely, are but few in number, and each has been carefully examined with respect to each of the particular categories. Respondent contends, in substance, while not admitting that the original newspaper and magazine advertisements were in any way misleading or deceptive, that they were cured by the subsequent literature mailed to the prospect when he sent in the return-mail coupon appearing on each advertisement. The general practice of the respondent was that when a lead was obtained by reason of a coupon returned to respondent's home office, it thereupon mailed advertising literature to such prospect, including Commission's Exhibits 21 and 22, several editions of a booklet entitled "Facts About Personal Accident, Health, Hospital and Surgical Insurance," as well as various letters of solicitation, Commission's Exhibits 28 to 37, inclusive. With at least some of these letters, an application blank, whereby the prospect applies for membership in respondent company, is also forwarded. If this does not get results, still further letters follow at about two-week intervals, until the series has been concluded. Respondent further contends, in substance, that this material explains fully to the prospect anything which may be left obscure in the original advertisement.

It may be noted that the "Facts" booklet in some respects not only does not clarify matters for the applicant but follows, in essence, the precise language of inducement in the original advertisement. The series of letters is in no way illuminating as to the matters alleged in the complaint to be misleading but are typical sales letters generally challenging the prospect's need for accident and health insurance protection. The rotogravures entitled "The Utica Bulletin," which are subsequently sent to members only, exploit prominent citizens in various walks of life who are members of the Association and while they are sometimes sent to prospective members or applicants they certainly are not revealing as to the provisions of respondent's certificates of insurance. The application blanks, Commission's Exhibits 23 to 27, inclusive, also contain some of the statements alleged to be misleading.

The complaint in the first category of alleged false, misleading, and deceptive statements and representations sets forth certain quotations from respondent's advertisements which are claimed to represent directly or by implication that the indemnification provided by respondent's certificates against loss caused by accident or sickness may be continued to age 65 or 70 or indefinitely at the option of the insured upon his continued payment of premiums. The second category sets forth advertising statements alleged to mislead those to whom they are addressed into mistakenly believing that the weekly benefits provided by respondent's certificates are payable for each mishap and each accident from the first day of total disability for as many as 104 weeks up to a maximum of \$5,200. As to the third category, it is charged that the statements of respondent falsely lead one to believe that an insured will be indemnified for loss caused by any kind of sickness with the sole exceptions of those caused by an alcoholic or venereal condition and, after one year, cancer, tuberculosis, heart trouble, or hernia. The fourth category of statements, it is charged, represent that an insured will be indemnified for each and every surgical operation in an amount up to \$150. Each of the categories will now be considered separately and in some detail.

In the first category, Commission's Exhibit No. 17, a typical advertisement appearing in the *New York Herald-Tribune* of February 14, 1954, states:

A man must be under 55 years of age to join, but once he becomes a member there is no age limit for the accident coverage, except for a reduction of the death benefit at age 70. Sickness coverage reduces 40% at age 60, but it and hospital and surgical benefits may continue to age 65 * * *. A member may resign or let his protection lapse at any time. *Accident coverage is effective the*

day the policy is issued, and health coverage 30 days thereafter. (Italic in original.)

Very similar language appears in Commission's Exhibit No. 18, an advertisement which appeared in the *New York Times Magazine*.

The "Facts" booklets, Commission's Exhibits Nos. 21 and 22, on page 12 of each, contain similar language, the important part of No. 21 being "eligible members may continue their accident protection indefinitely * * *," while the important language in Exhibit No. 22 is "accident indemnity may be continued without age limit, excepting only a reduction of the death benefit by 80% at age 70 * * *" and "Hospital and Surgical benefits which by the terms of this policy cease at age 65 *may nevertheless be continued without age limitation* [Italics in original] if, when you reach age 60, you elect this new feature and pay a moderately higher rate."

These statements represent that respondent's policies may be continued at the option of the insured until the age of 60, 65, or 70 or even for life if the insured makes the premium payments in the amounts and within the time provided by the certificate of membership. Such statements are false, misleading, and deceptive because each of respondent's policies contains Standard Provision 16, which provides:

This Association may at any time terminate the membership of the member herein named, and cancel this certificate, by personal service of a written notice of such termination and cancellation upon him or by mailing to him such a notice, postage prepaid, and addressed to him to the post-office address of such member last appearing upon the records of this Association, and by accompanying such notice with the Association's check for the sum of not less than \$2.00. Such termination and cancellation shall take effect at the time of mailing said notice, or at the time of personal service of the same, as the case may be. Upon termination of membership this Certificate of Membership is, without further action, cancelled, and all rights and interests in this Association are forthwith terminated, except as to a claim originating prior thereto.

Furthermore, each policy in two prominent places recites: "This Certificate is Cancellable by the Association." There is utterly nothing in the quoted advertising that suggests or advises that the insured will receive a certificate which permits the company to cancel his certificate and terminate his membership at any time by the service of a proper written notice with a refund of not less than \$2.00, which termination and cancellation take practically immediate effect. The evidence indicates that the respondent has been somewhat liberal in its claims practices, but this does not alter the fact that the insured does not have a fixed contractual right to retain his certificate and membership. Among the other powers of the board of directors is the "power to terminate the membership of any member for any

cause which they deem just and proper" (Report of Examination by Insurance Department of New York, March 31, 1954, Respondent's Exhibit 7-T). In the financial statement of such report, it is indicated that there were returned fees and assessments in 1952 amounting to \$35,689.77 and in 1953, \$37,271.40 (Respondent's Exhibit 7-W). How much of this was due to canceled memberships does not appear from the report. This report further shows that while 229 death claims were paid in full, in the amount of \$1,290,000, 117 were rejected without payment, in the amount of \$724,000, and 94 others were compromised by the rejection of substantial amounts. Of course, death claims must be in accordance with the provisions of the policy and nothing is taken against respondent by reason of these general figures above recited. Nevertheless, they do indicate that many claims are rejected in full or compromised with partial rejection. The Report on Examination, however, further shows that between March 31, 1951 and March 31, 1954, 4,033 certificates were cancelled by the respondent, although its membership remained essentially static with only a slight gain during that period. Some 4,000 cancellations out of about 246,000 members is not a large fraction of such membership; still it is an appreciable number. This figure, of course, does not include the 8,466 deceased members, and the 34,342 lapsed members during this period. (See Respondent's Exhibit 7-P.) These figures show that cancellation of policies by respondent, however fair and equitable its claims practices are, is not mere academic speculation when the truthfulness of respondent's advertising is under question.

Of course, in considering all the advertising, the testimony of respondent's officials, their interpretation of the advertising, and their several opinions to the effect that the questioned advertising was not in any way false, misleading, and deceitful have been given full consideration along with the expert witnesses from the New York State Insurance Department. The opinion evidence of respondent's said officials has been given but little weight because of the very apparent lack of objectivity on the part of such witnesses. They drafted, approved, and spread the questioned advertising, and in substantial effect they are on trial in this proceeding as much as, if not more than, the corporation which they serve in their respective capacities. This is not to say that either these gentlemen or the eminent members of the New York Insurance Department who testified are not highly competent, qualified, and skilled persons in the field of accident and health insurance. Notwithstanding, the hearing examiner is obliged to consider the advertising in question in the light of the little clerks and tradesmen who are appealed to by respondent's said advertising.

These people, while constituting a part of the preferred risks which are the only kind of risks accepted as members by the Association, nevertheless, are not expert in the field of insurance although some of the distinguished lawyers and insurance men whose names or pictures appear in the several issues of "The Utica Bulletin" may be. It is the duty of the Federal Trade Commission in the public interest to prevent false advertising in its very incipiency insofar as is possible with the legal machinery and limited personnel which are available to enforce the law. The examiner, while holding the said witnesses all in high personal and professional regard and respect, is nonetheless obliged to be entirely objective in the findings which he makes and the conclusions which he reaches in this proceeding.

Passing now to the second category of allegedly false, misleading and deceptive statements in respondent's advertising (Commission's Exhibit No. 17), respondent advertised as follows:

Accident Benefits include \$50.00 weekly, payable from the first day of total disability every 30 days for as many as 104 weeks for *each* mishap * * * \$25.00 weekly for as many as 26 weeks for partial disability * * * as much as \$5,200 for each accident, with no reduction on account of other insurance. * * * (Italic in original.)

And in Commission's Exhibits Nos. 21 and 22, the "Facts" booklet, the impression to be gained from the foregoing advertisement of benefits to be had "for each mishap" is not dissipated, as the latter state unqualifiedly:

If You Have an Accident membership in The Commercial Travelers pays you \$25.00 a week while you are totally disabled from pursuing the regular duties of your occupation, from the first day of disability for as many as 104 weeks—two whole years.

"Each" mishap is in no way qualified by any of this advertising, although the exclusions and limitations hereinbefore set forth, as contained in respondent's certificates, are in no way alluded to. One of the limitations is that if "respondent is liable under the certificate for indemnity because of loss of life, limb or sight it shall not be liable for loss of time arising out of the same accident. In the event that a single accident causes multiple losses in any combination of life, limb or sight the Association's liability is limited to the greatest single loss sustained." In Commission's Exhibit No. 17, immediately following the language above quoted, respondent states:

* * * The sum of \$10,000 is payable for death or loss of hands, feet or sight of both eyes by accidental means; lesser amounts for loss of one hand or one foot or sight of one eye.

One could readily assume that as a result of an accident a man might lie in the hospital for many weeks while physicians and surgeons were

endeavoring to save one of his eyes and two of his hands. In the advertisement under question read in normal unqualified language in the full context of the advertisement, such a person, in becoming insured as a result of reading said advertisement, might well believe that he would be entitled to his total disability pay plus \$10,000 for the loss of his hands and an additional amount for the loss of his eye should such injuries ultimately occur. The fact is that the \$10,000 for the loss of his hands would be all he could recover. That the illustration is an extreme one does not vitiate its force.

In the third category of alleged false, misleading, and deceptive statements, respondent advertised (Commission's Exhibit No. 17):

* * * All kinds of sickness are covered, excepting only venereal diseases and alcoholism. Even heart disease, cancer, tuberculosis and hernia arising after the first year's membership are included.

This statement is false, misleading, and deceptive as respondent unequivocally represents "all kinds of sickness are covered" with the sole exceptions of venereal diseases and alcoholism. The word "Even," while it clearly defers respondent's liability for one year after the certificate is issued for the four afflictions therein referred to, does emphasize by way of such four illustrations that "all kinds of sickness are covered." This statement, "excepting only venereal diseases and alcoholism" is unequivocal and positive, but as hereinbefore pointed out, respondent's certificates expressly provide for sickness benefits but upon the payment of any such loss all of respondent's liability for any further or other claims arising from the same cause shall cease. Recurrence of the same sickness will not be compensated nor will the insured receive benefits if the cause of his sickness is traceable to a condition which existed prior to or within thirty days from the effective date of his certificate. This is true whether or not such pre-existing condition was known to the insured when he made application but which he fraudulently concealed. While claims made on the basis of a pre-existing illness unknown to the claimant might be paid under respondent's liberal claims practices, this is entirely a matter of discretion with respondent's board of directors and not a contractual right on the part of the policyholder.

In the fourth category of alleged false, misleading, and deceptive advertising, respondent, in stating its surgical benefits (Commission's Exhibit No. 18) after reciting, "You get up to \$5,200 for each disabling accident," "You get up to \$2,600 for each disabling illness," and "Accident protection includes \$10,000 death benefit," further represents: "You get up to \$580 in Hospital & Surgical Benefits. In addition to all other benefits, you are paid for *each* injury or illness"

certain alternative daily benefits for hospital room or registered nurse at home "plus as much as \$150 for a surgical operation." Respondent has made a similar statement in Commission's Exhibit No. 20. Such statements are false, misleading, and deceptive because they definitely create the impression that in the event the policyholder undergoes surgery for any condition, the actual cost of such operation will be paid for by respondent under the certificate up to the amount of \$150. But to the contrary, respondent's certificates providing for surgical operations contain a schedule of fixed maximum fees for various classes of operations. Of 87 operations listed in this schedule, only 14 operations or classes thereof would pay the actual surgical expense of an insured up to \$150. The remaining 73 operations, respectively, range in amount from \$10 to \$100. The figures refer to double protection policies, the schedule in the single protection policies being fees of only one-half of the amounts listed in the double protection certificate schedules.

It is unnecessary to cite the numerous decisions of the Commission which have condemned language similar to that employed by respondent in each of the four foregoing categories. Therefore, the use of such false, misleading, and deceptive statements and representations by the respondent in its public advertising, with reference to the terms and conditions of its accident, health, and hospitalization insurance certificates or policies, has had a tendency and capacity to mislead and deceive a substantial portion of the purchasing public to whom the said advertisements are directed into believing erroneously that such statements and representations were true. That such statements and representations induced a substantial portion of the purchasing public to obtain a considerable number of said policies by reason of belief in said advertising may be inferred from the fact that during the period in question, despite substantial losses of members due to death, withdrawals, and cancellations, the membership actually increased. (See Respondent's Exhibit 7-P.) As previously stated, it is wholly immaterial that the Commission has not produced any of these new members, some 34,000 in number, to testify that they have been deceived or defrauded by respondent. Such acts and practices are all to the prejudice and injury of the public and constitute unfair and deceptive acts and practices by respondent in commerce within the meaning of the Federal Trade Commission Act.

Respondent has urged the defense of abandonment, in substance contending that, because of changes in the New York statutes governing all insurance companies in that State and regulations and requirements of the New York Department of Insurance implementing such

new statutes, during the pendency of this litigation it has been required "by force of law" to change all of its certificates and now issues an entirely new series of certificates. The statutory changes referred to are the adoption by New York of what respondent refers to as new Standard Provisions but which are generally referred to in the insurance industry as the "Uniform Provisions" adopted or in the course of adoption by nearly all of the States due to their approval by the National Association of Insurance Commissioners in June, 1950, and recommended to replace the "Standard Provisions" laws in order to bring back greater uniformity in such matters and to modernize such provisions. The new certificates of respondent are not in evidence nor is any of its advertising relating to the same. It may be properly assumed, however, that the redrafting of the certificates by respondent to conform to the new New York statutes and regulations has not resulted in any material change in the coverages, exclusions, exceptions, limitations, and reductions provided in such certificates as distinguished from those at bar. There is nothing, therefore, in the record on which a finding of a good-faith change in respondent's advertising methods and practices can be inferred. Moreover, respondent at all times has objected, and still objects, to the jurisdiction of the Federal Trade Commission over it personally and over the subject matter of the proceeding. Under such circumstances, the Commission has thus far uniformly refused to dismiss any of its proceedings against health and accident insurers on the grounds of abandonment. See cases cited on pages 25 and 26 of the initial decision in *Life Insurance Company of America*, Docket No. 6247, filed May 15, 1957.

Respondent, in substance, contends that it is a nonprofit corporation and, therefore, not subject to the Federal Trade Commission Act. Similar contentions have been adversely disposed of by the courts. See *Chamber of Commerce of Minneapolis v. F.T.C.* (C.C.A. 8, 1926), 13 F. 2d 673; *National Harness Mfg'r's Assn. v. F.T.C.* (C.C.A. 6, 1920), 268 F. 705; and *Quality Bakers of America, et al. v. F.T.C.* (C.C.A. 1, 1940), 114 F. 2d 393. But here respondent corporation cannot even claim to be a non-profit association or company. The very act under which it is incorporated provides that any cooperative life and accident insurance company, where its excess admitted assets over reserves permit, may apportion and distribute them as dividends to the members if the New York Superintendent of Insurance approves, such excesses being derived from savings on mortality or other gains and "from underwriting profits" (Book 27, *McKinney's Consolidated Laws of New York, Annotated*, Article 9-B, sec. 243). The many authorities and reasons cited or stated and referred to in the inter-

locutory order herein, filed June 9, 1955, rejecting the suggestion of respondent's immunity from the Commission's jurisdiction because of its alleged non-profit corporate character, for brevity, are hereby made a part of this initial decision by reference.

The general objection of respondent to the jurisdiction of this Commission over the subject matter by reason of respondent's interpretation of Public Law 15, 79th Congress, has been fully covered by authorities and references in the interlocutory order overruling motion to dismiss for lack of jurisdiction, filed herein on May 23, 1955, which also for brevity is made a part hereof by reference. Since the date of that order, the Commission in a long series of decisions has upheld its own jurisdiction over direct mail order companies such as respondent, which employ no agents. In these cases the jurisdictional question, in its substantial essence, is identical with the one raised by respondent here. See cases cited on page 26 of initial decision in *Life Insurance Company of America, supra*.

The respondent, during the period in question, did business throughout the entire United States in very substantial volume by mail. Its income from the premiums received were substantially in excess of \$6,000,000 in each of the years 1953 and 1954. Its advertising literature and its subsequent sale and distribution of its accident, health and hospitalization certificates in a constant stream of commerce, all from the State of New York, and particularly from its home office in Utica where all the advertising originates, amounts to a substantial course of trade in commerce, as "commerce" is defined in the Federal Trade Commission Act between and among each and all of the several States of the United States. Respondent's substantial interstate commerce between its home office and the Dominion of Canada is not involved herein.

Respondent's position, in substance, is that there can be no general public interest or jurisdiction on the part of the Federal Trade Commission over the subject matter of the proceeding because all of its activities are centered in New York State and the Insurance Department of that State has full and complete jurisdiction over its activities everywhere to the exclusion of any public interest or jurisdiction, and action by the Federal Trade Commission. In substance, respondent's position is that the Department of Insurance of the State of New York can and has amply protected the interests of all the people of the United States with respect to respondent's advertising matter disseminated throughout the Nation. The witnesses called by respondent who were members of the official staff of the Department of Insurance of the State of New York by their testimony, however, com-

pletely refute such contention by respondent. Their evidence points up the inability of insurance commissioners other than that of the domiciliary state to regulate mail order insurers which are not licensed in their respective jurisdictions. The witness, Joseph A. Oster, Associate Attorney of the New York State Insurance Department in charge of the Legal Bureau and who takes care of disciplinary actions against licensees and gives legal advice to various members of the Department in connection with their duties, admitted that the New York State Insurance Department was utterly powerless to regulate such a company which was not licensed by it, and that the only thing that could be done would be to take the matter up as one of comity with the commissioner having authority over such a foreign company. He testified as follows (R. 623) :

Q. Now, sir, what would you do if you received a complaint from a resident of the State of New York in which he stated that he had been misled by advertising sent from a mail order company located in California?

A. I would have to first ask you whether that company is licensed in the State of New York.

Q. It is not.

A. We cannot do anything against a company as such since it is not under our jurisdiction. If he has been misled by advertising we would write to him and suggest that he communicate with the superintendent of his state. If the matter is of sufficient weight the matter would be brought to the attention of the deputy or the Superintendent himself who may conceivably write such a letter to the Commissioner of the other state.

The witness, Samuel H. Dorf, Principal Examiner in charge and the Chief of the Complaint Bureau of the New York State Insurance Department, testified similarly (R. 604) :

Mr. Dorf, a few years ago, one of the distinguished members of your Department, Mr. George Kline, wrote a monograph on mail order companies which I read several times. Now, assuming that a company, say from Delaware or Indiana or West Virginia, doing a mail order business into the State of New York doesn't pay claims or claims with no coverage. How does your Claims Department handle that?

A. I assume the company is not authorized.

Q. Not licensed in the State of New York.

A. As a matter of fact, we can't do very much because if solicitation is made from a point outside of the State it doesn't come under our jurisdiction.

From the testimony of the several Department of Insurance witnesses, it is quite evident that the State of New York did not have, up to the time of the hearing at least, any system whereby the advertising of insurers licensed in the State of New York was examined prior to its publication. It was only after a person had procured a policy and then made a complaint to the Department that any action could

be taken. While there is no evidence that any complaint had been received by such Department concerning any of respondent's advertising, it is quite apparent that the policy of New York State with respect to regulating advertising is one of locking the barn after the horse is stolen. William C. Gould, Chief Insurance Examiner of the Property Bureau of the New York State Insurance Department, charged with the responsibility of supervising, among other things, the one cooperative accident and health corporation existing in the State, which is the respondent here, testified (R. 561-562) that the examiner in the Department had the duty of reading, analyzing, studying, and criticizing the advertisement of insurance policies but "there is not—I should state this to you—requirement for prior approval of these advertisements." When asked by the examiner:

It is only when the examiners go and look into claims and files of the company and find something wrong that the attention of the Department is drawn specifically to it, to you, and on to the Superintendent, if necessary, and other authorities?

he answered:

That is correct. And as you know, we have the requirements that we have referred to in the statute and specific regulations dealing with advertisements in the field of accident and sickness coverage, which was enacted to be effective as of May 1st of this year, which was formalized for the procedure of the Department.

Q. Will that require, in the future, all insurance advertisers in the field to submit in advance their advertising material?

A. It may well do that, your Honor, but that is a matter that rests with the discretion, as you well described in our recess, we have a personnel problem from that standpoint where it would impose a tremendous impact of work of prior approval. And that is a matter that the Superintendent has under advisement.

Q. The administrative details of how far the Department can go and what it can get done will depend on a lot of in-Court factors not settled yet, such as personnel and budget?

A. Yes, and what the Superintendent in his own business dictates as a procedure to be followed.

He further testified that even with respect to claims, the Department had no authority to compel the payment but could only use the art of persuasion (R. 597-598). Mr. Dorf further testified (R. 598):

Q. Now, sir, you mentioned that any company is permitted to submit their advertising for your approval.

A. If they want to.

Q. In other words, there is nothing that requires them to do it, is that correct?

A. Not to our bureau, anyway.

Q. Is there any bureau which requires the prior submission of advertisements?

A. Well, maybe the Property Bureau in connection with their investigation or examination of the company.

This evidence was surprising to the hearing examiner because he had always assumed that the Department of Insurance of the Empire State, with the largest number of employees and the largest appropriation for such a department of any of the States of the Union and which has taken the leadership in so many matters of constructive benefit to the public, would at least have some systematic method of preventing the dissemination of false, misleading, and deceptive advertising by the insurers which it licensed. There is no evidence, however, that such prior affirmative approval has ever been required despite the fact that since July 1, 1948, the New York State Department of Insurance has had all the power granted to it which might be necessary to regulate such matters. It was on that date that the Governor approved Article IX-D of the Insurance Law, which had for its express purpose the regulating of trade practices in the business of insurance in accordance with the intent of Congress in enacting Public Law 15. In such Act (Book 27, *McKinney's Consolidated Laws of New York, Annotated*, section 274), it is expressly provided:

The superintendent shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by section two hundred seventy-two of this act * * *.

Nearly ten years have passed since New York adopted the said act, but apparently nothing has been done to date, and the Federal Trade Commission has been obliged to step into this void and regulate such "business of insurance to the extent that such business is not regulated by State Law," as ordained in the proviso of Section 2(b) of Public Law 15. If the State of New York with its vast resources and its immense Insurance Department cannot and does not regulate the unfair or deceptive acts or practices of insurers who owe their very corporate life to it, it can scarcely be expected that the lesser States in the constellation of the Union can accomplish anything by similar acts and powers. "The proof of the pudding is in the eating thereof," an old adage, is certainly applicable here. New York has let its own corporate child freely advertise throughout the Union in ways which are fully capable of deceiving the public. If there is any basis for any jurisdiction at all by the Federal Trade Commission under Public Law 15, it must be in a case like this. Otherwise the said proviso in that Act is utterly meaningless. This hearing examiner cannot presume that Congress so intended by the use of the language which it employed in applying the Federal Trade Commission Act "to the business of

insurance to the extent that such business is not regulated by State Law."

The large volume of respondent's business clearly establishes the element of public interest in this proceeding. While respondent has made many other contentions throughout the record and in the proposed findings of its counsel, the foregoing cover all the material matters involved herein, and this decision will not be unduly lengthened by a point-by-point discussion of the others.

Upon the findings of fact hereinbefore made, the hearing examiner hereby makes the following conclusions of law:

1. The acts and practices of the respondent, incorporated under the laws of New York, under the original title of The Commercial Travelers Mutual Accident Association of America, which title was shortened by amendment to its present form of The Commercial Travelers Mutual Accident Association on May 22, 1953, hereinbefore found to be false, misleading, and deceptive, are all to the prejudice and injury of the public and constitute unfair and deceptive acts or practices in commerce within the intent and meaning of the Federal Trade Commission Act.

2. Respondent being a corporation within the intent and meaning of the Federal Trade Commission Act and having been duly served with process and made general appearance herein, the Commission has jurisdiction over the person of the respondent.

3. The Federal Trade Commission has jurisdiction over all of said corporate respondent's acts and practices which have been hereinbefore found to be false, misleading, and deceptive.

4. The public interest in the proceeding is clear, specific, and substantial.

Upon the foregoing findings of fact and conclusions of law, the following order is hereby entered:

ORDER

It is ordered, That the respondent, The Commercial Travelers Mutual Accident Association, 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 or certificate, do forthwith cease and desist from representing, directly or by implication:

1. That any such policy or certificate may be continued in effect by the insured upon payment of stipulated premiums

Order

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indefinitely or for any stated period of time, unless full disclosure of any other provision or condition of termination as to the insured contained in such insurance certificate is made conspicuously, prominently, and in sufficiently close conjunction with the representations as will fully relieve it of all capacity to deceive.

2. That any such policy or certificate provides for the payment of any special benefits in addition to other specified benefits unless such is the fact.

3. That any such policy or certificate provides for the payment of any specified benefits indemnifying the insured in cases of accident or sickness generally or in any or all cases of accident or sickness unless such is the fact.

4. That any such policy or certificate will pay in full or up to any specified amount for any medical, surgical, or hospital service unless such is the fact.

5. The extent or duration either of any coverage or of any benefits payable under the terms of any such policy or certificate unless a statement of all the conditions, exceptions, restrictions, reductions and limitations affecting the indemnification actually provided by such certificate relating to such coverage or benefits is set forth conspicuously, prominently, clearly, and in sufficiently close conjunction with the representations as will fully relieve it of all capacity to deceive.

ORDER DISMISSING THE COMPLAINT

This matter having come before the Commission upon respondent's appeal from the hearing examiner's initial decision, and the Commission having suspended action thereon pending final judicial disposition of a related matter; and

The Commission now having reviewed the record in this matter and having determined that the evidence relates to practices too remote in point of time to support the order contained in the initial decision and that for this reason the complaint herein should be dismissed:

It is ordered, That respondent's appeal be, and it hereby is, granted.

It is further ordered, That the complaint in this proceeding be, and it hereby is, dismissed without prejudice, however, to the right of the Commission to issue a new complaint or to take such further or other action against the respondent at any time in the future as may be warranted by the then existing circumstances.

Commissioner MacIntyre not participating.

Complaint

IN THE MATTER OF

GUARANTEE RESERVE LIFE INSURANCE COMPANY OF
HAMMOND ET AL.

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

Docket 6243. Complaint, Oct. 14, 1954—Decision, July 23, 1962

Order dismissing without prejudice—the evidence relating to practices too remote in point of time to support the recommended order—complaint charging a Hammond, Ind., insurance company with false advertising.

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 (U.S.C., Title 15, Secs. 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 Guarantee Reserve Life Insurance Company of Hammond, a corporation, sometimes hereinafter referred to as respondent corporation, and Ben Jaffe, Jerome F. Kutak and Eugene Jaffe, individually and as officers of respondent corporation, sometimes hereinafter referred to as individual respondents, have 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 Guarantee Reserve Life Insurance Company of Hammond is a corporation organized, existing and doing business under and by virtue of the laws of the State of Indiana, with its office and principal place of business located at 128 State Street, Hammond, Ind.

PAR. 2. Respondents Ben Jaffe, Jerome F. Kutak and Eugene Jaffe are President, Vice President and Secretary, respectively, of the respondent corporation and as such direct, dominate and control the acts and practices of respondent corporation at all times herein mentioned. The business address of each of the aforesaid individual respondents is 128 State Street, Hammond, Ind.

PAR. 3. Respondents are now, and for more than two years last past have been, engaged as insurers 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 Indiana,