

Complaint

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IN THE MATTER OF

MINNESOTA COMMERCIAL MEN'S ASSOCIATION

ORDER, ETC., IN REGARD TO THE ALLEGED VIOLATION OF THE FEDERAL TRADE
COMMISSION ACT*Docket 6453. Complaint, Nov. 18, 1955—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 Minneapolis, Minn., 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 Minnesota 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, Minnesota Commercial Men's Association, is a corporation organized, existing and doing business under and by virtue of the laws of the State of Minnesota, with its office and principal place of business located at 2550 Pillsbury Avenue, Minneapolis 4, Minn.

PAR. 2. Respondent is now, and for more than three 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 Minnesota, 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 during the three years last past has issued a variety of policies providing indemnification for various losses resulting from accident and sickness, including those designated by it as the Ideal

Health Policy (Forms H-25, HH-25, H-52, HH-52, H-12 and HH-12), the Ideal Accident Policy (Forms A-52, A-104 and AX-104), the Ideal Surgery Policy (Forms S-75, S-100 and S-125), and the Ideal Hospital Policy (Form R-4812).

Respondent is licensed, as provided by the law of the State of Minnesota, to engage in the business of insurance in the State of Minnesota. Respondent is not now, nor has it been during the three years last past, licensed to engage in the business of insurance in any State of the United States other than the State of Minnesota.

Respondent solicits business by mail in the various States of the United States in addition to the State of Minnesota. 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 and it is not subject to the jurisdiction of such States.

PAR. 3. In the course and conduct of its said business, and for the purpose of inducing members of the public to become insured by the respondent under the terms and provisions of the policies advertised, respondent has made and is now making numerous statements and representations concerning the benefits provided in its said policies of insurance by means of magazine advertisements, circulars and form letters, and other advertising material disseminated throughout the various States of the United States. Typical, but not all inclusive of said statements and representations, are the following:

1. With respect to the duration of coverage:

ADULTS: Coverage Continued to Age 70.

Coverage Ages—18 to 60 For Health Insurance 18 to 70 For Accident Insurance.

COVERAGE—AGES 18 to 70.

2. With respect to health status of prospective policyholders:

No medical examination is required * * *

3. With respect to the accidents and sickness covered:

Our contracts provide protection against all types of accidents and sickness.

Do you know that our Health Insurance Policies * * * will pay you an income of up to \$216.00 per month for one year during periods when you are unable to be at work because of any sickness? And after the policy has been in effect 30 days, your income starts with the first day you are laid up.

The policies described in this folder are not the so-called Limited type, but give you full protection against all types of accidents and sickness. You are protected everywhere, whether at work, at home, in recreation or in travel.

4. With respect to requirements for disability:

ACCIDENTS happen * * * BUT membership in the MINNESOTA COMMERCIAL MEN'S ASSOCIATION pays you \$50.00 per week while you are totally

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disabled from performing the regular duties of your job. These payments start with the first day of disability and may continue for as long as 104 weeks * * * two years.

5. With respect to the amount of indemnity:

Pays you for surgery for a single operation up to—\$125.00.

The surgery policy which will pay you a maximum of \$125.00 for any one operation costs \$6.00 a year.

6. With respect to beginning point of coverage:

Likewise, the benefits start with the *first day* of disability.

HEALTH POLICY

Pays for time loss *from the first day* of confining sickness at the rate of \$10.00 per week for the first week and \$25.00 a week thereafter for up to 12 weeks.

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

1. That respondent's said policies providing indemnification for losses caused by accident or sickness can and will be continued until the age of sixty or seventy so long as the insured makes premium payments within the time and in the amounts provided by the policy.

2. That in determining whether or not cash benefits are payable for losses resulting from sickness or disease, respondent does not take into consideration the condition of health of the assured existing prior to or at the time of the effective date of the policy.

3. That respondent's said policies provide that full benefits are payable for loss resulting from any and all sicknesses and accidents.

4. That cash benefits for total loss of time will be paid as the result of an accident in the event the insured is totally disabled from performing the regular duties of his job up to a maximum of 104 weeks.

5. That said policies provide that surgical benefits up to \$125.00 are payable for any one operation.

6. That cash benefits are payable from the first day for loss due to sickness or accident.

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

1. Respondent's said insurance policies providing indemnification against losses caused by sickness or accident cannot be continued at the option of the insured to age 60 or 70, or any other age, so long as the insured makes premium payments within the time and in the amounts provided by the policy. On the contrary, respondent's insurance policies provide that respondent may cancel the said policies at any time by written notice delivered to the insured together with the

return of any unearned portion of the premium paid by the insured.

2. In determining whether or not cash benefits are payable for losses resulting from sickness or diseases, respondent does consider the condition of health of the insured existing prior to or at the time of the effective date of the policy. Under the terms of respondent's said policies, no benefits are payable for a loss resulting from any sickness the cause of which is traceable to a condition that existed prior to or within 30 days from the effective date of the policy.

3. Respondent's said policies of insurance do not provide indemnification against all types of accident and sickness. On the contrary, respondent's Ideal Accident Policies provide for the payment of cash benefits for losses of life, limbs, sight or time if such losses are caused by accidental bodily injury and independent of all other causes result in the loss of life, limbs or sight. Further, no cash benefits are payable for such losses unless such losses occur within 90 days of the date of the accident causing such losses and the insured shall have been wholly and continuously disabled from the time of receiving said injury until the said loss. Further, in no event are cash benefits payable for more than one loss of limb or sight resulting from the same accident. Further, such cash benefits as are payable commence from the time that the insured is first treated by a physician. In no event will the cash benefit payable for bodily injuries resulting in hernia exceed \$50 if during the 90 day period loss of time or life occurs. Respondent's said accident policies further provide that no benefits are payable for losses caused wholly or in part by sickness or disease resulting from accident or from bodily or mental infirmity or medical or surgical treatment therefor, or for any loss resulting from the use of intoxicating liquor or narcotics by the insured.

Respondent's said accident insurance policies do not provide cash benefits for losses caused by accidental injury resulting in loss of time unless such loss is caused by accidental bodily injury independent of all other causes and immediately, wholly and continuously disabled the insured from doing work of any kind or transacting any business.

Respondent's said insurance policies do not provide indemnification for loss resulting from any and all sicknesses. Respondent's Policies H-25, HH-25, H-52, HH-52, H-12 and HH-12 providing indemnification for loss caused by sickness and resulting in loss of time limit by their provisions such cash benefits as are payable. For example, no benefits are payable under the provisions of those policies for loss of time caused by mental disorders, attempts to commit suicide, drunkenness, drugs, or accidental bodily injuries. Further, no cash benefits are payable for any loss caused by sickness the cause

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of which is traceable to a condition existing prior to or within 30 days after the effective date of such policies. Loss of time cash benefits for losses caused by sickness are payable only if such sickness results in total disability causing a complete inability to perform any occupational duties and any other work for which the insured is reasonably fitted and, further, providing that during the time such benefits are payable the insured is continuously confined within a house or hospital and is regularly treated by a physician.

Respondent's Ideal Hospital Policy (Form R-4812) does not provide benefits for hospital expenses for all losses resulting from sickness. Such policy provides in effect that no hospitalization benefits are payable for any sickness the cause of which is traceable to a condition existing prior to or within 30 days after the effective date of the policy. Further, no benefits are payable for hospital expenses resulting from a loss caused by sickness if such loss resulted from insanity or any mental disorder; rest cure or diagnostic work which could have been performed by the attending physician outside a hospital; any loss caused by use of liquor or narcotics; or any loss arising out of conditions of maternity, pregnancy or miscarriage, unless otherwise covered by rider. Such rider limits the payment of such cash benefits for losses resulting from pregnancy, childbirth or miscarriage to a sum not to exceed \$50, even though such loss might result in loss of life, limb, sight or time.

4. Respondent's said Ideal Accident Policies do not provide for the payment of cash benefits for total loss of time as a result of an accident in the event the insured is totally disabled from performing the regular duties of his job up to a maximum of 104 weeks. On the contrary, respondent's said Ideal Accident Policy under which cash benefits are payable up to 104 weeks for loss of time when totally disabled provides that in no event are benefits payable for loss of time unless such loss resulting from accidental bodily injury and independent of all other causes immediately, wholly and continuously disabled the insured from doing work of any kind or transacting any business. Such cash benefits as are payable commence only with the first treatment by a physician and continue only during such time as the insured during such period of disability is regularly treated by a physician. No cash benefits are payable up to 104 weeks in cases of hernia caused by accidental bodily injury. Respondent's said policies provide that for hernia the maximum benefit payable shall not exceed \$50.

5. Respondent's Ideal Surgery Policies do not provide for the payment of cash benefits up to \$125 for a single operation. Only one of respondent's policies—S-125—provides for a maximum payment of

\$125 for a surgical operation. All of such policies provide that no cash benefits are payable if surgery results from any injury or disease the cause of which is traceable to a condition existing prior to the effective date of the policy. Further, no cash benefits are payable for surgery on account of pregnancy, childbirth, miscarriage, or the results of any of such conditions. Respondent's said policy S-125, providing for the payment of a benefit of \$125, limits such payment to 10 named operations listed in a schedule made a part of such policy. The maximum benefits payable for surgery for the 77 other operations itemized range in amounts from \$10 to \$100. Further, it is provided in all of respondent's surgery policies that in the event two or more operations are performed as a result of any one accident or sickness only one benefit is payable, whichever is the greater.

6. Cash benefits are not payable under the terms of respondent's said policies from the first day for loss due to sickness or accident. Such cash benefits as are not otherwise excluded by the terms of the respondent's said policies are payable only from the first day that the insured is treated by a physician.

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 a 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 statements and representations were and are true, and to induce such portions of the purchasing public to purchase a substantial number of said insurance policies by reason of said erroneous and mistaken belief.

PAR. 7. The aforesaid acts and practices of the 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. William A. Somers for the Commission.

Mr. Maurice H. Rieke, of Minneapolis, Minn., for respondent.

INITIAL DECISION BY FRANK HIER, HEARING EXAMINER

Complaint in this case issued November 18, 1955, charging respondent with the use of false, deceptive, and misleading representations in the sale of its accident and health insurance policies in violation of Section 5 of the Federal Trade Commission Act (Title 15 U.S.C.A. 45). Respondent's answer filed December 21, 1955, denied jurisdic-

tion of the Federal Trade Commission over the proceeding or over the person of respondent, admitted the description of the character and nature of its business, corporate existence, and address, alleged that the excerpts quoted as being misrepresentations were unfairly lifted out of context, alleged that the latter were true and were not misrepresentative, alleged respondent had complied with the February 3, 1950, Trade Practice Rules Relating to Advertising and Sales Promotion of Mail-Order Insurance and further alleged that an investigator of the Commission had examined all of respondent's advertising and policies and found nothing objectionable therein. Two hearings were held for the receipt of evidence tending to establish the allegation, and evidence submitted on behalf of respondent was stipulated. Motion to dismiss at the close of the Government's case on various grounds was denied. The record consists of 82 pages of transcript plus some 50 exhibits. Proposed findings and conclusions were then submitted by all counsel, on consideration of which, together with the record herein, the examiner finds the public interest in this proceeding clear and substantial and makes the following:

FINDINGS OF FACT

1. Respondent, Minnesota Commercial Men's Association, is a corporation organized, existing, and doing business under and by virtue of the laws of the State of Minnesota, with its principal office and place of business located at 2550 Pillsbury Avenue, Minneapolis 4, Minnesota. Under the laws of that state respondent is licensed to engage in the business of insurance in the State of Minnesota but is not licensed in any other state. It solicits the public to become members of respondent's association entirely by mail, having no agents for this purpose. For many years it has, therefore, been engaged in selling insurance contracts providing indemnification for sickness and accident to insureds located in the various states of the United States and in the District of Columbia in a constant stream of commerce, as "commerce" is defined in the Federal Trade Commission Act. Respondent is not a fraternal or ritualistic association, but is a mutual assessment insurance association, and to secure insurance a member of the public must become a member of the association. As of December 31, 1955, it had 11,229 members insured, of which 313 were new additions in the year 1953, and 371 in the year 1954. When a prospect receives advertising matter from the respondent association there is enclosed an application and, if he is interested, he fills it out and mails it to the respondent with the initial premium, or, as respondent calls it, membership fee, whereupon respondent assesses the application

and, if the risk is deemed desirable, issues it and mails it to the newly insured direct. All premium notices are sent to respondent's insureds by mail from Minneapolis and returned there by the insureds with payment. During 1953, 1954, and 1955 respondent's income from its insured members was approximately \$340,000 in each year. Respondent writes health, accident, and medical and surgical insurance and is also authorized to write life insurance, although it has not done so, except for an insignificant number of policies.

2. In the solicitation of its business above described, respondent has disseminated by mail in interstate commerce in substantial amount, various advertisements containing statements and representations relative to the coverage, duration, and benefits provided in its policies of insurance for the purpose of inducing, and which will likely induce, the purchase of said insurance policies by means of United States mails by the public throughout the various states of the United States.

3. With respect to the duration of coverage offered, respondent represents:

Adults: coverage continued to age 70.

Ideal Coverage—Ages 18–70.

Ideal Coverage—Ages 18–60.

The above excerpts of the entire advertisement in which they appear reasonably represent that respondent's policies can and may be continued until age 60 or 70 so long as insured makes the required premium payments within the time and in the amounts provided by said policy, whereas the policy itself contains a provision that it may be cancelled by respondent at any time, and for any reason, by written notice delivered to the insured, together with the return of any unearned portion of the premium paid by the insured. These representations are substantially the same as those heretofore ruled to be false, deceptive, and misleading by the Commission in National Casualty Company, Docket 6311, and pursuant to that ruling respondent's herewith are likewise so found.

4. With respect to the health of the prospective insured respondent has represented:

No medical examination required and a small application fee pays all costs of your insurance for 4 to 5 months.

No agents will call and no physical examination required.

A reading of the entire mail piece in which these excerpts appear, reasonably gives the impression that the health of the prospective insured at the time of application for issuance is not considered by the respondent. The materiality of this as an inducement to prospective

insureds of middle age or older is obvious. Respondent's policy, however, provides that no benefits are payable for loss resulting from any sickness, the cause of which is traceable to any condition existing prior to or 30 days from effective date of policy. These representations have heretofore been found false, deceptive, and misleading by the Commission in American Hospital & Life Insurance Company, Docket 6237, and National Casualty Company, Docket 6311. Consonant therewith the finding here, therefore, is the same.

5. As to the coverage of its accident and sickness policies, respondent has advertised:

Our contracts provide protection against all types of accident and sickness.

The Health and Accident Protection described in this folder is not the so-called limited type, but gives you full protection against all types of sickness and accidents, whether at work, at home, in recreation or in travel.

Accidents Happen * * * but membership in the Minnesota Commercial Men's Association pays you \$50.00 per week while you are totally disabled from performing the regular duties of your job. These payments start with the first day of disability and may continue for 104 weeks—two whole years.

thereby reasonably giving the impression that respondent's policies provide for indemnification for losses resulting from any and all sicknesses and accidents, and that cash benefits for total loss of time will be paid as a result of an accident in the event the insured is totally disabled from performing the regular duties of his job, up to a maximum of 104 weeks. In fact, however, respondent's policies are replete with exceptions, limitations, exclusions and restrictions, which cut the indemnity to far less than "any and all." Thus, respondent's health policies exclude any benefit for sickness caused by mental disorders, suicide attempts, drunkenness, drug use, or accidental bodily injury, or caused by any condition existing prior to, or within 30 days of the effective date of the policies. Furthermore, the sickness must result in such total disability as precludes the performance of any occupational duty or any other work; and such sickness must be such as to confine the insured continually to home or hospital, and be regularly treated by a physician. Similar exclusions and limitations appear in respondent's hospital policy, with additional exclusions for hospitalization by reason of pregnancy, maternity or miscarriage. Respondent's accident policies likewise do not indemnify against all accidents. The loss must result solely from accident, independent of all other causes, before it is indemnified; it must occur within 90 days of the accident, and meanwhile the insured must have been totally and continuously disabled. Only one loss of limb or sight from the same accident is indemnified, and no benefits are payable for losses caused wholly or in part by sickness or disease resulting from acci-

dent, or from bodily or mental infirmity, or medical or surgical treatment therefor, or for any loss resulting from the use of intoxicating liquor or narcotics. The contrast between breadth of promise "any and all" and the narrowness of actual coverage is deceptive and misleading.

6. To sell its surgical benefit policies, respondent has represented the indemnity amount as:

Pays you for surgery for a single operation up to \$125.00.

The surgery policy which will pay you a maximum of \$125.00 for any one operation costs you \$6.00 a year.

The policies to which these representations applied, limit the \$125 benefit to ten listed operations and exclude more than one operation resulting from the same sickness or accident. Excluded also is surgery for pregnancy, childbirth or their effects, or for a condition existing prior to the effective date of the policy. This type of representation with these policy exclusions and limitations, and in particular, the use of "up to" and "maximum" in the representation have been expressly found to be false, misleading, and deceptive by the Commission in reversing a contrary finding by this examiner in National Casualty Company, Docket 6311. The examiner is, of course, bound thereby and finds herewith in accordance therewith.

7. Respondent's advertising has also said:

Likewise, the benefits start with the first day of disability, so our service to you represents a real value in quality.

There are many forms of Health Insurance. Some policies pay you starting after you have been sick for a week or month; others exempt many sicknesses from benefits. This association offers the broad form coverage with all benefits COMMENCING WITH THE FIRST DAY of disability.

This is much too broad as respondent's policies provide for cash benefits only from the first day that the insured is treated by a physician. In addition, there are a number of exclusions and limitations as set out above in immediately preceding paragraphs. The finding is that these representations are deceptive and misleading.

8. The respondent contends that the above-quoted excerpts are unfairly lifted from full context. The examiner has read the entire descriptive piece from which each has been taken, and finds no unfair excerpting but, on the contrary, finds nothing in the entire context which dispels or dilutes the impression created by such excerpt.

9. In its defense, respondent produced by stipulation with counsel supporting the complaint, statements of what its general manager and the attorney for the insurance department of Minnesota would, if called, testify to, which statements are incorporated in the record as

testimony. The former reiterated therein, the denials made in respondent's answer, that any of its advertising was false, misleading or deceptive, gave a history of the respondent and its operations, and testified he had never received any complaint with reference to its advertising from anyone. The attorney for the insurance department of the State of Minnesota likewise so testified and, in addition, testified that from his examination of respondent's advertising, none of it was, in his personal and official opinion, false, misleading, and deceptive. The Federal Trade Commission, of course, is in no way bound by the opinions or actions of other regulatory bodies or officials—it is autonomous, and bound by statute to reach its own conclusions.

10. There is a sharp conflict in the testimony of respondent's general manager and that of the Commission investigator who visited respondent's office and examined its advertising and insurance policies, the former testifying that such investigator, after such investigation, stated he could find nothing objectionable in respondent's advertising, the latter contending that he made no such statement. Credibility is unnecessary to assess, however, since the Commission is not, and cannot be, bound or estopped by any opinion expressed by its staff, on the ultimate issues which it alone can, and by statute, must, solely decide.

11. Respondent also vigorously contends that it is fully and adequately regulated as to its practices by Minnesota state law within the intent and meaning of Public Law 15 (the McCarran Act) (Title 15 U.S.C. 1011-5) and, therefore, the Federal Trade Commission has no jurisdiction over this proceeding. The construction of the McCarran Act on this jurisdictional point has heretofore been fully discussed by this and other examiners and by the Commission (American Hospital & Life Insurance Company, Docket 6237, National Casualty Company, Docket 6311, both of which cases are now on appeal in two Circuit Courts of Appeal) and while this examiner is of a contrary opinion, he is bound to follow the majority opinion of the Commission and therefore rules that it has full and complete jurisdiction over this proceeding.

12. Respondent also contends that the Federal Trade Commission has no jurisdiction over it, because such jurisdiction is limited by its basic act to a corporation or association (as applicable here) which is "organized to carry on business for its own profit or that of its members" (15 U.S.C. 44) and that respondent is a mutual assessment association, makes no profit, is not organized or operated to do so, and has never made any. Factually, respondent has never paid a dividend, but over the 50 years of its existence respondent has accu-

mulated a surplus of income over outgo of \$611,000, \$377,000 of which is invested in government, municipal and state bonds, \$41,000 in selected stocks, \$102,000 in other securities, debentures and savings accounts, \$13,000 in real estate, and \$75,000 in cash. There is no evidence that "reserves" in this or any other amount are required to be kept by law. Profit to this examiner means excess of income over all expenses regardless of what technical accounting designation is applied. This contention of respondent was one of the grounds on which it moved for dismissal at the close of proponent's case and in denying that motion, the examiner discussed the point, both factually and legally, at some length, and incorporates herein his reasons given then, by reference, without exhaustively repeating them here. No factual change or addition has occurred in the record since then which would affect the point. This defense is accordingly rejected.

13. Lastly, respondent defends on the ground that it not only signed but fully complied with "Trade Practice Rules Relating to Advertising and Sales Promotion of Mail-Order Insurance" promulgated by the Commission on February 3, 1950. Regardless of whether or not respondent has so complied, such rules are advisory and persuasive on their signatories only, they do not have the force and effect of law, have, indeed, no statutory basis, and are neither binding nor enforceable. Noncompliance does not necessarily constitute law violation, compliance constitutes per se, no defense to law violation.

14. The use by respondent of the false, deceptive or misleading representations as found in Paragraphs 3 to 7 above, with respect to the terms, conditions, and benefits of its insurance policies, and specifically as to duration of coverage, physical condition at time of issuance, extent of coverage, amount of indemnity and inception of coverage, have the tendency and capacity to mislead and deceive a substantial part of the purchasing public into the mistaken belief in their truth and to induce such purchasing public to buy such insurance policies from respondent because of such mistaken belief.

CONCLUSIONS OF LAW

1. The Federal Trade Commission has full jurisdiction of this proceeding and of respondent.
2. The public interest in this proceeding is clear and substantial.
3. Compliance with trade practice rules is no defense to charges of law violation.
4. The representations made by respondent, hereinabove found to be false, deceptive or misleading are to the prejudice and injury of the public and constitute unfair and deceptive acts and practices within the meaning of the Federal Trade Commission Act.

ORDER

It is ordered, That Minnesota Commercial Men's Association, a corporation, and its officers, agents and representatives, and employees, directly or through any corporate or other device, in connection with the offer for sale, sale or 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 any such policy may be continued in effect by the insured upon payments of stipulated premiums, indefinitely or for any stated time, unless full disclosure of any other provision or condition of termination, contained in the policy is made conspicuously, prominently and in sufficiently close conjunction with the representation as will fully relieve it of all capacity to deceive.

2. That no medical examination is required unless the respondent actually insures the policyholder without regard to his physical condition before, at, or after issuance of the policy; or otherwise representing that the insured's health will not be considered by the respondent in determining its liability thereunder, or that the respondent will not, as a claims practice, require proof of good health of insured at the time of issuance of the policy.

3. That any such policy provides for indemnification to insureds in cases of sickness and accidents generally or in any and all cases of sickness or accident when such is not a fact.

4. That any such policy provides a weekly, or other cash benefit, to insureds, when disabled by sickness or accident, for a longer period of time or in a larger amount than is in fact provided.

5. That any such policy will pay in full or in any specified amount or will pay up to any specified amount for any surgical operation when the policy does not so provide.

6. That any such policy provides for the payment of benefits from the first day for loss due to sickness or accident when such is not a fact.

7. The extent or duration of either coverage or benefits payable under the terms of any policy, unless a statement of all the conditions, exceptions, restrictions and limitations affecting the indemnification actually provided is set forth conspicuously, prominently, and in sufficiently close conjunction with the representation 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.
