IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

DEAN L. JUDD, TRISSA C. JUDD and
DEAN AND TRISSA JUDD FAMILY TRUST,

Plaintiffs, MEMORANDUM AND ORDER

v. 06-C-355-S

AIG/AMERICAN GENERAL LIFE
INSURANCE COMPANY,

Defendant.

Plaintiffs Dean L. Judd, Trissa C. Judd, and Dean and Trissa Judd Family Trust commenced this civil action against defendant AIG/American General Life Insurance Company in Sauk County Circuit Court seeking monetary relief. Plaintiffs seek monetary relief under two separate theories of liability: breach of an insurance contract and bad faith. Additionally, plaintiffs seek both interest for an allegedly untimely payment of a claim and attorneys' fees. Defendant removed this action pursuant to 28 U.S.C. § 1441 and 28 U.S.C. § 1446 alleging 28 U.S.C. § 1332 as grounds for removal. Jurisdiction is based on 28 U.S.C. § 1332. The matter is presently before the Court on defendant's motion for summary judgment and on plaintiffs' motion for partial summary judgment. The following facts are undisputed.

BACKGROUND

On March 1, 2005 plaintiff Dean Judd (hereinafter Judd) both applied for and completed an application for a term life insurance

policy (hereinafter the policy) in the amount of $300,000 from defendant American General Life Insurance Company.[1] This application also contained a Limited Temporary Life Insurance Agreement (hereinafter LTLIA) which was likewise in the amount of $300,000. Mr. John Hibner, an agent for defendant American General Life Insurance Company, assisted plaintiff Judd in completing his application. Specifically, plaintiff Judd provided information to Mr. Hibner (such as his social security number and date of birth) and Mr. Hibner would then use this information to complete the application. Accordingly, the handwriting on the application is exclusively Mr. Hibner's with the exception of plaintiff Judd's signatures.

The application itself consists of two parts labeled as Part A and Part B. Part A is entitled Term Insurance Application Wisconsin Version and Part B is entitled Life Insurance Application Wisconsin Version. Page three of Part A provides in relevant part as follows:

> I understand that this application (1) will consist of Part A, Part B, and if applicable, related forms; and (2) shall be the basis for any policy issued....Except as may be stated in a Limited Temporary Life Insurance

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[1] In its answer, defendant states that it is improperly designated as AIG/American General Life Insurance Company. Defendant asserts its proper designation is as simply American General Life Insurance Company. Accordingly, the Court will refer to defendant as American General Life Insurance Company throughout the course of this Memorandum and Order.

> Agreement (LTLIA) for which all requirements are met, I understand and agree that no insurance will be in effect under this application, or any new policy issued by the insurer, unless or until: the policy has been delivered and accepted; the full first modal premium for the policy has been paid; and there has been no change in the health of the proposed insured that would change the answers to any questions in the application.
>
> I understand and agree that no agent may: accept risks or pass upon insurability; make or modify contracts; or waive any of the insurers rights or requirements.

Additionally, page three of Part A contains the following language:

> Limited Temporary Life Insurance Agreement - If eligible, I have received and accepted the LTLIA. This insurance is available only if; the full first modal premium is submitted with this application and "no" answers have been given by the proposed insured to the Health and Age questions in section 8.

Plaintiff Judd signed page three of Part A of the application indicating that he had read all of the above statements. Additionally, in conjunction with his application plaintiff Judd submitted the full first modal premium in the amount of $229.32. Further, plaintiff Judd answered "no" to the Health and Age questions contained in section eight. Accordingly, coverage under the LTLIA was available to plaintiff Judd.

The LTLIA is contained on page six of Part A of the application. Section two of the LTLIA is entitled "Conditions of Temporary Life Insurance" and it provides in relevant part as follows:

> A. The first modal premium must be paid with Part A of the application....

> B. The answer to both Health and Age questions in section 8 part A, must be no for the proposed insured....
>
> D. Coverage under this agreement will begin on the date the later of the following events have been completed:
>
> - The application has been signed by the proposed insured; or
> - All required medical examinations have been taken....

Additionally, the LTLIA provides that "[n]o changes may be made in the terms and conditions of this agreement. No statement that tries to make such a change will bind the Company."

According to the conditions of the LTLIA an applicant may be required to complete medical examinations before coverage begins. As such, page two of Part A of the application contains a list of potentially required medical examinations. Said list (which is included in the Agent/Agency Information section of page two) consists of nine possible medical examination requirements with corresponding boxes for the agent to check. The medical examination section states as follows:

> I have ordered/obtained the following requirements: APS; Blood Profile/Urinalysis; EKG; Inspection Report; MD Exam; Oral Fluids (*as state permits*); Paramedical Exam; Treadmill; Urinalysis Only (*If requirements are scheduled, please provide name of examiner, clinic and date ordered:*)

While Mr. Hibner signed page two of Part A of the application, he failed to check any of the nine medical examination boxes on plaintiff Judd's application. In his affidavit Mr. Hibner states

that he did not check any of the boxes because Diversified Brokerage Services (the general agent for plaintiff Judd's policy) prefers to arrange for any medical examinations. However, Mr. Hibner and plaintiff Judd discussed the need for a medical examination while they were completing the application. Accordingly, plaintiff Judd was aware that defendant required him to complete a medical examination before a policy would issue. Plaintiff Judd indicated to Mr. Hibner that he would complete such an examination when he returned from a planned visit away from home.

When plaintiff Judd applied for insurance on March 1, 2005 he was thirty-nine years old. According to Mr. Jeff Winkelman, who serves as defendant's Director of Underwriting, all thirty-nine year old applicants seeking $300,000 in coverage must undergo a Paramedical examination including height/weight, blood pressure and pulse, and a full blood profile and urinalysis before coverage begins under the LTLIA. However, in his supplemental affidavit Mr. Hibner states that he did not inform plaintiff Judd that a medical examination was required for the LTLIA to become effective nor did they discuss such a requirement. Rather, Mr. Hibner states that they discussed the need for a medical examination before the policy would issue.

On March 9, 2005 plaintiff Judd died in a snowmobile accident. He never took or completed any medical examinations before his

death. On April 13, 2005 defendant notified plaintiff Trissa Judd by letter of its decision to deny her claim for benefits under the LTLIA.[2] Said letter provides in relevant part as follows:

> ...As stated in the application, 'no insurance will be in effect pursuant to this application, or under any policy issued by the Company, unless or until: the policy has been delivered and accepted; the full first modal premium for the issued policy has been paid; and there has been no change in the health of any proposed insured that would change the answers to any questions in the application.'
>
> Since the conditions stated above that are necessary to put coverage in force under the policy were not met, no contract of insurance was effective at the time of [plaintiff] Judd's death and we have closed our application file. Further, as the required medical examination was not completed, there was no temporary coverage insuring the life of [plaintiff] Judd under the [LTLIA.]...

Accordingly, pursuant to the terms of the letter the only condition defendant alleges disallows coverage under the LTLIA is the failure to complete the required medical examination, a condition listed in subsection 2D of the LTLIA concerning the effective date of coverage. However, defendant's letter fails to advise plaintiff Trissa Judd as to what medical examination her late husband was required to complete before his life was temporarily insured. Subsequent to its April 13, 2005 letter defendant returned plaintiff Judd's full first modal premium in the amount of $229.32.

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[2] Plaintiff Judd named plaintiff Trissa Judd as his beneficiary under the policy.

Plaintiff Trissa Judd then filed a complaint against defendant with the Wisconsin Office of the Commissioner of Insurance. On June 6, 2005 defendant responded to plaintiff's complaint by letter. Said letter explained defendant's reasons for denying plaintiff Trissa Judd's claim for benefits as follows:

> ...The application was signed on March 1, 2005 and a check was written out to the Company for $229.32 on the same date. These items were received in the Home Office on March 15, 2005. A para-med exam, blood profile, and urine specimen were ordered per normal underwriting procedures but were never completed. The conditions outlined in section D describing the date on which the [LTLIA] becomes effective were not fully met, as the required medical examinations had not been taken. Therefore, the LTLIA was not inforce at the time of [plaintiff] Judd's death....

Additionally, on January 3, 2006 defendant sent a letter to plaintiffs' counsel explaining its reasons for denying plaintiff Trissa Judd's claim for benefits. Said letter provides in relevant part as follows:

> ...In regards to the [LTLIA]...there are a number of conditions required in order to cause coverage to be effective under this agreement. These are listed under section 2 of the LTLIA with the heading of 'Conditions of Temporary Life Insurance' and are noted by letters A through G.
>
> [Plaintiff] Judd did complete and sign the application for life insurance, did answer 'no' to both LTLIA questions on the application for life insurance and did provide the first modal premium with the application for life insurance. However, [plaintiff] Judd did not complete the medical examination required as a part of his application for life insurance. Section 2, condition D states that 'Coverage under this agreement will begin on the date the later of the following events have been completed' 1) The application has been signed by the proposed insured or 2) All required medical examinations have been taken.

> The boxes you refer to in page 2 of your letter are located within the Agent/Agency Information section of the application and allow the agent to give the home office notice that he/she has ordered certain requirements so that the ordering is not duplicated at the agency or home office level. As none of the boxes were checked by the agent, it appears that at the time of completion of the application, the agent had not yet scheduled an appointment for the examination. These check boxes do not establish the requirement of a medical examination.
>
> Since the required medical examination was not completed, there was no temporary coverage insuring the life of [plaintiff] Judd under the LTLIA and no benefits are payable under either the application for life insurance or the LTLIA.

Plaintiffs commenced this action in Sauk County Circuit Court on May 31, 2006. Defendant was served with a copy of the summons and complaint on June 2, 2006 and it filed its notice of removal on June 30, 2006.

MEMORANDUM

Defendant asserts the plain language of the LTLIA provides that coverage does not begin until an applicant completes all required medical examinations. Additionally, defendant asserts plaintiff Judd did not complete the required paramedical examination including height/weight, blood pressure and pulse, and a full blood profile and urinalysis before his death. Accordingly, defendant argues coverage does not exist under the LTLIA and as such its motion for summary judgment should be granted as it concerns plaintiffs' breach of contract claim. Additionally, defendant argues its motion for summary judgment should be granted

as it concerns plaintiffs' bad faith claim because at the very least its interpretation of the LTLIA is fairly debatable which precludes a finding of bad faith as a matter of law.

Plaintiffs assert the writings constituting the LTLIA fail to expressly specify that a medical examination was in fact required of plaintiff Judd at the time he accepted the agreement because Mr. Hibner failed to check any of the medical examination boxes. Accordingly, plaintiffs assert a reasonable person in plaintiff Judd's position would have expected the LTLIA to be effective immediately upon signing the application. As such, plaintiffs argue their motion for summary judgment should be granted on their breach of contract claim. Additionally, plaintiffs argue defendant's motion for summary judgment should be denied as it concerns their bad faith claim because based upon the law and facts the only reasonable inference that can be drawn is that defendant acted with bad faith towards its insured.

A. Standard of Review

Summary judgment is appropriate where the "pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c).

A fact is material only if it might affect the outcome of the suit under the governing law. Anderson v. Liberty Lobby, Inc., 477

U.S. 242, 248, 106 S.Ct. 2505, 2510, 91 L.Ed.2d 202 (1986). Disputes over unnecessary or irrelevant facts will not preclude summary judgment. Id. Further, a factual issue is genuine only if the evidence is such that a reasonable fact finder could return a verdict for the non-moving party. Id. A court's role in summary judgment is not to "weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." Id. at 249, 106 S.Ct. at 2511.

To determine whether there is a genuine issue of material fact for trial courts construe all facts in the light most favorable to the non-moving party. Heft v. Moore, 351 F.3d 278, 282 (7th Cir. 2003)(citation omitted). Additionally, a court draws all reasonable inferences in favor of that party. Id. However, the non-movant must set forth "specific facts showing that there is a genuine issue for trial" which requires more than "just speculation or conclusory statements." Id. at 283 (citations omitted). If a court determines that the material facts are not in dispute then the "sole question is whether the moving party is entitled to judgment as a matter of law." Santaella v. Metro. Life Ins. Co., 123 F.3d 456, 461 (7th Cir. 1997)(citation omitted). The Court finds that the material facts of this action are not in dispute. Accordingly, the Court's analysis will focus on whether the moving party is entitled to judgment as a matter of law.

B. Breach of an Insurance Contract

As a preliminary matter, the parties agree that Wisconsin law governs this controversy. Accordingly, the Court will decide the parties' motions for summary judgment under Wisconsin law. Insurance policies are contracts and as such they are governed by the same rules that govern contract interpretation in general. Wis. Label Corp. v. Northbrook Prop. & Cas. Ins. Co., 2000 WI 26, ¶ 23, 233 Wis.2d 314, 327-328, 607 N.W.2d 276, 282 (citing Smith v. Katz, 226 Wis.2d 798, 806, 595 N.W.2d 345 (1999); Kremers-Urban Co. v. Am. Employers Ins. Co., 119 Wis.2d 722, 735, 351 N.W.2d 156 (1984)). The primary goal in interpreting a contract is to determine and give effect to the parties' intention. State ex rel. Journal/Sentinel, Inc. v. Pleva, 155 Wis.2d 704, 711, 456 N.W.2d 359, 362 (1990).

Where the language of a contract is clear and unambiguous courts construe the contract according to its literal meaning. Gorton v. Hostak, Henzl & Bichler, S.C., 217 Wis.2d 493, 506, 577 N.W.2d 617, 623 (1998)(citing Eden Stone Co., Inc. v. Oakfield Stone Co., Inc., 166 Wis.2d 105, 115, 479 N.W.2d 557 (Wis.Ct.App. 1991)). However, when contractual language is reasonably susceptible to more than one meaning the contract is ambiguous. Id. (citing Maas v. Ziegler, 172 Wis.2d 70, 79, 492 N.W.2d 621 (1992)).

Whether a contract is ambiguous is a question of law. Wis. Label Corp., at ¶ 24, 233 Wis.2d at 328, 607 N.W.2d at 283

(citation omitted). Any ambiguity that does exist will be interpreted against the drafter. Id. However, where language of a policy is not ambiguous courts "will not engage in construction, but will merely apply the policy terms." Kremers-Urban Co., 119 Wis.2d at 736, 351 N.W.2d at 163 (citation omitted).

Additionally, when the contract at issue is an insurance policy courts are guided by the principle that "words of the policy should be given the meaning that a reasonable person in the position of the insured would have given them." Wis. Label Corp., at ¶ 25, 233 Wis.2d at 328, 607 N.W.2d at 283 (citation omitted). However, courts are instructed not to rewrite an insurance policy so as to provide coverage for "a risk which the insurer did not contemplate and for which it has not been paid." Qualman v. Bruckmoser, 163 Wis.2d 361, 365, 471 N.W.2d 282, 284 (Wis.Ct.App. 1991)(citing Wis. Builders, Inc. v. Gen. Ins. Co. of Am., 65 Wis.2d 91, 103, 221 N.W.2d 832, 838 (1974)).

It is undisputed that plaintiff Judd was not insured under the policy. Accordingly, the issue is whether plaintiff Judd was required by the terms of the LTLIA to complete any medical examinations before coverage began under the agreement. There is a great deal of authority for the proposition that "the requirement of a medical examination may be made a condition precedent to coverage." Fox v. Catholic Knights Ins. Soc'y, 2003 WI 87, ¶ 36, 263 Wis.2d 207, 231, 665 N.W.2d 181, 192. Additionally, whether a

condition is a condition precedent to coverage "depends on the language of the contract itself." Id. If a medical examination is a condition precedent to coverage and the proposed insured does not "then get an examination required for coverage to take effect, there is no contract for insurance." Id. (citing *Couch on Insurance* § 13.10).

The policy behind such a proposition is simple and logical: were courts to determine that temporary insurance arises when an applicant pays a premium with his or her application but dies before fulfilling conditions precedent to coverage insurers would either have to "charge high rates to cover the risk of providing interim insurance or stop providing it altogether." Id. at ¶ 41, 263 Wis.2d at 234, 665 N.W.2d at 194. Additionally, applicants would have "no incentive to actually get the required medical examinations or fulfill other required conditions of coverage if even the uninsurable were guaranteed coverage for some period of time before the insurability determination." Id. Accordingly, there is no question that defendant can make completion of medical examinations a condition precedent to coverage under the LTLIA. However, the question is whether the plain language of plaintiff Judd's contract required him to complete a medical examination as a condition precedent to coverage under the LTLIA. The Court finds that it did not.

The outcome of this action is controlled by the holdings of both the Wisconsin Court of Appeals and the Wisconsin Supreme Court

in Fox ex rel. Fricker v. Catholic Knights Ins. Soc'y, 2002 WI App 117, 254 Wis.2d 632, 649 N.W.2d 307; Fox, 2003 WI 87, 263 Wis.2d 207, 665 N.W.2d. 181. On May 21, 1997 Patrick Fox completed a CKIS "Application For Membership And Life Insurance" for a $150,000 term life insurance policy in which he named his son Austin the primary beneficiary. Fox ex rel. Fricker, at ¶ 3, 254 Wis.2d at 636, 649 N.W.2d at 309. Additionally, on said date Mr. Fox paid CKIS $31.94 for the first premium. Id. Mr. Fox's application included a section entitled "Receipt For Payment and Conditional Insurance Agreement" which provided in relevant part as follows:

> C. When Coverage Begins...
> *Coverage under this Agreement begins on the* ***latest*** *of the following dates:*
> *-The date of this application*
> *-The date of this Agreement*
> -The effective date specifically requested in the application
> *-The date of completion of all examinations and medical studies required by the rules and practices of CKIS.*

Id. at ¶ 4, 254 Wis.2d at 636-637, 649 N.W.2d at 309 (bold and italics in original).

Additionally, Mr. Fox's application included a section entitled "Agent's Report" which concluded with a subsection stating: "Check medical requirements ordered." Id. at ¶ 5, 254 Wis.2d at 637, 649 N.W.2d at 309. There followed four options "allowing the agent to indicate whether 'Exam,' 'Blood,' 'EKG,' and/or 'Urine Specimen' was required." Id. On Mr. Fox's application the agent entered an "x" in only the "Yes" box for

"Blood." Id. Mr. Fox was scheduled to have his blood drawn on the afternoon of June 6, 1997. However, Mr. Fox died in the morning hours of June 6, 1997 in a car accident. Id. at ¶ 6, 254 Wis.2d at 637, 649 N.W.2d at 309. CKIS denied insurance coverage because Mr. Fox failed to obtain the necessary blood draw meaning the policy never took effect. Id. at ¶ 7, 254 Wis.2d at 638, 649 N.W.2d at 310.

In an August 26, 1997 letter to plaintiff's attorney CKIS stated in relevant part as follows:

> ...[[T]he agent] states that he gave Mr. Fox a Receipt for Payment and Conditional Insurance Agreement which clearly states that coverage will [not] begin until 'the date of completion of all examinations and medical studies required by the rules and practices of CKIS.' The Catholic Knights Rate Book...specifies that a blood profile is a routine requirement for all applications for coverage in excess of $99,999. Mr. Fox applied for $150,00[0] in coverage, and, therefore, a blood profile was a condition of our Conditional Insurance Agreement form, without which a final decision for insurance coverage could not be made....

Id. at ¶ 9, 254 Wis.2d at 639-640, 649 N.W.2d at 310-311. Resolving the action on summary judgment, the circuit court concluded that coverage had not begun under the Conditional Insurance Agreement before Mr. Fox died. Id. at ¶ 10, 254 Wis.2d at 640, 649 N.W.2d at 311.

On appeal, CKIS argued that "it 'required both a blood and urine sample as a condition to commencement of the coverage subject to a determination of insurability,' and that 'no urine sample as required for this level of insurance was ever submitted.'" Id. at

¶ 21, 254 Wis.2d at 644, 649 N.W.2d at 313. Additionally, the agent involved in the transaction submitted an affidavit indicating that he informed Mr. Fox "that 'the terms of the Conditional Insurance Agreement required that a blood *and* urine specimen be collected and analyzed before coverage could become effective.'" Id. at ¶ 21, 254 Wis.2d at 644-645, 649 N.W.2d at 313 (italics in original). Further, a CKIS representative submitted an affidavit in which he stated that "'[w]ithout a reliable blood *and* urine sample from the applicant, [CKIS] is unable to complete the underwriting process in accord with its standards and guidelines.'" Id. at ¶ 21, 254 Wis.2d at 644, 649 N.W.2d at 313 (italics in original).

However, the Court of Appeals disagreed finding that Mr. Fox's contract "required only a blood test....As noted, on [Mr. Fox's] application, the agent did not enter an 'x' indicating that 'Urine Specimen' was among the 'medical requirements ordered.'" Id. at ¶ 21, 254 Wis.2d at 645, 649 N.W.2d at 313. Additionally, the Court of Appeals held that CKIS could not prove that Mr. Fox's failure to provide a blood sample before his death "'increase[d] the risk at the time of the loss,'" under Wis. Stat. § 631.11(3). Id. at ¶ 23, 254 Wis.2d at 646, 649 N.W.2d at 314. Accordingly, the Court of Appeals held that Mr. Fox's coverage was in effect on the date of his death. Id. at ¶ 25, 254 Wis.2d at 647, 649 N.W.2d at 314.

The Wisconsin Supreme Court reversed the holding of the Court of Appeals concerning both the application of Wis. Stat. §

631.11(3) and the coverage determination. Fox, at ¶ 42, 263 Wis.2d at 324-325, 665 N.W.2d at 194. Specifically, the Supreme Court determined that Mr. Fox "understood that certain requirements, including the blood test, had to be fulfilled before he would have coverage. However, he died before the requirements were met. As a result, we must conclude that there was no insurance policy in effect at the time [Mr.] Fox died." Id. However, the Supreme Court's findings concerning CKIS' urine specimen argument are as follows:

> CKIS asserts that a urine test was also required, despite the fact it was not marked in the Agent's Report. Several affidavits included in the record affirm that [Mr. Fox] was to complete both blood and urine tests. Because we find the blood test issue alone to be dispositive in this case, this dispute is not material and we do not reach a conclusion about whether a urine test was required.

Id. at ¶ 7, n. 2, 263 Wis.2d at 214, 665 N.W.2d at 184. Accordingly, the Wisconsin Supreme Court did not specifically reverse the Court of Appeals holding that a urine specimen was not a condition precedent to Mr. Fox's coverage because the agent failed to mark an "x" in its corresponding "Yes" box.

The general rule in Wisconsin is "that holdings not specifically reversed on appeal retain precedential value." Sweeney v. Gen. Cas. Co. of Wis., 220 Wis.2d 183, 192, 582 N.W.2d 735, 738 (Wis.Ct.App. 1998)(citing Spencer v. County of Brown, 215 Wis.2d 635, 644, 573 N.W.2d 222, 226 (Wis.Ct.App. 1997)). This general rule is not applied when an appellate court expresses

reservation concerning the basis of the lower court's decision on the issue not specifically reached or reversed by the appellate court. Id. at 192, 582 N.W.2d at 739. For example, courts have declined to apply the general rule when an appellate court decision includes language such as "'we emphasize that our decision should not be taken as approval of the reasoning of the Court of Appeals on that issue.'" Id. (citations omitted). The Wisconsin Supreme Court in Fox failed to include such language in its opinion. Accordingly, the Court finds it should apply Wisconsin's general rule to this action. As such, the Wisconsin Court of Appeals holding in Fox ex rel. Fricker that a urine specimen was not a condition precedent to Mr. Fox's coverage because the agent failed to mark an "x" in its corresponding "Yes" box retains precedential value and controls the outcome of this action.

It is undisputed that Mr. Hibner failed to check any of the nine medical examination boxes on plaintiff Judd's application. Defendant asserts Mr. Hibner did not check a box on the application indicating that he had ordered either the Blood Profile/Urinalysis or the Paramedical Exam because he had not done so. Defendant argues this fact is not dispositive because Mr. Hibner's indication concerning whether tests were ordered does not control whether the company requires completion of such examinations before coverage begins. However, the medical examination section involved in Fox ex rel. Fricker contained the language "[c]heck medical

requirements ordered," Fox ex rel. Fricker, at ¶ 5, 254 Wis.2d at 637, 649 N.W.2d at 309, while the medical examination section at issue contains the language "I have ordered/obtained the following requirements." The language contained in the two contracts is essentially identical. Accordingly, failure to check either the Blood Profile/Urinalysis box or the Paramedical Exam box is fatal to defendant's argument that the plain language of the LTLIA made it clear that said examinations were conditions precedent to coverage just as the identical failure was fatal for defendant CKIS concerning its urinalysis requirement in Fox ex rel. Fricker. Id. at ¶ 21, 254 Wis.2d at 644-645, 649 N.W.2d at 313.

However, defendant argues said medical examinations were required pursuant to its underwriting requirements. It is undisputed that defendant's underwriting requirements establish that all applicants in plaintiff Judd's position (thirty-nine year old applicants applying for $300,000 worth of coverage) must complete a Paramedical examination including height/weight, blood pressure and pulse, and a full blood profile and urinalysis before coverage begins under the LTLIA. Additionally, it is undisputed that Mr. Hibner could not waive or modify any of defendant's rights or requirements. However, because the contract is not ambiguous defendant's underwriting requirements either had to be expressly stated in the contract or incorporated by reference and they were neither.

Section two of the LTLIA is entitled "Conditions of Temporary Life Insurance" and it provides that coverage under the agreement will begin on either the date the application has been signed by the proposed insured or the date "[a]ll required medical examinations have been taken." This language does not indicate what medical examinations are required and it does not mention defendant's underwriting requirements.

In contrast, the "Receipt for Payment and Conditional Insurance Agreement" at issue in Fox ex rel. Fricker contained the following language: "When Coverage Begins...*Coverage under this Agreement begins on the* ***latest*** *of the following dates:...The date of completion of all examinations and medical studies required by the rules and practices of CKIS.*" Id. at ¶ 4, 254 Wis.2d at 637, 649 N.W.2d at 309 (bold and italics in original). Had plaintiff Judd's contract included similar language the Court would be inclined to find that defendant's underwriting requirements were incorporated into the LTLIA by reference. However, plaintiff Judd could not have been aware of defendant's underwriting requirements because no language contained within the LTLIA even mentioned or referenced such requirements. Accordingly, the unambiguous language of the LTLIA establishes that defendant's underwriting requirements were not incorporated into the agreement by reference.

Additionally, Mr. Hibner did not inform plaintiff Judd that a medical examination was required for the LTLIA to become effective

nor did they discuss such a requirement on March 1, 2005. Rather, Mr. Hibner states that they discussed the need for a medical examination before the policy would issue. The policy and the LTLIA are distinct from one another. Accordingly, without the benefit of such information a reasonable person in plaintiff Judd's position would not know that either a Blood Profile/Urinalysis nor a Paramedical Exam was a condition precedent to coverage when neither box was marked "Yes" on the application. Wis. Label Corp., at ¶ 25, 233 Wis.2d at 328, 607 N.W.2d at 283 (citation omitted). Accordingly, because the language of the LTLIA is unambiguous the Court construes it according to its literal meaning and finds that neither a Blood Profile/Urinalysis nor a Paramedical Exam was a condition precedent to coverage under the LTLIA. As such, coverage began under the LTLIA on March 1, 2005 which was the date plaintiff Judd signed the application and plaintiff's motion for summary judgment on its breach of contract claim is granted.

C. Bad Faith

To sustain a claim for bad faith a plaintiff must demonstrate the "absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim." Anderson v. Cont'l Ins. Co., 85 Wis.2d 675, 691, 271 N.W.2d 368, 376 (1978). Additionally, where a claim is "fairly debatable" an insurer is entitled to debate it and any subsequent decision by such an

insurer cannot be said to be made in bad faith. Id. The "fairly debatable" test requires that "a claim [] be investigated properly and the results of that investigation [] be subject to reasonable evaluation and review." Trinity Evangelical Lutheran Church and School-Freistadt v. Tower Ins. Co., 2003 WI 46, ¶ 33, 261 Wis.2d 333, 347, 661 N.W.2d 789, 795 (citation omitted).

Additionally, an insurer has a duty to exercise ordinary care and reasonable diligence when it handles claims and it must exercise "honest and informed judgment." Id. at ¶ 34, 261 Wis.2d at 348, 661 N.W.2d at 796 (citation omitted). Accordingly, bad faith "'is the absence of honest, intelligent action or consideration based upon a knowledge of the facts and circumstances upon which a decision in respect to liability is predicated.'" Id. at ¶ 34, 261 Wis.2d at 347-348, 661 N.W.2d at 796 (citation omitted). Plaintiffs failed to meet their burden of establishing that defendant acted in bad faith. Accordingly, defendant's motion for summary judgment is granted as it concerns said claim.

Plaintiffs argue that had defendant "read the Court of Appeals decision in *Fox*, which it would have found had it exercised even ordinary care, [it] would have concluded that its denial of benefits in a case involving nearly identical facts was not fairly debatable." (Pls.' Br. Opp'n Def.'s. Mot. Summ. J. at page 7). While the Wisconsin Supreme Court in Trinity did find that the insurer (Tower) acted in bad faith when it ignored a seminal case

with nearly identical facts, the Supreme Court based this finding on the fact that Tower was the defendant in the prior action. Accordingly, the Court found it had actual notice of the decision. Trinity, at ¶ 39, 261 Wis.2d at 349, 661 N.W.2d at 796. However, defendant was not the defendant in Fox. Accordingly, defendant was not "put on notice" by any court that denying plaintiff Trissa Judd's claim would result in a finding of bad faith.

Additionally, plaintiffs argue that defendant acted with reckless disregard of the facts because it did not consult with Mr. Hibner concerning discussions he had with plaintiff Judd on March 1, 2005. However, it is undisputed that Mr. Hibner could not waive or modify any of defendant's rights or requirements. Accordingly, discussions that occurred between Mr. Hibner and plaintiff Judd on March 1, 2005 would have been largely irrelevant to defendant's investigation of plaintiff Trissa Judd's claim for benefits.

Defendant denied plaintiff Trissa Judd's claim for benefits when it determined that coverage did not exist under the LTLIA because plaintiff Judd failed to complete the medical examinations required by its underwriting requirements. While defendant's determination was incorrect, there is no evidence in the record suggesting that defendant failed to exercise ordinary care and reasonable diligence when it handled said plaintiff's claim. Id. at ¶ 34, 261 Wis.2d at 348, 661 N.W.2d at 796 (citation omitted). Accordingly, plaintiffs failed to meet their burden of establishing

that defendant denied plaintiff Trissa Judd's claim in bad faith. As such, defendant is entitled to summary judgment as a matter of law on plaintiffs' bad faith claim and its motion is hereby granted.

ORDER

IT IS ORDERED that plaintiffs Dean L. Judd, Trissa C. Judd, and Dean and Trissa Judd Family Trust's motion for summary judgment on their breach of contract claim is GRANTED.

IT IS FURTHER ORDERED that defendant American General Life Insurance Company's motion for summary judgment is GRANTED as it concerns plaintiff's bad faith claim and in all other respects is DENIED.

IT IS FURTHER ORDERED that judgment is entered in favor of plaintiffs against defendant on the breach of contract claim in the amount of $300,000.00 plus interest at the rate of 12% per annum from the date of April 13, 2005 and costs.

IT IS FURTHER ORDERED that judgment is entered in favor of defendant against plaintiffs on their bad faith claim dismissing said claim with prejudice and costs.

Entered this 16th day of November, 2006.

BY THE COURT:

S/

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JOHN C. SHABAZ
District Judge