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## **§1.1 ELEMENTS OF AN INSURANCE CONTRACT**

A valid insurance contract requires both an offer and an acceptance. A blank application provided to the potential insured is typically not considered an offer; but once the application is completed and returned to the insurer, it becomes an offer for an insurance contract.

1A COUCH ON INSURANCE §11.1 (3d ed 1995 & Supp 2011).

### §1.1-1 Basic Requirements

Insurance is, essentially, a contract by which one party gives a consideration, typically paid in money, in exchange for a promise from another party to make a return payment if a certain loss has occurred. The word *insurance* means “a contract whereby one undertakes to indemnify another or pay or allow a specified or ascertainable amount or benefit upon determinable risk contingencies.” ORS 731.102(1). For more on the contents typically contained in an insurance policy, see §§1.2-1 to 1.2-1(a)(6).

The contract of insurance includes not only the policy itself, which is the written form embodying the agreement of the parties, but also, depending on varying circumstances, the application riders, endorsements, statutes, charters, bylaws, and whatever else the parties agree will be part of the contract. *See, e.g., First Far West Transp., Inc. v. Carolina Casualty Ins. Co.*, 47 Or App 339, 344, 614 P2d 1187 (1980) (endorsement becomes part of insurance contract and, to extent of any conflict between endorsement and policy, endorsement controls); *Rhone v. Louis*, 282 Or 693, 695–696, 580 P2d 549 (1978) (requirements of statutes and ordinances will be deemed covered by insurance policies, adding to or displacing provisions of policy itself); *Collins v. Farmers Ins. Co.*, 312 Or 337, 341, 822 P2d 1146 (1991) (because statute listing mandatory contents of motor vehicle liability policy refers to statute stating minimum coverage requirements, every such policy must contain that coverage as a minimum); *Brock v. State Farm Mut. Auto. Ins. Co.*, 195 Or App 519, 531-532, 98 P3d 759 (2004) (if application contains language indicating policy will not issue until acceptance, then it

typically does not contain an enforceable binder); *Baylor v. Cont'l Cas. Co.*, 190 Or App 25, 78 P3d 108 (2003) (while ruling that certificate of insurance did not provide temporary provision of coverage, court acknowledged possibility that certificate could be construed as enforceable binder); *Safeco Ins. Co. of Am. v. Am. Hardware Mut. Ins. Co.*, 169 Or App 405, 9 P3d 749 (2000) (policy exclusion held invalid in light of statutory provision). Furthermore, the basic contents of certain insurance policies are dictated by statute (*see* ORS 742.450 (auto policies), ORS 742.370 (surety bonds), ORS 742.202 (fire insurance)) and the forms of most applications and policies must be pre-approved by the Oregon Department of Consumer and Business Services (*see* §.1-1(b)). Even employer rules relating to an employer's group life policy may be part of the contract of insurance. *Rhodes v. Equitable Life Assurance Soc.*, 109 Or 586, 592–593, 220 P 736 (1924).

Except for binders and contracts for temporary insurance covered by ORS 742.043 (discussed in §§1.1-3 to 1.1-3(c)), every contract of insurance is to be construed in accordance with the terms and conditions of the policy. The written application is considered part of the policy if the insurer delivers a copy of the application with the policy to the insured. ORS 742.016(1). If a copy of the application is not delivered to the insured, it is not part of the contract and the insurer is precluded from introducing the application as evidence in any action involving the policy. ORS 742.016(1). *See also* §§1.4-3 to 1.5-6 (rescission and reformation). The term *copy* includes a typewritten transcription of a signed, handwritten application. *Ives v. INA Life Ins. Co.*, 101 Or App 429, 433, 790 P2d 1206 (1990).

When an endorsement adequately states the coverage provided by the policy, it may constitute a contract. In *Wright v. State Farm Mut. Auto. Ins. Co.*, 332 Or 1, 22 P3d 744 (2001), the court held that an endorsement satisfied the statutory requirement to state the coverage afforded by the policy (ORS 742.450(1)), even though neither the declarations page nor the endorsement itself explicitly set forth the limits of liability. The declarations page stated that other limits and exclusions could apply and that the policy consisted of the declarations page, endorsements, and the policy form. The court stated that the statute does not require that all rules related to a particular kind of claim must appear together in one place in the policy. *Wright*, 332 Or at 15–16. *See also Waller v. Auto-Owners Ins. Co.*, 174 Or App 471, 476, 26 P3d 845 (2001) (endorsement and uninsured motorist coverage define *named insured*); *First Far West Transp., Inc. v. Carolina Casualty Ins. Co.*, 47 Or App 339, 344, 614 P2d 1187 (1980) (endorsement becomes part of insurance contract and, to extent of any conflict between endorsement and policy, endorsement controls).

When the agreement is represented in a written policy, strict parol evidence rules apply, and an unattached application is inadmissible. *Progressive Ins. v. Nat'l Am. Ins. Co.*, 201 Or App 301, 307, 118 P3d 836 (2005) (court would not admit evidence of unattached application even if evidence would prove that insured had duplicative coverage). See §1.1-2 regarding oral contracts.

Policy provisions making any portion of the insurer's charters, bylaws, or other constituent documents a part of the insurance contract

are invalid unless that portion is set out in full in the policy. ORS 742.033.

**§1.1-1(a) Steps in Formation**

**§1.1-1(a)(1) Offer**

A completed application for an insurance policy is an offer to make a contract and is subject to the prospective insurer's acceptance or rejection. *Morford v. California Western States Life Ins. Co.*, 166 Or 575, 589–593, 113 P2d 629 (1941) (when insurer issued policy that contained terms at variance with completed application, it was actually a counter-offer and no contract could be made until applicant accepted policy).

Basic policy or application forms for insurance must be pre-approved by the Director of the Department of Consumer and Business Services (the Director). ORS 742.003 (also listing four exceptions, ORS 742.003(1)(a)–(d)).

Absent a statute to the contrary, an application need not be completed and signed before the parties can enter into a binding contract of insurance. 1A COUCH ON INSURANCE §11.1 (3d ed 1995 & Supp 2011). In Oregon, a single life or health insurance policy may not be made on an individual without a written application or written consent by the individual insured at the time of making the insurance contract. ORS 743.027. This statute does not apply to group life or to group or blanket health insurance. Other exceptions from the requirement of written application or consent are:

- (1) One spouse may take out insurance on the other spouse;

(2) A person having an insurable interest in the life of a minor, or a person on whom a minor depends for support and maintenance, may effectuate insurance on the minor;

(3) Family policies may be issued insuring any two or more members of the family pursuant to an application signed by either parent, a stepparent, or by a husband or wife;

(4) A person on whom an adult depends for support and maintenance may effectuate insurance that provides for the final expenses of the dependent adult; and

(5) A person may effectuate insurance that provides for the funeral expenses of an adult if the person:

(a) Is closely related to the adult by blood or by law or has a substantial interest in the adult engendered by love and affection; and

(b) Has a lawful and substantial interest in having the life, health, and bodily safety of the adult continue. ORS 743.027.

If a written application is not expressly required, the application may be either written or oral. *See* §§1.1-2 to 1-1.2(b)(1) (oral contracts). But it logically follows that the less formal the application for insurance, the more likely a future dispute arises. 1A COUCH ON INSURANCE §11.2.

An insurer may establish its own requirement that an application be filed and signed before issuing a policy by establishing it as a condition precedent to the inception of the risk. But even with an express provision, such a condition precedent may be waived if the insurer represents orally that the insured is covered or delivers a policy to the insured before obtaining the insured's signed application. 1A COUCH ON INSURANCE §11.2.

If the terms of the coverage and the parties to the insurance contract may be determined from the application, the application may serve as an effective binder. *See* §§1.1-3 to 1.1-3(c) (binders).

As with general contracts, an application or an offer for an insurance contract generally may be revoked at any time. 1A COUCH ON INSURANCE §11.3.

For more on the construction of language in an application in relation to the scope of the coverage provided, see §§1.2 to 1.2-4(c).

### **§1.1-1(a)(2) Acceptance**

As indicated in §1.1-1(a)(1), unless a specific statute requires otherwise, a completed application is not required before a binding contract of insurance can be made. However, when a statute or the insurer requires an application, the completed application often is considered a mere offer that the insurer must accept in order to complete the insurance contract. *Krause v. Washington Nat'l Ins. Co.*, 255 Or 446, 457, 468 P2d 513 (1970); *Morford v. California Western States Life Ins. Co.*, 166 Or 575, 583, 113 P2d 629 (1941); *Cranston v. California Ins. Co.*, 94 Or 369, 379, 185 P 292 (1919).

Acceptance may be conditional. For example, an application may provide that the insurance will not take effect until the applicant receives the policy and the first premium is paid in full during the applicant's lifetime and good health. In *Olsen v. Fed. Kemper Life Assurance Co.*, 299 Or 169, 173, 700 P2d 231 (1985), the application stated that the policy would not be effective even if the application was received and approved, the policy issued and delivered, and the first premium paid to and accepted by the insurance company, unless the applicant's health and

habits were as described in the application. The applicant learned he had cancer after signing the application but before the policy was delivered back to him. The policy delivered to the applicant contained an “effective date” that predated the applicant’s knowledge of his illness. The court held that the language of the application created a condition precedent to effectiveness of the policy that was not satisfied and, therefore, the policy never took effect. The court found that, because the policy never took effect, the “effective date” listed in the policy did not create conflicting terms.

The insurance policy itself may also provide that the policy not become effective until the first premium has been paid in full or until the policy has been delivered to the insured. *See Krause*, 255 Or at 457; *Olsen*, 299 Or at 173.

With contracts in general, the “acceptance of an offer . . . must . . . correspond to the offer at every point, leaving nothing open for future negotiations.” *Arboireau v. Adidas-Salomon AG*, 347 F3d 1158, 1163 (9th Cir 2003).

An acceptance of an application or offer for insurance may be established not only by an insurer’s express statement but also by acts and conduct. 1A COUCH ON INSURANCE §11.4 (3d ed 1995 & Supp 2011). For example, the insurer may be held to have accepted an application for insurance by acquiescence if the insurer receives and retains the premium for an unreasonable length of time. *Zerba v. Ideal Mut. Ins. Co.*, 96 Or App 607, 611, 773 P2d 1333 (1989) (issue of fact existed whether coverage was rejected or rejection was not properly communicated); *see also Sonnen v. AmerUs Life Ins. Co.*, 250 Fed Appx

222 (9th Cir 2007) (insurer's holding premiums while awaiting acceptance from insured regarding proposed changes to life insurance policy did not constitute acceptance).

The length of time that an insurer must hold a premium to constitute acceptance has not been squarely addressed in Oregon. *See Douglass v. Mutual Benefit Health & Accident Ass'n*, 76 P2d 453, 459-460 (NM 1937) (when insurer held premium for "more than fifty days" and policy was to take effect on receipt of application and premium, reasonable presumption arose that insurer accepted applicant's offer as embodied in application); *Hahn v. National Casualty Co.*, 136 P2d 739, 741 (Idaho 1943) (insurer's retaining premium for "some four months" before refund, after accident, indicated insurer's acquiescent acceptance of application).

Some jurisdictions hold that actual notice to the insured of the acceptance of his or her application for insurance is not required unless the terms of the application require it. *Van-Arsdale-Osborne Brokerage Co. v. Cooper*, 115 P 779, 781 (Okla 1911). Under this view, the application is an offer of a unilateral contract that calls only for the performance of an act, that is, the issuance of a policy; notice is not required. Other jurisdictions hold that acceptance is not effective until communicated to the applicant. The acceptance must be either communicated to the offeror or evidenced by some definitive act, such as placing the policy in the mail. *Munhall v. Travelers' Ins. Co.*, 150 A 645, 648 (Pa 1930). *Cf.* 1A COUCH ON INSURANCE §§11.3–11.10.

Once the application has been completed, assuming it is not revoked, the insurer can either accept it, decline it, impose conditions to

the making of it, or submit a counteroffer. *See Morford*, 166 Or at 583, 589, 113 P2d 629 (1941); 1A COUCH ON INSURANCE §11.3.

If the application requests one kind of benefits but the policy issued covers different benefits, the issuance of a policy with such changes constitutes a counteroffer that the applicant must accept before a valid insurance contract is formed. *Morford*, 166 Or at 583 (when insurer issued policy that differed from specific insurance requested and premium was few cents cheaper, policy was held to be mere counteroffer.); *see also Cranston*, 94 Or 369 (policy and “covering notes,” sent to insurance broker in response to receipt of letter from broker to plaintiff stating that plaintiff would be covered, were counteroffer that would not give rise to contract until accepted).

For there to be a valid acceptance, the parties must agree on the amount of the premium—either expressly or impliedly—by reference to rates established by law or through prior course of dealing. In *Simmons v. All Am. Life Ins. Co.*, 115 Or App 409, 413, 838 P2d 1088 (1992), the court held that there was no valid contract of insurance when the applicant enrolled in a life insurance program offered by an alumni association but the applicant did not know the amount of the premium and had not agreed to pay it.

Insurers may designate parties authorized to accept applications but must keep a list of insurance producers, who are contractually authorized to accept applications on behalf of insurer. ORS 744.078(2).

An insurer that accepts an incomplete application cannot later deny liability based on the applicant’s failure to complete the application. 1A COUCH ON INSURANCE §11.3.

**§1.1-1(a)(3) Execution and Delivery of Policy**

Insurers frequently impose the condition that the contract of insurance will not be effective before the execution, or signing or countersigning, and delivery of the policy. 1A COUCH ON INSURANCE §14.1 (3d ed 1995 & Supp 2011).

Signing by the insurer is required before a valid written contract of insurance is effective. 1A COUCH ON INSURANCE §14.3. Sometimes a policy may require the insured's signature and acceptance of the insurer's written offer (the policy). *Morford v. California Western States Life Ins. Co.*, 166 Or 575, 586, 113 P2d 629 (1941). In Oregon, a single life or health insurance policy may not be made on an individual without a written application or written consent by the individual insured. ORS 743.027 (with some exceptions).

If a policy provides that it must be signed and issued before it takes effect, the term *issued* means that the policy has been drafted, signed, and executed by the company, making the policy ready for delivery. The term *issued* does not include delivery. *See Stringham v. Mutual Life Ins. Co.*, 44 Or 447, 457, 461, 75 P 822 (1904); *Brock v. State Farm Mut. Auto. Ins.*, 195 Or App 519, 98 P3d 759 (2004).

When the application or the contract of insurance requires that the policy be delivered to the insured before it becomes effective, that provision is effective in accordance with its terms. *Morford*, 166 Or at 588. *See also Stringham*, 44 Or at 461 (no binding delivery of life insurance policy after death of applicant). In the absence of such a provision or a statutory requirement, delivery is not necessary for the

contract to become effective. *Krause v. Wash. Nat'l Ins. Co.*, 255 Or 446, 457, 468 P2d 513 (1970).

Delivery of the policy is satisfied when the policy is delivered to a broker or other agent for the insured. *Krause*, 255 Or at 459. Receipt by an agent for the insurance company of a policy to be delivered without condition by the agent to the applicant constitutes delivery to the insured, even if the agent never parts with the policy. *Morford*, 166 Or at 588; *Krause*, 255 Or at 459. See also *Lathrop v. Modern Woodmen of America*, 63 Or 193, 126 P 1002 (1912) (when applicant had complied with all conditions and was not in default, deposit of policy with a delivery clerk constituted delivery to applicant). If the policy or application contains conditions, however, that require the applicant to take further steps before final delivery, mailing the policy to the insurer's local agent does not constitute delivery. *Morford*, 166 Or at 586 (delivery conditioned on applicant's signature as acceptance of offer of insurance); *Krause*, 255 Or at 458 (delivery conditioned on payment of premium).

Except when the insured has not met a condition required by the insurer, every policy must be mailed or delivered to the insured or the person entitled to the policy "within a reasonable period of time" after it is issued. ORS 742.046(1). The statute does not make delivery a condition precedent to the effectiveness of the policy, but merely requires that the policy reach the hands of the person entitled to it within a reasonable time.

Delivery of an insurance policy may be completed by actual delivery to the insured, or by constructive delivery. 1A COUCH ON INSURANCE §§14:5, 14:12. A policy is delivered when it is deposited in

the mail, directed to the insured at the insured's proper address, with postage prepaid, even though the insured does not receive it. 1A COUCH ON INSURANCE §14:15.

Failure to attach the application to the delivered policy precludes admissibility of the application in an action based on or involving the policy. *Progressive Ins. v. Nat'l Am. Ins. Co.*, 201 Or App 301, 306–307, 118 P3d 836 (2005) (insurer could not introduce application as evidence that driver of automobile at time of accident was excluded). See ORS 742.013 (discussed in §§1.3-3 to 1.3-3(h)).

If the insured fails to show damages caused by the insurer's failure to timely deliver the policy, the trial court should not submit the issue of delivery to a jury. *Stuart v. Pittman*, 235 Or App 196, 207, 230 P3d 958 (2010), *reversed on other grounds*, 350 Or 410, \_\_\_ P3d \_\_\_ (2011).

Whether a self-insurer has the same or a different duty to deliver has not been squarely decided in Oregon. In *Wilson v. Tri-County Metro. Transp. Dist. of Or.*, 343 Or 1, 11 n 2, 161 P3d 933 (2007), the court stated that “The parties do not discuss in their briefs whether TriMet, as a self-insurer, has the same or a different duty as an ordinary motor vehicle liability insurer to deliver to or otherwise notify an insured of the terms of its uninsured motorist coverage under the TriMet Code. Consequently, we do not address that issue.”

### **§1.1-1(b) Statutes Regulating Content or Form**

When a statute regulates the content of an insurance policy, the statutory requirements are deemed to be part of the policy, adding to or displacing provisions of the policy itself. *Rhone v. Louis*, 282 Or 693, 695–696, 580 P2d 549 (1978) (construing Portland city ordinance);

*Viking Ins. Co. v. Petersen*, 308 Or 616, 621, 784 P2d 437 (1989) (“the endorsement attempting to restrict coverage to only those 25 years or older violates the minimum requirements of Oregon's financial responsibility laws”); *Moore v. Mutual of Enumclaw Ins. Co.*, 317 Or 235, 243, 855 P2d 626 (1993) (“in cases involving fire insurance policies, the requirement of a written waiver imposed by ORS 742.222 supersedes the common law rule recognizing oral waiver and waiver by conduct”); *Safeco Ins. Co. v. Am. Hardware Mut. Ins. Co.*, 169 Or App 405, 416, 9 P3d 749 (2000) (insurance policy violated requirement in financial responsibility law to “provide minimum coverage to all permissive users of its insured's vehicles,” and therefore must be construed to cover permissive user of vehicle); *Cambron v. North-West Ins. Co.*, 70 Or App 51, 54, 687 P2d 1132 (1984) (“the law existing at the time and place of the making of an insurance contract is as much a part of the contract as if it had been specifically included in the contract”); *see also Hansen v. Western Home Ins. Co.*, 89 Or App 68, 747 P2d 1007 (1987) (former version of ORS 742.048 prohibited insurers from reducing coverage in policy that was present in binder); 2 COUCH ON INSURANCE §21.20 (3d ed 1995 & Supp 2011) (majority rule is same).

Many Oregon statutes require that a liability insurance policy contain certain provisions or coverages. *See, e.g.*, ORS 742.031 (bankruptcy clause), ORS 742.502 (uninsured motorist coverage), ORS 742.520–742.544 (personal injury protection benefits). The statutes also control the effect of certain acts or omissions of the parties. *See, e.g.*, ORS 742.013 (misrepresentations in insured's application), ORS 742.056

(insurers' conduct as waiver or estoppel), ORS 742.564 (method and timing of cancellation).

Any policy provisions that are less favorable to the insured than the provisions required by statute are unenforceable. *Erickson v. Farmers Ins. Co.*, 331 Or 681, 685, 21 P3d 90 (2001). But an insurer may add neutral or more favorable terms than those required by statute. *Erickson*, 331 Or at 685.

An exclusion that is contrary to a statutory requirement, however, is effective in excluding coverage above the statutory minimum. In *Collins v. Farmers Ins. Co.*, 312 Or 337, 345-347, 822 P2d 1146 (1991), the court held that a policy provision excluding statutorily required coverage would be disregarded only to the extent that it conflicted with the statutory requirement. The insurer was thus liable to only the statutory minimum coverage of \$25,000 and not the full \$100,000 coverage that the policy would have provided without the exclusion. The court went on to hold that an insurance company could exclude some persons from the higher coverage limits in a policy, as long as the statutory minimums were provided. *See also Oregon Auto. Ins. Co. v. Thorbeck*, 283 Or 271, 583 P2d 543 (1978) (parsing the word "coverage"); *Hartford Acci. & Indem. Co. v. Kaiser*, 242 Or 123, 126, 407 P2d 899 (1965) (insurance companies have "the right to exclude certain named individuals from the full-face-value coverage of a policy so long as they cover the same individuals to a limited degree as 'omnibus insureds' when they choose to write the minimum coverage required by the financial-responsibility statutes"); *Olson v. National Indem. Co.*, 112 Or App 359, 829 P2d 716 (1992) (appropriate remedy,

when limitations provision of policy was invalid as contrary to statutory requirement, was to construe policy to include one-year limitations period required by statute, not disregard provision and apply six-year period provided for contracts); *Mathews v. Federated Serv. Ins. Co.*, 122 Or App 124, 130–131, 857 P2d 852 (1993) (“leased auto” exclusion invalid to extent it would deny minimum coverage required by financial responsibility law).

But when an insurer attempts to exclude any coverage in the policy that exceeds the statutory minimums, the provision may be too confusing or obscure for ordinary purchasers to understand or for courts to apply. *N. Pac. Ins. Co. v. Hamilton*, 332 Or 20, 29, 22 P3d 739 (2001) (exclusion was “obscure to the point of being incomprehensible,” and therefore was construed against insurer); *Medyanikov v. Cont’l Ins. Co.*, 176 Or App 297, 302–305, 31 P3d 495 (2001) (citing *Hamilton* and holding that “the policy language attempting to create a family member exclusion from liability coverage is unenforceable”).

A statutory requirement that a certain entity insure against a particular risk does not obligate insurers to provide such coverage. *See, e.g., Employers-Shopmens Local 516 Pension Trust v. Travelers Cas. & Sur. Co. of Am.*, 235 Or App 573, 592-593, 235 P3d 689 (2010) (when ERISA bonding provision does not require insurance policy to cover every person who must be bonded, doctrine of statutory incorporation does not apply); *Derosiers v. Hudson Specialty Ins. Co.*, Slip Copy, 2010 US Dist LEXIS 40391, 2010 WL 1727119, (D Or 2010) (upholding magistrate’s ruling that statutory provisions requiring liquor licensees to insure against certain injuries related to sale of alcohol do not invalidate

such exclusions in an insurance policy, and distinguishing between statutes that require licensees obtain particular type of coverage and those that require insurers to issue policies with particular language or coverage).

Some courts have held that if there is a statutory form of policy, such as the standard fire insurance policy, an oral contract of insurance is not enforceable. *See* §§1.1-2 to 1.1-2(b)(1).

A statutorily required suit-limitation provision in an insurance policy is a contract condition rather than a statute of limitations. In *Herman v. Valley Ins. Co.*, 145 Or App 124, 130, 928 P2d 985 (1997), the court construed ORS 742.240, which applies to fire insurance policies, to apply to homeowner's insurance policies as well. But the suit-limitations are not conditions of forfeiture. Instead, failure to timely bring a claim "precludes an insured from starting an action against its insurer once the limitation period has passed, regardless of the extent of coverage." *Herman*, 145 Or App at 131. An insurer is not required to show that it was prejudiced by its insured's failure to file suit within the statutory limitations period before the insurer can assert the limitations period as an affirmative defense. *Herman*, 145 Or App at 130–132.

In *Savage v. Grange Mut. Ins. Co.*, 158 Or App 86, 94–95, 970 P2d 695 (1999), the court held that an insurer's breach of its statutory duty to offer underinsured motorist (UIM) coverage "does not merely give rise to some inchoate entitlement to seek reformation but, instead, results in the imposition of UIM coverage *ab initio* by operation of law." The court also held that the subsequent enactment of a statute exempting umbrella policies from the requirement to offer UIM coverage (ORS

742.468) did not abrogate the existing UIM coverage under the insured's umbrella policy. *Savage*, 158 Or App at 95-96.

Even when the insured rejected the statutorily required provisions when renewing the insurance policy, the doctrine of statutory incorporation applies. *Buccino v. California Cas. Ins. Co.*, 159 Or App 654, 659, 978 P2d 441 (1999) ("Defendants had a statutory duty to offer UM/UIM coverage at issuance up to their insured's bodily injury liability limits," did not offer that coverage as required, and therefore were not entitled to judgment as a matter of law).

Other cases involving the doctrine of statutory incorporation include *ZRZ Realty Co. v. Beneficial Fire & Cas. Ins. Co.*, 222 Or App 453, 484, 194 P3d 167 (2008), *reversed in part on other grounds*, *ZRZ Realty Co. v. Beneficial Fire & Cas. Ins. Co.*, 349 Or 117 (2010) (ORS 731.102 does not write into insurance policies the requirement that the loss be unexpected); *Mid-Century Ins. Co. v. Perkins*, 344 Or 196, 217, 179 P3d 633 (2008) (comparison of UIM limits to liability coverage limits, rather than to damages, determined whether vehicles were underinsured.); *Smith v. Guideone Mut. Ins. Co.*, 336 Fed Appx 607 (9th Cir 2009) (operator's policy that provided less favorable UIM coverage than general coverage under model provisions of Oregon's statutory scheme was unenforceable); *Country Mut. Ins. Co. v. White*, 212 Or App 323, 330-331, 157 P3d 1212 (2007) (other-insurance provision in policy issued by passenger's insurer did not comport with statutory "anti-stacking" provision); *Heffner v. Farmers Ins. Co.*, 213 Or App 289, 162 P3d 277 (2007) (anti-stacking clause that limited UIM benefits to single policy with highest limit of liability was enforceable).

**§1.1-1(b)(1) Effect of Change in the Law**

All statutes in force at the time the policy is issued are incorporated into the policy, even if the statutes are later repealed during the policy period. *See Savage v. Grange Mut. Ins. Co.*, 158 Or App 86, 95–96, 970 P2d 695 (1999) (although statute exempting umbrella liability policies from statutory requirement of uninsured motorist coverage was enacted before loss, it was in effect when policy was issued; thus insurer had duty to provide coverage). *See also Buccino v. California Cas. Ins. Co.*, 159 Or App 654, 978 P2d 441 (1999) (insurer’s breach of statutory duty to offer UM/UIM coverage in amount of bodily injury liability limits at the time policy issued required that such coverage be imputed).

Conversely, statutes that are enacted after a policy is issued do not become part of the policy absent expression of a clear legislative intent to the contrary. *Cambron v. North-West Ins. Co.*, 70 Or App 51, 54, 687 P2d 1132 (1984) (“the law existing at the time and place of the making of an insurance contract is as much a part of the contract as if it had been specifically included in the contract”).

Judicial constructions of statutorily required clauses will be read into policies that continue to be issued by insurers with same or similar language. *See I-L Logging Co. v. Manufacturers & Wholesalers Indem. Exchange*, 202 Or 277, 325, 275 P2d 226 (1954) (stating soundness of rule, but refusing to apply rule when language of particular statutory provision had not been given “uniform judicial construction”).

**§1.1-1(b)(2) Effect of Conformity Clause**

A conformity clause, which incorporates all applicable statutes into a policy, extends only to statutes directly applicable to the issuance and

content of insurance policies. In *Totten v. New York Life Ins. Co.*, 298 Or 765, 769, 696 P2d 1082 (1985), the life insurance policy included a conformity clause stating that the policy was subject to all applicable laws. The court held that the policy incorporated “only those sections of the Oregon Revised Statutes directly applicable to issuance and content of insurance policies.” The life insurance policy was not subject to all the statutes (in particular, in *Totten*, the statutes relating to aeronautics).

A conformity clause that excludes any provided-for coverage that may exceed the statutory minimums may be ambiguous when the policy expressly provides for coverage exceeding the statutory minimums. In *Wright v. State Farm Mut. Auto. Ins. Co.*, 332 Or 1, 7, 22 P3d 744 (2001), and *N. Pac. Ins. Co. v. Hamilton*, 332 Or 20, 22 P3d 739 (2001), the court construed the ambiguous provisions against the insurance companies.

### **§1.1-1(b)(3) Effect of Statutory Violations**

If an insurance policy violates a statute by excluding required coverage, the policy must be construed to include whatever coverage is mandated by statute. *Collins v. Farmers Ins. Co.*, 312 Or 337, 347, 822 P2d 1146 (1991) (“The Financial Responsibility Law requires specified coverage. As to amounts and other coverage apart from that minimum, it is lawful to restrict that additional coverage by an exclusion”). See also *Savage v. Grange Mut. Ins. Co.*, 158 Or App 86, 93, 970 P2d 695 (1999), and *Buccino v. California Cas. Ins. Co.*, 159 Or App 654, 978 P2d 441 (1999), in which the court imputed the statutorily required coverage.

**§1.1-1(b)(4) Effect of Issuance in Another State**

The procedural insurance statutes of the forum may be considered as part of an insurance contract even though the policy was issued and delivered in another state. *See, e.g., Vancouver Furniture Co. v. Industrial Indem. Co.*, 74 Or App 642, 648, 704 P2d 518 (1985) (insured was awarded attorney fees under *former* ORS 743.114 (renumbered ORS 742.061), even though substantive issues were governed by Washington law); *Aetna Casualty & Surety Co. v. Brathwaite*, 90 Or App 109, 118, 751 P2d 237 (1988) (for policy issued in Washington, insurance company had burden of proof on issue of insured's intent when shooting weapons).

**§1.1-1(b)(5) Effect of Statute of Frauds**

The statute of frauds requirement that a contract not performed within one year must be in writing does not apply to an oral contract of insurance if the contract may be performed within one year by the happening of the contingency insured against. See §1.1-2(b) on the effect of the statute of frauds on oral contract agreements.

**§1.1-2 Oral Contracts**

In the absence of a controlling statute or an internal limitation on the power of the insurer (such as a charter or bylaw), an oral contract of insurance is valid. *Cerino v. Or. Physicians' Service*, 202 Or 474, 484, 276 P2d 397 (1954); *Mock v. Glens Falls Indem. Co.*, 210 Or 71, 80, 309 P2d 180 (1957) (“a sufficiently definite oral agreement of insurance, by a general agent, is valid in this state”). Binders or other contracts for temporary insurance may also be made orally or in writing. ORS 742.043(1).

Unattached applications are inadmissible if the policy is written (see §1.1-1). However, when the binder or contract is based on an oral agreement, the application may be introduced as evidence. *Collver v. Salem Ins. Agency, Inc.*, 132 Or App 52, 59–60, 887 P2d 836 (1994). If the applicant introduces the application at trial, the application is admissible by either party on appeal. *Kentner v. Gulf Ins. Co.*, 298 Or 69, 689 P2d 955 (1984).

Any oral representations made by the insured that are not included in the application are not part of the policy and may not be introduced by the insurer as evidence in any action involving the policy. ORS 742.016(1).

### **§1.1-2(a) Requirements for Validity**

In order to have a valid oral contract of insurance, all requirements of an ordinary contract must be met, although some of those requirements may be implied. Those requirements include competent contracting parties, consideration, the existence of a subject matter, and an agreement on all essential elements of the contract. 1A COUCH ON INSURANCE §13:18 (3d ed 1995 & Supp 2011).

Essential elements of the contract are as follows:

- (1) Identity of insured;
- (2) Identity of insurer;
- (3) Subject matter to be insured;
- (4) Risk insured against;
- (5) The commencement and period of risk;
- (6) Amount of insurance; and
- (7) Amount of premium and time in which it is to be paid.

*Cody v. Insurance Co. of Oregon*, 253 Or 587, 591–592, 454 P2d 859 (1969) (evidence existed of all essential elements of oral contract of insurance); *Bird v. Central Mfrs. Mut. Ins. Co.*, 168 Or 1, 7–8, 120 P2d 753 (1942) (meeting of minds occurred between parties on all essential elements of oral contract despite fact that written policy, delivered after plaintiff's loss, contained terms not agreed to by plaintiff); *Cleveland Oil & Paint Mfg. Co. v. Norwich Union Fire Ins. Soc.*, 34 Or 228, 233, 55 P 435 (1898) (no contract existed when evidence failed to show duration of insurance issued by insurer on similar risks); *Rodgers Ins. Agency, Inc. v. Andersen Machinery*, 211 Or 459, 316 P2d 497 (1957) (agent was not liable for failing to procure insurance when testimony did not establish agreement on amount of the indemnity, duration of risk, or premium to be paid).

Some terms of an oral contract of insurance may be supplied by implication as long as those terms are readily inferable from a prior course of dealing or from established insurance business standards. The court presumes that the parties contemplated such terms, conditions, and limitations found in policies issued to cover similar risks or in policies used by the parties in their past dealings. *Cleveland Oil & Paint Mfg. Co.*, 34 Or at 236; *Sproul v. Western Assurance Co.*, 33 Or 98, 103, 54 P 180 (1898). Likewise, when the oral agreement to insure does not specify the premium to be paid and the rates are standard in the community, it may be assumed that the contract is to insure at customary rates. *Cleveland Oil & Paint Mfg. Co.*, 34 Or at 236 (customary rates); *Hamacher v. Tummy*, 222 Or 341, 352, 352 P2d 493 (1960) (rate

established in same manner as in previous dealings); *see also* 1A COUCH ON INSURANCE §13:19.

A potential insured does not have to prove all the essential elements of a contract when only claiming that an oral contract to *procure* insurance existed, as opposed to an actual oral contract of insurance. *Hamacher*, 222 Or at 348–349; *see also Harris v. Albrecht*, 86 P3d 728 (Utah 2004) (detailed discussion of *Hamacher* distinction).

**§1.1-2(b) Effect of the Statute of Frauds and Other Statutory Provisions on Oral Agreements**

The statute of frauds requirement that a contract be in writing if it may not be performed within one year does not apply to an oral contract of insurance if the contingency insured against may occur within one year and the contract may be performed. ORS 41.580. If the insurance contract is subject to cancellation and neither party is bound to maintain the insurance for an entire year, then it is not within the prohibition of the statute of frauds. *Frontier Ins. Agency v. Hartford Fire Ins. Co.*, 262 Or 470, 483, 499 P2d 1302 (1972) (contract, by its own terms subject to cancellation by either party within one year, was not within statute of frauds even though absent termination it would continue for more than a year); *see also* 1A COUCH ON INSURANCE §13:16 (3d ed 1995 & Supp 2011). But the statute of frauds provision requiring contracts answering for the debt, default, or miscarriage of another to be in writing proscribes oral contracts for fidelity insurance. ORS 41.580(1)(a); *Craswell v. Biggs*, 160 Or 547, 564, 86 P2d 71 (1938) (noting that effect of statute was “to require that every guarantee shall be evidenced by a writing”).

**§1.1-2(b)(1) Statutory Form Requirements**

Some courts have held that if there is a statutory form of policy, such as the standard fire insurance policy, an oral contract of insurance is not enforceable. 1A COUCH ON INSURANCE §13.17 (3d ed 1995 & Supp 2011). Oregon subscribed to that rule in *Salquist v. Or. Fire Relief Ass'n*, 100 Or 416, 420, 197 P 312 (1921), in which the court held that an oral contract of insurance was impossible under the statute prohibiting the use of a fire policy that did not conform to certain statutory conditions. The court stated that the standard policy law prescribed an exclusive evidence of contract analogous to the statute of frauds.

However, the *Salquist* holding was expressly overruled in *Ramstead v. North West Ins.*, 252 Or 423, 431, 450 P2d 538 (1969), to the extent that it held that an insurance agent's authority to effect insurance must be in writing. Furthermore, in *Frontier Ins. Agency, Inc. v. Hartford Fire Ins. Co.*, 262 Or 470, 483 n 2, 499 P2d 1302 (1972), the court distinguished the statutory underpinnings of the *Salquist* case from the current standard fire insurance policy law (ORS 742.202), which does not prevent the making of oral fire insurance contracts. Also, in view of *Cody v. Insurance Co. of Oregon*, 253 Or 587, 591-592, 454 P2d 859 (1969) (jury question whether oral contract of fire insurance was created), and ORS 742.043 (permitting oral binders or contracts of temporary insurance, except for life or health insurance), it seems quite clear that oral contracts of temporary fire insurance are valid. For further discussion, see §§1.1-3–1.1-3(c) on binders.

Courts in other jurisdictions have held that standard policy laws do not invalidate an oral contract of insurance but apply only to a policy that was in fact written. 1A COUCH ON INSURANCE §13.17.

### **§1.1-3 Binders**

A *binder* or *binding receipt* is a memorandum given to the insured that obligates the insurer to pay insurance if a loss occurs before the policy is issued or the application is denied. *See generally* 1A COUCH ON INSURANCE §13 (3d ed 1995 & Supp 2011). A binder evidences a contract of temporary insurance until the permanent policy is issued or disapproved or some other temporary impediment is removed. *United Pacific Ins. Co., v. Truck Ins. Exchange*, 273 Or 283, 289–290, 541 P2d 448 (1975).

Binders may be made “orally or in writing, and shall be deemed to include all the usual terms of the policy . . . except as superseded by the clear and express terms of the binder.” ORS 742.043(1). A policy featuring identical terms and premiums must be issued within 90 days of the binder, unless the Director of the Department of Consumer and Business Services grants a written extension. ORS 742.043(2)–(3) (except as provided in ORS 746.195).

Note that the statute describing binders does not apply to life or health insurance. ORS 742.043(4)

#### **§1.1-3(a) Validity**

Binders are valid contracts of insurance unless an express statutory provision prohibits them. 1A COUCH ON INSURANCE §13:1 (3d ed 1995 & Supp 2011). A binder generally must contain the same requisite terms as a contract of insurance. 1A COUCH ON INSURANCE §13:2. However, a

binder need not contain all necessary elements of a contract of insurance as long as the protection that the parties contracted for can be determined. In *United Pacific Ins. Co., v. Truck Ins. Exchange*, 273 Or 283, 289–290, 541 P2d 448 (1975), a binder listing the parties, type of coverage, limits of coverage, and property covered was found to be sufficient to create a valid binder. See also *United States Pipe & Foundry Co. v. Northwestern Agencies, Inc.*, 284 Or 167, 171, 585 P2d 691 (1978) (same). The binder need not state the premium or consideration because the agreement to pay the premium is sufficient. *United Pacific Ins. Co.*, 273 Or at 290.

It is possible for a binder to be made part of a written application. In *United Pacific Ins. Co.*, 273 Or at 288, the application contained the coverage and limits of liability in detail, the vehicles insured, the name of the insured, the agents' signature and the word "Binder" written on the left side of the form. The agent also testified that this was his regular method of issuing a binder.

But if the application contains language that indicates the policy will not issue until acceptance by the insurer or a binder is issued, then the application likely does not contain an enforceable binder. In *Brock v. State Farm Mut. Auto. Ins. Co.*, 195 Or App 519, 531, 98 P3d 759 (2004), the application stated in large print that "No insurance is effective under this agreement (A) unless the binder is completed designating the company accepting this application and signed by an authorized agent of such company or (B) until the date the policy or binder is issued by the company accepting this application." The court held that because the application expressly stated that a policy would not issue until further

action by the insurer's agent or on issuance of a separate binder, the application was merely an application. *Brock*, 195 Or App at 532–533.

A certificate of insurance is not a binder, provided that the certificate does not demonstrate some temporary provision of coverage pending the issuance of a formal policy. In *Baylor v. Cont'l Cas. Co.*, 190 Or App 25, 78 P3d 108 (2003), the insured passed away three years after creating an accidental death and dismemberment policy, but the insurer denied coverage based on a drug-use exclusion. The decedent's wife argued that the certificate of insurance was a binder and, since it contained no such drug use exclusion, neither could the policy. The court ruled that the certificate of insurance was not a binder because, by its own terms, it stated that it was not a policy, as well as referring to the actual policy. It was mere notice that a policy existed. *Baylor*, 190 Or App at 32–34.

### **§1.1-3(b) Effect**

When issued, a binder provides temporary coverage until a complete and formal policy of insurance is issued. A binder is, in and of itself, a contract of insurance. A binder is deemed to include all the usual terms of the policy for which the binder is given, together with the applicable endorsements designated in the binder, except as superseded by the clear and express terms of the binder. ORS 742.043(1).

As the language of ORS 742.043 suggests, a presumption exists that a binder includes the terms that are often contained in the policy for which the binder was issued. *Bank of California, N.A. v. Livingston*, 65 Or App 743, 746 n 2, 672 P2d 386 (1983).

An exclusion that appears in the policy sent to the insured but is not included in the binder is not effective. *Gifford v. Western Aviation Ins. Group*, 77 Or App 645, 650, 713 P2d 1085, *adhered to as clarified*, 79 Or App 228 (1986). The *Gifford* opinion demonstrates the importance of designating the applicable endorsements in the binder. In *Gifford*, the court held that an exclusion for Alaska travel for the insured's aircraft, which crashed in that state, was not applicable because the exclusion was not included in the binder letter. *See also Avemco Ins. Co. v. Hill*, 76 Or App 185, 708 P2d 640 (1985) (court refused to allow insurer to exclude renter pilots from coverage because exclusion was not included in binder). In both the *Gifford* and the *Avemco Ins. Co.* cases, the relevant exclusion first appeared in the policy sent to the insured.

The presumption that the binder includes the terms of the policy must be overcome by the clear and express terms of the binder, which may be difficult in instances of an oral binder. In *Stuart v. Pittman*, 350 Or 410, \_\_\_ P3d \_\_\_ (2011), the insurer during conversations about types of insurance had agreed to provide the insured with a "safety net" of coverage "in all instances that something goes wrong" and provide some type of coverage for "faulty work." The court held that those expressions were "were not vague or obscure. Rather, those terms, in the context in which they were used, were easily understood and were not implied or left to inference, and thus were sufficient under the 'clear and express' requirement in ORS 742.043(1)." *Stuart*, 2011 Ore LEXIS at \*16.

### **§1.1-3(c) Period of Protection**

A binder is valid for up to 90 days, and an insurer must issue a policy with identical coverage within that time. ORS 742.043(2); *Hansen*

*v. Western Home Ins. Co.*, 89 Or App 68, 71–72, 747 P2d 1007 (1987) (construing *former* ORS 743.075, current ORS 742.043). A binder may be extended beyond 90 days with the written approval of the Director of the Department of Consumer and Business Services. ORS 742.043(3).

With respect to insurance on property securing a loan or an extension of credit, when a lending institution closes on a binder, the agent or insurer issuing the binder must provide a policy of insurance within 60 days from the date of the binder. ORS 746.195(1)(b).

ORS 742.043(2) does not invalidate a binder after 90 days, but obligates the insurer to issue a policy within 90 days that conforms to the binder. The insurer has the obligation to avoid a lapse in coverage for risks insured against in the binder. *Hansen*, 89 Or App at 71-72 (before Oregon Legislature materially amended the statute, Oregon Supreme Court had held that a prior version of ORS 742.043 invalidated binder after 90 days).

Binders may be extended or renewed beyond 90 days with the written approval of the Director of the Department of Consumer and Business Services, or in accordance with rules promulgated by the director. ORS 742.043(3).

An oral contract of insurance that overreaches the time limit allowed by statute on oral binders is invalid. 1A COUCH ON INSURANCE §13:17 (3d ed 1995 & Supp 2011); *Flowers by Di Alton's v. American Ins. Co.*, 127 A2d 175, 176 (NJ App 1956). However, in *Restaurant Enterprises, Inc. v. Sussex Mut. Ins. Co.*, 243 A2d 808, 810 (NJ 1968), the court held that a statute limiting the duration of a binder does not

render binders exceeding that limit void. Instead, the statute is intended to require the insurer to issue a policy within that time.

It may be possible for a binder to extend beyond the term of the insurance policy. In *Collver v. Salem Ins. Agency*, 132 Or App 52, 887 P2d 836 (1994), the plaintiff claimed that the oral binder was effective for 60 days, while the policy provided for only 56 days of coverage. An application completed by the insured allowed for an adjustment in the policy term. The insured was denied coverage for a loss that occurred after the 56th day but before the 60th day. The court held that it was an issue for the jury to decide whether the binder agreement incorporated the terms of the application. If the binder incorporated the application, then the policy conformed to the terms of the binder. If not, and the jury believed the oral binder was for 60 days, then the binder was in effect on the date of the accident. *Collver*, 132 Or App at 59.

### **§1.2 RULES FOR INTERPRETING INSURANCE POLICIES**

Section 1.2-1 of this chapter addresses the interpretation policy language. More particularly, §§1.2-1 to 1.2-1(a)(6) provides an overview of the common components of an insurance policy (as distinguished from the *elements* of an insurance *contract* discussed in §§1.1 to 1.1-3(c)). Sections 1.2-2 to 1.2-2(b) review the special principles of construction that guide the interpretation of policy language, and the effect of statutory provisions on the interpretation of insurance policies. Sections 1.2-3 to 1.2-3(c) examine how other general legal principles apply to the interpretation of insurance policies.

**§1.2-1 Reading Insurance Policies**

Many policy forms and provisions are standard. Others are specifically prescribed by legislation. Many require administrative approval. For example, ORS 742.003 requires prior approval by the Director of the Oregon Department of Consumer and Business Services of most policy forms delivered or issued for delivery in Oregon. Uniform provisions have been developed by insurance industry committees and national rating organizations, most notably the Insurance Service Organization (ISO). For further information about the ISO, see < <http://www.iso.com/>.>

**§1.2-1(a) Policy Contents and Format**

Every policy must specify the names of the parties to the contract, the subject of the insurance, the hazards or perils insured against, the time for which the insurance takes effect and the period during which the insurance is to continue, the premium, and any conditions and provisions pertaining to the insurance. ORS 742.023(1). If the premium will be adjusted through the life of the contract, a statement of the basis for calculating the rates is required. ORS 742.023(2). ORS 742.023 does not apply to surety insurance policies, or to group life or health insurance policies. ORS 742.023(3).

The policy itself generally consists of (1) a declarations page, (2) coverage grants, (3) exclusions, (4) conditions, and (5) endorsements. A liability insurance policy should contain a copy of the insured's application for insurance.

**§1.2-1(a)(1) The Application**

If a written application is not expressly required, the application may be either written or oral. See §§1.1-2 to 1.1-2(b) 1 for further discussion of oral contracts. Basic policy or application forms for insurance must be pre-approved by the Director of the Department of Consumer and Business Services before delivery or issuance. ORS 742.003 (also listing four exceptions, ORS 742.003(1)(a)–(d)).

A completed application for insurance is generally considered an offer to make an insurance contract. See 1.1-1(a)(1) for discussion of the application’s role in creating a contract; *Morford v. California Western States Life Ins. Co.*, 166 Or 575, 589–593, 113 P2d 629 (1941).

Misrepresentations or omissions by the insured in a written application for insurance that are either fraudulent or material to acceptance of the risk and on which the insurer justifiably relied may prevent recovery under the policy in the event of a claim. ORS 742.013(1). *See, e.g., Eslamizar v. American States Ins. Co.*, 134 Or App 138, 146, 894 P2d 1195 (1995) (“to void plaintiff’s policy in defense of his claim on the basis of plaintiff’s misrepresentations, defendant must establish that it relied on those misrepresentations”); *Story v. Safeco Life Ins. Co.*, 179 Or App 688, 694, 40 P3d 1112 (2002) (“the insurer must show ‘some evidence of a detrimental action or change in position’”) (quoting *Eslamizar*, 134 Or at 146).

Under Oregon law, such misrepresentations in an application meet the statutory requirements only if “the insurer delivers a copy of such application *with the policy* to the insured.” ORS 742.016(1) (emphasis added). *See also* §1.1-1(a)(3); *Ives v. INA Life Ins. Co.*, 101

Or App 429, 790 P2d 1206 (1990) (unsigned, transcribed copy of original signed, handwritten application form was sufficient to meet statutory requirement in *former* ORS 743.042 (renumbered ORS 743.013(1))); *Brock v. State Farm Mut. Auto. Ins. Co.*, 195 Or App 519, 98 P3d 759 (2004).

When the agreement is represented in a written policy, strict parol evidence rules apply, and an unattached application is inadmissible. *Progressive Ins. v. Nat'l Am. Ins. Co. of Cal.*, 201 Or App 301, 307, 118 P3d 836 (2005) (unattached application was inadmissible even if it would prove that insured had duplicate coverage). See §1.1-2 for a discussion of policies based on oral agreement.

Representations by the insured not included in an application are not a part of the policy and may not be introduced as evidence in any action involving the policy. ORS 742.016(1).

For further discussion of an insured's misrepresentations in an application, see §1.4-1(g).

### **§1.2-1(a)(2)    Declarations Page**

The declarations page is usually a separate document attached to a standard policy form, specifying the named insured, the policy period, the coverages purchased, the risks covered (such as damage to vehicles or premises), the insurer's limits of liability, and the premiums charged.

### **§1.2-1(a)(3)    The Grant of Coverage**

A typical grant of coverage in a liability insurance policy provides that the company will pay on behalf of the insured all sums that the insured becomes legally obligated to pay as damages caused by

an occurrence resulting in bodily injury or property damage to which the insurance applies.

In any claim on a policy, the first issue is whether the coverage language applies to the particular circumstances of the claim. Coverage may depend on whether the policy definitions encompass the specific circumstances of the claim. *See, e.g., Wyoming Sawmills, Inc. v. Transp. Ins. Co.*, 282 Or 401, 578 P2d 1253 (1978) (when policy defined property damage as physical injury to tangible property, policy did not include consequential or intangible damages). Coverage must be found in the insuring agreement, not in the exclusions. *Progressive Casualty Co. v. McManus*, 83 Or App 582, 586 n 5, 732 P2d 932 (1987).

Examples of specific coverage issues may be found in *Minnis v. Or. Mut. Ins. Co.*, 334 Or 191, 48 P3d 137 (2002) (pizza parlor manager did not act within scope of employment when he sexually assaulted female employee at his apartment); *Klamath Pac. Corp. v. Reliance Ins. Co.*, 151 Or App 405, 950 P2d 909 (1997), *aff'd as modified*, 152 Or App 738 (1998) (allegations of injury from intentional infliction of emotional distress were covered under policy's definition of *bodily injury*; employers' exclusion not applicable to president of corporate employer); *McLeod v. Tecorp Int'l*, 318 Or 208, 865 P2d 1283 (1993) (employer not covered for employee's claims for wrongful discharge and intentional infliction of emotional distress); *Milgard Mfg. v. Continental Ins. Co.*, 92 Or App 609, 759 P2d 1111 (1988) (building design alterations and consequent diminution in value not covered); and *Albertson's Inc. v. Great Southwest Fire Ins. Co.*, 83 Or App 527, 732 P2d 916 (1987) (duty to defend arose because customer's allegations of

injury caused by insured's security staff were accidental from insured's perspective).

**§1.2-1(a)(4) Policy Conditions**

Policy conditions define the rights and obligations of the parties involved in the insurance agreement. *See* 6 COUCH ON INSURANCE §81.19, et seq. (3d ed 195 & Supp 2011) (distinguishing conditions and warranties). For example, a widely used standard condition limits the insurer's liability if the insured has other applicable insurance coverage. Other standard conditions require the insured to give prompt notice of an accident or loss and thereafter to cooperate in the defense of any claim against the insured. The insured's breach of such policy conditions may defeat recovery under the policy, but only on a showing of prejudice to the insurer. *See, e.g., Lusch v. Aetna Casualty & Surety Co.*, 272 Or 593, 597, 538 P2d 902 (1975) (insured fled scene of car accident and did not timely notify insurer); *Emplrs Ins. of Wausau v. Tektronix, Inc.*, 211 Or App 485, 156 P3d 105 (2007) (discussing *Lusch*, its progeny, and whether prejudice to insurer is a matter of law or an issue for jury); *Dewsnup v. Farmers Ins. Co.*, 349 Or 33, 239 P3d 493 (whether removing shake roof for repairs was breach of policy condition); *Nike, Inc. v. Northwestern Pac. Indem. Co.*, 166 Or App 312, 999 P2d 1197 (2000) (discussing "discovery of the loss," events that trigger notice provisions, and surrounding case law); *Carl v. Oregon Auto. Ins. Company/North Pac. Ins. Co.*, 141 Or App 515, 520–521, 918 P2d 861 (1996) (discussing late-notice defense requirements).

Other kinds of policy conditions are those that must be met or fulfilled before the policy becomes effective—conditions precedent.

Examples of such conditions precedent are found in *Olsen v. Federal Kemper Life Assurance Co.*, 299 Or 169, 171, 700 P2d 231 (1985) (clause provided that policy would not be effective unless health, habits, and any other condition relating to each person proposed for insurance were as described in application); and *Coos Head Timber Co. v. Unigard Indem. Co.*, 73 Or App 598, 699 P2d 1143 (1985), *overruled on other grounds*, *Kabban v. Mackin*, 104 Or App 422, 431, 801 P2d 883 (1990) (condition required that insured must exercise due diligence in maintaining in complete working order all equipment and services pertaining to operation of sprinkler system for insurance to be effective).

Policy conditions are not always clearly demarcated in an insurance contract. For example, the court of appeals has found that a consent-to-settle provision, even if styled as an exclusion, is actually a condition of forfeiture because coverage is nullified by the insured's breach of the provision. *Federated Serv. Ins. Co. v. Granados*, 133 Or App 5, 8, 889 P2d 1312 (1995); *Richardson v. Guardian Life Ins. Co. of Am.*, 161 Or App 615, 625, 984 P2d 917 (1999).

When an insurer has failed to timely notify the insured of forfeiture or has misrepresented to the insured that it will provide coverage for a loss, the insurer may be estopped from arguing a condition of forfeiture at a later date. *ABCD Vision, Inc. v. Fireman's Fund Ins. Cos.*, 304 Or 301, 306, 744 P2d 998 (1987). But see the discussion of *Day-Towne v. Progressive Halcyon Ins. Co.*, 214 Or App 372, 381-383, 164 P3d 1205 (2007) in §1.2-1(a)(5).

For more on conditions of coverage, see §2.9.

**§1.2-1(a)(5) Exclusions**

An exclusion eliminates coverage for a described event or risk that, but for the exclusion, would be covered by the initial coverage grant. *Cimarron Ins. Co. v. Travelers Ins. Co.*, 224 Or 57, 61, 355 P2d 742 (1960). “Exclusions are intended to be unambiguous exceptions to the operation of coverage provisions.” *State Farm Fire & Casualty Co. v. Jones*, 86 Or App 584, 588, 739 P2d 1090 (1987), *rev’d on other grounds*, 306 Or 415 (1988). “Conceptually, then, the coverage provisions of an insurance policy define the universe of claims that are covered by the policy; the exclusions constitute a subset of claims that, although within that universe of covered claims, are nonetheless excluded.” *ZRZ Realty Co. v. Beneficial Fire & Cas. Ins. Co.*, 222 Or App 453, 473, 194 P3d 167 (2008), *reversed in part on other grounds*, 349 Or 117 (2010), *modified on other grounds*, 349 Or 657 (2011). An exclusion should be distinguished from a condition of coverage. For more on exclusions, see §§2.5-2.5-9.

The purpose of an exclusion may be to eliminate coverage for situations or events that create risks of loss greater than those normally associated with the hazard. *See, e.g., Yosemite Ins. Co. v. Meisner*, 277 Or 519, 561 P2d 185 (1977) (racing or speed contest exclusions); *Ferguson v. Birmingham Fire Ins. Co.*, 254 Or 496, 460 P2d 342 (1969) (exclusions for damage to property in the care, custody, or control of insured). An exclusion may be designed to prevent the “adverse selection of risks” by eliminating coverage for risks that are more properly insured under separate, specialized policies. *Ferguson*, 254 Or at 503.

An ambiguous exclusion is construed against the insurer. *N. Pac. Ins. Co. v. Hamilton*, 332 Or 20, 26, 22 P3d 739 (2001) (family member exclusion in automobile policy); *Wright v. State Farm Mut. Auto. Ins. Co.*, 332 Or 1, 7, 22 P3d 744 (2001) (same); *Medyanikov v. Cont'l Ins. Co.*, 176 Or App 297, 304, 31 P3d 495 (2001) (same).

When a specific loss is excluded, an insured may not expand the scope of coverage through the argument of estoppel because coverage for the loss never existed in the first place. *Day-Towne v. Progressive Halcyon Ins. Co.*, 214 Or App 372, 381-383, 164 P3d 1205 (2007); *Verex Assurance, Inc. v. John Hanson Sav. & Loan*, 816 F2d 1296, 1304 (9th Cir 1987); *Richardson v. Guardian Life Ins. Co. of Am.*, 161 Or App 615, 625, 984 P2d 917 (1999). Note, however, that ORS 742.056 provides that certain actions by insurers do not constitute waiver or estoppel as a matter of law. For further discussion of exclusions and conditions of forfeiture, see §1.4-3(h)

Common exclusions in automobile liability and homeowners' policies include bodily injury that is expected or intended, *Ledford v. Gutoski*, 319 Or 397, 877 P2d 80 (1994); *Mutual of Enumclaw v. Merrill*, 102 Or App 408, 794 P2d 818 (1990); and injuries to employees in the course of their employment for the insured, *McLeod v. Tecorp Int'l*, 318 Or 208, 865 P2d 1283 (1993). Courts have invalidated some exclusions for violating the Oregon Financial Responsibility Law, ORS chapter 806. *See, e.g., Collins v. Farmers Ins. Co.*, 312 Or 337, 822 P2d 1146 (1991) (exclusions relating to coverage of resident relatives held void as violation of Oregon Financial Responsibility Law).

NOTE: For an example of the detailed treatment of a specific exclusion, see Carl A. Salisbury, *Pollution Liability Insurance Coverage, the Standard-Form Pollution Exclusion, and the Insurance Industry: A Case Study in Collective Amnesia*, 21 ENVTL L 357 (1991).

### **§1.2-1(a)(6) Endorsements**

An endorsement is a written amendment added to and made a part of the policy for the purpose of restricting or expanding the coverages granted by the policy (the term *rider* is more often used regarding life or health insurance and is a functional equivalent). 1 COUCH ON INSURANCE §1.3 (3d ed 1995 & Supp 2011). Examples of common restrictive endorsements are those eliminating coverage for underage drivers and for punitive damages. Examples of endorsements that expand coverage are the broad-form property damage endorsement and the personal injury endorsement. The latter endorsement extends liability coverage to defamation, invasion of privacy, and other described offenses. For a discussion on inconsistencies between the endorsements and the policy, see §§1.2-3(f) to 1.2-3(f)(3).

### **§1.2-2 The Basic Contract Interpretation Rule**

Oregon follows the general rule that, except as otherwise dictated by statute or public policy, insurance policies are interpreted in a similar manner as ordinary business contracts between individuals, subject to the same general principles of construction. *Compare Hoffman Constr. Co. v. Fred S. James & Co.*, 313 Or 464, 836 P2d 703 (1992), with 1A COUCH ON INSURANCE §11.1 et seq. (3d ed 1995 & Supp 2011)

**§1.2-2(a) Judicially Created Principles**

In interpreting a provision in an insurance policy, Oregon courts follow the “*Hoffman* analysis.” The courts’ task is “to ascertain the intention of the parties.” *Hoffman Constr. Co. v. Fred S. James & Co.*, 313 Or 464, 469, 836 P2d 703 (1992) (quoting *Totten v. New York Life Ins. Co.*, 298 Or 765, 770, 696 P2d 1082 (1985)). The interpretation of an insurance policy is a question of law. *Hoffman Constr. Co.*, 313 Or at 469. Courts determine intent by looking to the terms and conditions of the policy, *Hoffman Constr. Co.*, 313 Or at 469, as interpreted from the perspective of the “ordinary purchaser of insurance,” *Totten*, 298 Or at 770. The policy “must be viewed by its four corners and considered as a whole.” *N. Pac. Ins. Co. v. Hamilton*, 332 Or 20, 24, 22 P3d 739 (2001) (quoting *Denton v. International Health & Life Ins. Co.*, 270 Or 444, 449–450, 528 P2d 546 (1974)).

The courts sometimes apply the doctrine of necessary implication to imply a provision that is necessary to carry out the purpose of the contract. *Card v. Stirnweis*, 232 Or 123, 134, 374 P2d 472 (1962) (reviewing opinions and treatises on the doctrine). For example, in *Morrow v. Red Shield Ins. Co.*, 212 Or App 653, 660–662, 159 P3d 384 (2007), the court held that an obligation to process an address change form was not necessary for the purpose of the policy since the policy was for a specific term and the change of address form concerned a future policy, not the present one. But the court also held that such an obligation arose from a duty of good faith and fair dealing.

If the policy expressly defines the term in question, courts apply that definition. *Holloway v. Republic Indem. Co. of Am.*, 341 Or 642,

650, 147 P3d 329 (2006); *Gonzales v. Farmers Ins. Co.*, 345 Or 382, 387, 196 P3d 1 (2008). *Groshong v. Mutual of Enumclaw Ins. Co.*, 329 Or 303, 307–308, 985 P2d 1284 (1999).

If the term at issue is not defined in the policy, the court looks to the plain meaning of the term. The court in *Hoffman Constr. Co.*, 313 Or at 469-471 creates the analytical framework for this inquiry:

- If the term has only one plausible interpretation, courts apply that interpretation and conduct no further analysis.
- But if a phrase has more than one plausible meaning, courts will examine the particular context in which the term is used within the policy and the broader context of the policy as a whole.
- If two or more plausible interpretations remain after all other methods of resolving the dispute are exhausted, only then will Oregon courts construe the ambiguous term against the drafter, i.e., the insurer.

When a proposed interpretation of a policy is not plausible, courts will not proceed with the *Hoffman* analysis. *See, e.g., Cain Petroleum, Inc. v. Zurich Am. Ins. Co.*, 224 Or App 235, 242–243, 197 P3d 596 (2008) (“As we have noted, a “reasonable” interpretation of an insurance policy, at a minimum, must not be contradicted by the terms of that policy”).

Even though the *Hoffman* opinion provided a method for analyzing insurance contracts and Oregon courts have subsequently applied that method, the court did not overrule pre-*Hoffman* cases. *See also Alexander Mfg. v. Illinois Union Ins. Co.*, 560 F3d 984 (9th Cir

2009) (discussing *Hoffman* and *Holloway*, and holding that *Groce v. Fidelity General Ins. Co.*, 252 Or 296, 448 P2d 554 (1968), which held that certain anti-assignment clauses applied only to pre-loss assignment, was still good law).

NOTE: The Oregon Supreme Court frequently cites *Hoffman* and its progeny. Key cases are highlighted in this section, especially those that announce new rules. But attorneys should be aware that the case law in this area is expansive, and that an exhaustive search will likely turn up several cases with fresh analyses of clauses or phrases.

### **§1.2-2(b) Statutorily Created Principles**

Except for oral binders or other forms of temporary insurance, “every contract of insurance shall be construed according to the terms and conditions of the policy.” ORS 742.016(1). Oregon statutes place specific restrictions on general rules of interpretation of insurance contracts, including prohibiting policy provisions that require construction according to the laws of other states (ORS 742.018) and directing that policy language not in compliance with the Oregon Insurance Code be disregarded (ORS 742.038). Other statutes, such as ORS chapter 42 on interpretation of private writings, may apply if insurance-specific provisions do not provide a rule. *See, e.g., Totten v. New York Life Ins. Co.*, 298 Or 765, 771, 696 P2d 1082 (1985) (relying on ORS 42.250 for rule that terms of insurance contract “are presumed to have been used in their primary and general acceptance”).

**§1.2-3 Application of General Principles and the *Hoffman* Analysis**

**§1.2-3(a) Determining the Intent of the Parties**

As explained in §1.2-2(a), the primary goal in construing insurance contracts is to ascertain the intent of the parties from the perspective of the ordinary purchaser of insurance. *Hoffman Constr. Co. v. Fred S. James & Co.*, 313 Or 464, 469, 836 P2d 703 (1992); *Totten v. New York Life Ins. Co.*, 298 Or 765, 770, 696 P2d 1082 (1985).

The entire policy, including coverages not purchased by the insured, may be considered to determine if and to what extent one clause is modified, limited, or controlled by others. In *Fisher v. California Ins. Co.*, 236 Or 376, 388 P2d 441 (1964), the insured's auto policy provided coverage for collision but not comprehensive loss, although the policy contained clauses for both. To determine the intent of the parties, the court read all the clauses together, even the clauses in the policy that the insured did not purchase. "Contracts, including insurance contracts, are to be construed as a whole, not as a congeries of separate parts. We do not think it is reasonable to say that the insured is required to read only that part of a policy which directly deals with the coverage he seeks." *Fisher*, 236 Or at 380.

**§1.2-3(b) Looking to the Terms and Conditions of the Policy to Determine Ambiguity**

When the effect of policy language is an issue, the threshold inquiry is whether the language is ambiguous. This inquiry turns on the common and ordinary meaning of the words used, not meaning strained for the purpose of raising ambiguity or expanding coverage. *Totten v. New York Life Ins. Co.*, 298 Or 765, 772, 696 P2d 1082 (1985) ("any

aircraft” includes hang gliders); *Mortgage Bancorporation v. New Hampshire Ins. Co.*, 67 Or App 261, 263-264, 677 P2d 726 (1984).

Thus, language not otherwise reasonably susceptible to more than one meaning is not rendered ambiguous “by attributing possible but unlikely meanings to the terms employed without some basis in the policy for doing so.” *Western Fire Ins. Co. v. Wallis*, 289 Or 303, 308, 613 P2d 36 (1980) (parsing “period of disability”); *Jarrard v. Continental Casualty Co.*, 250 Or 119, 440 P2d 858 (1968) (parsing “insured dependent”); *see also N. Pac. Ins. Co. v. Hamilton*, 332 Or 20, 25, 22 P3d 739 (2001) (phrase under review was simply not comprehensible).

The fact that an insurance policy both provides coverage and excludes coverage under specified circumstances does not make the policy ambiguous because exclusions are intended to be unambiguous exceptions to operation of coverage provisions. *See Miller v. Miller*, 276 Or 639, 647, 555 P2d 1246 (1976) (when recital clause of sale contract is inconsistent with operative provision of contract, the contract as a whole is ambiguous); *Timber Access Industries v. U.S. Plywood-Champion Papers, Inc.*, 263 Or 509, 514, 503 P2d 482 (1972), *superceded on other grounds in State v. Rodriguez-Castillo*, 210 Or 479 (2007) (in sale contract, “[b]ecause the provisions of the two paragraphs are inconsistent, the contract is ambiguous”); *State Farm Fire & Casualty Co. v. Jones*, 86 Or App 584, 739 P2d 1090 (1987), *rev’d on other grounds*, 306 Or 415 (1988) (exclusion not invalid under financial responsibility law); *Jacob v. Blue Cross & Blue Shield of Ore.*, 92 Or App 259, 263, 758 P2d 382 (1988) (although medical policy was

contract of adhesion, there was no ambiguity in language of exclusionary provisions that required construction against drafter).

Policy language is considered legally ambiguous when the language can “reasonably be given a broader or a narrower meaning, depending upon the intention of the parties in the context in which such words are used by them.” *Shadbolt v. Farmers Ins. Exchange*, 275 Or 407, 411, 557 P2d 478 (1976). Stated differently, policy language is susceptible to more than one interpretation, and is therefore legally ambiguous, when reasonably intelligent persons reading the language would honestly differ on its meaning, *State Farm Mut. Auto. Ins. Co. v. White*, 60 Or App 666, 672, 655 P2d 599 (1982); when it is capable of more than one sensible and reasonable interpretation, *Kelch v. Industrial Indem. Co.*, 93 Or App 538, 542, 763 P2d 402 (1988); or when “special circumstances” show that the parties may have intended something different from the plain and ordinary meaning of the language used, *Truck Ins. Exch. v. Bill Olinger Mercury, Inc.*, 262 Or 8, 15, 495 P2d 1201 (1972). For example, an implied exclusion from specified perils coverage of fire caused by collision creates an ambiguity that requires construction in favor of coverage. *Northwest Agricultural Cooperative Assn. v. Continental Ins. Co.*, 95 Or App 285, 769 P2d 218 (1989).

**§1.2-3(b)(1) Who Determines that an Ambiguity Exists**

The rights and obligations of the parties to an insurance contract are determined within the “four corners” of the document taken as a whole. *Portland Federal Employees Credit Union v. Cumis Ins. Soc., Inc.*, 894 F2d 1101, 1103 (9th Cir 1990); *N. Pac. Ins. Co. v. Hamilton*,

332 Or 20, 24, 22 P3d 739 (2001) (citing *Denton v. International Health & Life Ins. Co.*, 270 Or 444, 449–450, 528 P2d 546 (1974)).

Over the last decade, the court of appeals has explicitly proscribed the admissibility of extrinsic evidence, even to create or explain an ambiguity. *See, e.g., Laird v. Allstate Ins. Co.*, 232 Or App 162, 167, 221 P3d 780 (2009) (“extrinsic evidence of the parties’ intent is not part of the interpretation of an insurance policy under Oregon law”); *Rhiner v. Red Shield Ins. Co.*, 228 Or App 588, 593, 208 P3d 1043 (2009); *Bresee Homes, Inc. v. Farmers Ins. Exch.*, 227 Or App 587, 594, 206 P3d 1091 (2009), *rev. allowed*, 347 Or 533, (2010) (“in determining the meaning of an insurance contract, we follow the three-step process . . . . Extrinsic evidence does not enter into that process, either to create or explain any ambiguities in the policy”); *Emplrs Ins. of Wausau v. Tektronix, Inc.*, 211 Or App 485, 503, 156 P3d 105 (2007) (“Issues of contractual intent are determined by the objective manifestations of the parties based on the terms that they use and not on what they subjectively believe that the terms mean”); *Andres v. Am. Std. Ins. Co.*, 205 Or App 419, 424, 134 P3d 1061 (2006) (noting that even though the Oregon Supreme Court has not explained why, it “has been clear since *Hoffman* . . . that the interpretation of insurance policies is a question of law, not one that is resolved by reference to evidence extrinsic to the policy itself,” as is done when interpreting general contracts).

This ban on extrinsic evidence has been applied against insurers as well as insureds. *See Tektronix, Inc.*, 211 Or App at 505 (rejecting insurer’s extrinsic evidence of the meaning of “sudden”); *Tualatin*

*Valley Hous. Partners v. Truck Ins. Exch.*, 208 Or App 155, 163, 144 P3d 991 (2006) (rejecting insured’s extrinsic evidence of the meaning of “anyone else”). *See also McHugh v. United Serv. Auto. Ass’n*, 164 F3d 451, 454 (9th Cir 1999) (“[expert] testimony cannot be used to provide legal meaning or interpret the policies as written”); *Nationwide Transp. Fin. v. Cass Info. Sys.*, 523 F3d 1051, 1058–1059 (9th Cir 2008) (district court did not abuse its discretion when it excluded expert-witness testimony that contained legal conclusions).

For this stance on extrinsic evidence, the courts have relied on the statement in *Hoffman Constr. Co. v. Fred S. James & Co.*, 313 Or 464, 469, 836 P2d 703 (1992), that interpreting an insurance policy is a question of law. *See also Farmers Ins. Co. v. Munson*, 145 Or App 512, 519, 930 P2d 878 (1996), in which the court emphatically reiterated its exclusive prerogative to construe generic, nonnegotiated policy language—in this case, the meaning of phrase *available for regular use* when applied to insured’s vehicle,— and also noting in footnote 6 that when evidence of customized negotiations exist, the result may be different.

Oregon’s strict prohibition of extrinsic evidence to create or explain an ambiguity in insurance policies is unique among other jurisdictions and relatively new to the Oregon courts. The majority rule in other jurisdictions is to allow extrinsic evidence in to explain an ambiguity. *See* 2 COUCH ON INSURANCE §21.11, et seq. (3d ed 1995 & Supp 2011)

**§1.2-3(b)(2)      The Question of Extrinsic Evidence**

As explained in §1.2-3(b)(1), the Oregon Court of Appeals has explicitly stated that extrinsic evidence is inadmissible to resolve or create ambiguities in insurance cases.

Prior to *Hoffman Constr. Co. v. Fred S. James & Co.*, 313 Or 464, 469, 836 P2d 703 (1992), Oregon courts were more lenient with admissibility of extrinsic evidence, in line with the majority rule. *See, e.g., Timberline Equipment Co. v. St. Paul Fire & Marine Ins. Co.*, 281 Or 639, 643, 576 P2d 1244 (1978) (when insurance contract is ambiguous, “the question becomes one of fact”); *Botts v. Hartford Acci. & Indem. Co.*, 284 Or 95, 98, 585 P2d 657 (1978) (general contracts and insurance policies interpreted the same); *Busto v. Manufacturers Life Ins. Co.*, 276 Or 707, 712, 556 P2d 96 (1976) (“when the agreement is ambiguous the actual intention of the parties becomes a question of fact, and, unless the meaning of the writing is clear from the surrounding circumstances and usages, the issues should be submitted to the jury”); *May v. Chicago Ins. Co.*, 260 Or 285, 292–294, 490 P2d 150 (1971) (jury may be called upon to interpret insurance contract); *Zerba v. Ideal Mut. Ins. Co.*, 96 Or App 607, 610, 773 P2d 1333 (1989) (intent of parties is fact question); *McGaughey v. St. Paul Fire & Marine Ins. Co.*, 88 Or App 181, 184, 744 P2d 598 (1987) (“If an insurance contract is ambiguous, the meaning of the ambiguous term is a question of fact”); *Horizon Aviation Inc. v. Cam*, 80 Or App 577, 580, 722 P2d 1291 (1986) (“Generally, the interpretation of a contract is a question of law for the court, but if its provisions are ambiguous and there is extrinsic evidence introduced, its meaning becomes a question of fact for the jury”); *A-1 Sandblasting v. Baiden*, 53 Or App 890, 893, 632 P2d 1377

(1981), *aff'd*, 293 Or 17 (1982) (if evidence reasonably permits different conclusions regarding intent or purpose of policy, the question of meaning to be assigned to language is one of fact); *First Far West Transp. v. Carolina Casualty Ins.*, 47 Or App 339, 346–347, 614 P2d 1187 (1980) (evidence showing that parties reasonably contemplated certain risks would be covered by insurance policy is admissible to establish intent).

COMMENT: The court in *Hoffman* implicitly relied on and approved many of these prior supreme court cases. Also, less than a month before deciding the *Hoffman* case, the supreme court decided *Joseph v. Utah Home Fire Ins. Co.*, 313 Or 323, 328, 835 P2d 885 (1992), in which it noted that “parties presented no evidence, such as evidence of their negotiations, about what meaning they actually intended.” Although *Hoffman* did not mention that passage, it did cite positively to *Joseph*. If the court intended to bar extrinsic evidence altogether, it seems odd that it did so only with the statement that interpretation of an insurance policy was a question of law.

Following *Hoffman*, in the mid- to late-1990s the Oregon Supreme Court has on a few occasions implied in dicta that extrinsic evidence may be admissible to “resolve an ambiguity in the meaning of a policy.” *Interstate Fire & Casualty Co. v. Archdiocese of Portland*, 318 Or 110, 118, 864 P2d 346 (1993). Likewise, several cases from the court of appeals have mentioned the admissibility of extrinsic evidence. *See, e.g., Farmers Ins. Exch. v. Crutchfield*, 200 Or App 146, 153, 113 P3d 972 (2005) (quoting prior cases that if insurance contract is

ambiguous or contains technical words, local phrases, or terms of art, construing it becomes question of fact); *Walker v. Woodworth*, 160 Or App 636, 645, 981 P2d 1282 (1999) (construction of contract presents fact questions only if language is ambiguous or if technical words, terms of art, or local phrases are used); *Protection Mut. Ins. Co. v. Mitsubishi Silicon Am. Corp.*, 164 Or App 385, 397–398, 992 P2d 479 (1999) (court may “consider such extrinsic evidence in interpreting an insurance contract only if it first finds the policy to be ambiguous,” citing *Yogman v. Parrott*, 325 Or 358, 363, 937 P2d 1019 (1997) (general contract interpretation)); *National Chiropractic Mut. Ins. Co. v. Morgan*, 116 Or App 196, 201, 840 P2d 732 (1992) (“As we have already said, the policy terms are susceptible to alternative reasonable interpretations. Even if we were to consider extrinsic evidence as suggested by the dictum in *Timberline Equipment v. St. Paul Fire & Marine Ins. Co.*, [281 Or 639, 576 P2d 1244 (1978)], there is no relevant evidence to consider”).

However, following *Andres v. Am. Std. Ins. Co.*, 205 Or App 419, 424, 134 P3d 1061 (2006), the court of appeals has consistently upheld trial court rulings in which extrinsic evidence was barred, and the Oregon Supreme Court has continued to state that interpretations of insurance policies are a matter of law.

NOTE: The Oregon Supreme Court has not squarely addressed the issue of using extrinsic evidence to resolve ambiguities in insurance contracts. In *Bresee Homes, Inc. v. Farmers Ins. Exch.*, 227 Or App 587, 594, 206 P3d 1091 (2009), *rev. allowed*, 347 Or 533(2010), the court of appeals stated bluntly

that “in determining the meaning of an insurance contract, we follow the three-step process . . . . Extrinsic evidence does not enter into that process, *either to create or explain any ambiguities in the policy*” (emphasis added). Attorneys should be aware of this pending case.

**§1.2-3(b)(3) If the Policy Contains a Definition of the Term or Phrase**

If the policy expressly defines the term in question, courts apply that definition. *Holloway v. Republic Indem. Co. of Am.*, 341 Or 642, 650, 147 P3d 329 (2006); *see also Groshong v. Mut. of Enumclaw Ins. Co.*, 329 Or 303, 307–308, 985 P2d 1284 (1999) (noting that court in *Hoffman Constr. Co. v. Fred S. James Co.*, 313 Or 464, 836 P2d 703 (1992), first looked for definition within policy); *Allstate Ins. Co. v. Handegard*, 70 Or App 262, 266, 688 P2d 1387 (1984) (“When a policy of insurance defines terms in a manner which differs from the ordinary understanding of those terms, the policy definition controls”).

If the policy defines the term or phrase, the court must then determine whether internal terms within the definition have a plain meaning or are susceptible to more than one definition. In *Gonzales v. Farmers Ins. Co.*, 345 Or 382, 387, 169 P3d 1 (2008), the court noted that the first step in *Hoffman* and *Holloway* was to turn to internal definitions. Here the court looked to the policy’s definition of “loss” and applied it. The court held the definition to be unambiguous. (However, the *Gonzales* case turned on the definition of “repair,” and the court looked to prior judicial decisions to aid in defining the term.) For more information, see §1.43; *see also Or. State Bar Prof’l Liab.*

*Fund v. Benfit*, 225 Or App 409, 416, 201 P3d 936 (2009) (applying policy's unambiguous, internal definition of "same or related claims").

Courts attempt to interpret internal definitions as written and in such a way as to avoid rendering those definitions meaningless. In *Andres v. Am. Std. Ins. Co.*, 205 Or App 419, 423-425, 134 P3d 1061 (2006), an insured worked for a company that rented a pickup truck for the insured's use at work. The insurer refused to defend because the policy covered only the use of a car. The insured then brought an action against the insurer, claiming that the vehicle was covered as a passenger car. The court disagreed, stating that in isolation the argument appeared valid. But if the definition of a "private passenger car" could be read to include a four-wheel truck with 4,000 pounds of hauling capacity used exclusively for work, the definition of "car" would become superfluous. Citing *Hoffman*, the court stated that it was "constrained not to interpret the terms of insurance policies so that provisions become meaningless." *Andres*, 205 Or App at 426. *See also Ruede v. City of Florence*, 231 Or App 435, 220 P3d 113 (2009) (building that sank into sand had not "collapsed" as defined within policy); *Hennessy v. Mut. of Enumclaw Ins. Co.*, 228 Or App 186, 193, 206 P3d 1184 (2009) (policy did not define *collapse* and court held that policy was ambiguous). The interpretation of unambiguous policy language is a matter of law for the court. *Farmers Ins. Co. v. Munson*, 145 Or App 512, 519, 930 P2d 878 (1996).

When internal definitions use undefined terms, courts consider the context of the definition to aid in the construction of the term or phrase. In *Employers-Shopmens Local 516 Pension Trust v. Travelers*

*Cas. & Sur. Co. of Am.*, 235 Or App 573, 235 P3d 689 (2010), the policy defined *employee* in an ERISA compliance endorsement, and the court applied ERISA's statutory definitions to the terms *administrators* and *officers*, which were undefined terms used in the *employee* definition. In *Malbco Holdings, LLC v. AMCO Ins. Co.*, 629 F Supp2d 1185 (D Or 2009), the policy defined *collapse*, but the parties offered different interpretations of that term. The judge looked to other courts' definitions of *collapse* and held that *abrupt falling down or caving in* was an ambiguous phrase within policy's definition. See also *St. Paul Fire & Marine Ins. Co. v. McCormick & Baxter Creosoting Co.*, 324 Or 184, 210–211, 923 P2d 1200 (1996) (construing internal definitions of *occurrence* and *sudden and accidental*, as well as dictionary and common-law interpretations); *Rhiner v. Red Shield Ins Co.*, 228 Or App 588, 593, 208 P3d 1043 (2009) (policy plainly and unambiguously defined *temporary worker*); *Gage v. All Nations Ins. Co.*, 108 Or App 534, 816 P2d 682 (1991), *aff'd*, 314 Or 700 (1992) (coverage denied because plaintiff insured had “charge of” damaged vehicle); *McGaughey v. St. Paul Fire & Marine Ins. Co.*, 88 Or App 181, 183, 744 P2d 598 (1987) (exclusion for workers' compensation claim); *Mortgage Bancorporation v. New Hampshire Ins. Co.*, 67 Or App 261, 264, 677 P2d 726 (1984) (exclusion for vandalism unless building “is being constructed”).

In *Dixon v. Sentinel Ins. Co.*, 2010 US Dist LEXIS 46454, 2010 WL 1924699, \*3–\*4 (D Or Apr 8, 2010), *adopted in entirety*, 2010 US Dist LEXIS 46455, 2010 WL 1924697 (D Or May 10, 2010), the policy defined *insured*, but the parties offered differing interpretations of that

definition. The magistrate judge recommended the only interpretation that was reasonable on a plain reading of the policy in its entirety.

**§1.2-3(b)(4) If the Policy Does Not Contain a Definition of the Term or Phrase**

An insurer may insert its own definition of a term or phrase into a policy. But if the insurer does not do so, it must accept the ordinary meaning of that term or phrase as understood by an ordinary member of the purchasing public. In *Chale v. Allstate Life Ins. Co.*, 353 F3d 742, 746 (9th Cir 2003), the court concluded that “Allstate could have explicitly defined ‘accidental’ or ‘accident’ any way it wished.

...Because it did not, and because the rest of the contract sheds no additional light on the parties' intent, Allstate must accept the common understanding of the term by the ordinary member of the purchasing public.” See also *Botts v. Hartford Acci. & Indem. Co.*, 284 Or 95, 103, 585 P2d 657 (1978) (when “‘accident’ or ‘accidental’ are not defined in the policy, it is for the court to decide the definition which is properly applicable to the particular factual situation, taking into consideration what we believe to be the popular non-technical understanding of the term”); *Groshong v. Mutual of Enumclaw Ins. Co.*, 329 Or 303, 307-308, 985 P2d 1284 (1999); *Hoffman Constr. Co. v. Fred S. James & Co.*, 313 Or 464, 469, 836 P2d 703 (1992). In absence of anything in the context of the policy indicating otherwise, a word or phrase is interpreted consistently throughout the policy. *Schweigert v. Beneficial Standard Life Ins. Co.*, 204 Or 294, 303, 282 P2d 621 (1955).

When policy language has a plain and ordinary meaning, and is not therefore reasonably susceptible to different interpretations, it is

considered unambiguous. *Twilleager v. North American Acci. Ins. Co.*, 239 Or 256, 260, 397 P2d 193 (1964) (plain and ordinary meaning); *State Farm Mut. Auto. Ins. Co. v. White*, 60 Or App 666, 672, 655 P2d 599 (1982) (“a reasonable interpretation of the term ‘operator’ does not include ... grabbing the wheel”).

Courts will always look at the entire policy to make sure its interpretation is consistent with the policy as a whole. In *Marsh v. Am. Family Mut. Ins. Co.*, 231 Or App 332, 339, 218 P3d 573 (2009), one clause granted coverage for losses caused by water or steam, but another clause excluded losses caused by leakage of water over a period of time. The court was not persuaded that the clauses conflicted.

If possible, courts construe a term or phrase narrowly in order to avoid rendering other clauses or phrases moot. *Rhiner v. Red Shield Ins. Co.*, 228 Or App 588, 593, 208 P3d 1043 (2009) (insured’s proposed interpretation of *furnished* was untenable with remainder of policy and would render superfluous the entire phrase *a person who is furnished to you*); *Andres v. Am. Standard Ins. Co.*, 205 Or App 419, 426, 134 P3d 1061 (2006) (including pickup truck in definition of “car” because truck had passenger seat would render definition redundant).

The discussion below highlights some cases and rules concerning the interpretation of ambiguous texts and phrases with the aid of common understanding, dictionaries, and common law. Many of these cases use more than one aid to interpret the policy.

(1) **Common Understanding**

When language of common understanding is used in an insurance policy, and the meaning is clear and subject to only one reasonable

interpretation, no further interpretation is necessary and the language is to be taken in its plain, ordinary, and popular sense. *Hoffman Constr. Co.*, 313 Or at 469 (methodology of using aids when policy does not define terms); *Groshong*, 329 Or at 308 (“The meaning of a term is ‘plain’ -- that is, unambiguous -- if the term is susceptible to only one plausible interpretation”).

When a policy consistently uses second-person pronouns to refer to the insured, the only plausible interpretation of the word *your* is it referred to the insured. *Holloway v. Republic Indem. Co. of Am.*, 341 Or 642, 651, 147 P3d 329 (2006) (the court applied common understanding to determine to whom the phrase *your rights and duties* was directed); *see also Uno v. Provident Life & Accident Ins.*, 221 Or App 661, 666–667, 191 P3d 738 (2008) (plain meaning of *operation of [a] business or profession* was in accord with remainder of policy); *Country Mut. Ins. Co. v. White*, 212 Or App 323, 331, 157 P3d 1212 (2007) (second sentence of *other insurance* provision did not “conform contextually” with third sentence).

### (2) Dictionaries and Black’s Law Dictionary

A common source of ordinary meaning is the dictionary. *See, e.g., Dewsnup v. Farmers Ins. Co. of Or.*, 349 Or 33, 40, 239 P3d 493 (2009) (dictionary definition of “roof”); *Smith v. State Farm Ins.*, 144 Or App 442, 447, 927 P2d 111 (1996) (dictionary definition of “watercraft”); *St. Paul Fire & Marine Ins. Co. v. McCormick & Baxter Creosoting*, 324 Or 184, 210–211, 214, 923 P2d 1200 (1996) (dictionary meaning of *sudden and accidental*); *Laird v. Allstate Ins. Co.*, 232 Or App 162, 170, 221 P3d 780 (2009) (dictionary definitions of *policyholder* and *policy*);

*Uno*, 221 Or App at 666–667 (dictionary definition of *operation* and *business*).

In addition to *Webster’s Third New International Dictionary*, courts look at definitions in *Black’s Law Dictionary*. See, e.g., *Gonzales v. Farmers Ins. Co.*, 345 Or 382, 387-388, 169 P3d 1 (2008) (defining “repair”).

The court may look to relevant statutes. In *Trout v. Liberty Northwest Ins. Corp.*, 154 Or App 89, 97, 961 P2d 235 (1998), the court addressed an argument that the term *employee* in an insurance policy should have a meaning other than its dictionary or common-law meaning because the insurance policy had been written to govern workers’ compensation claims arising under the Employer Liability Act (ELA). The ELA defined *employee* broadly because the ELA protected two classes, employees and the public (or others’ employees). By its plain language, the policy did not extend coverage to a larger class than the employer’s employees, and the court declined to apply the statute’s broader definition of employee to the policy. Because the plaintiff conceded that he was not an employee, his loss was not covered. See also *Employers-Shopmens Local 516 Pension Trust v. Travelers Cas. & Sur. Co. of Am.*, 235 Or App 573, 235 P3d 689 (2010) (similar holding construing *employee* under ERISA);

### (3) **Common Law**

Courts may rely on prior judicial decisions that have construed the same or similar policy terms. The fact that courts have come to differing conclusions about a term or phrase may indicate an ambiguity. See *Cimarron Ins. Co. v. Travelers Ins. Co.*, 224 Or 57, 64–66, 355 P2d

742 (1960) (parsing “insured”). “[D]iffering results reached by [other] courts and the disagreement among the judges of those courts which have considered [a term or phrase] are strong indications that it contains a real ambiguity.” *Jones v. Insurance Co. of North America*, 264 Or 276, 282, 504 P2d 130 (1972). See also *I-L Logging Co. v. Manufacturers & Wholesale Indem. Exchange*, 202 Or 277, 313–317, 273 P2d 212, 275 P2d 226 (1954) (varying decisions regarding “employee” status were not conclusive); *Purcell v. Washington Fidelity Nat’l Ins. Co.*, 146 Or 475, 486–487, 30 P2d 742 (1934) (reviewing other states’ decisions regarding “confinement”).

In *Gonzales* 345 Or 382, the court analyzed two prior Oregon Supreme Court cases, *Rossier v. Union Automobile Ins. Co.*, 134 Or 211, 291 P 498 (1930), and *Dunmire Co. v. Ore. Mut. Fire Ins. Co.*, 166 Or 690, 114 P2d 1005 (1941), to aid in a definition of *repair*. The court did not explicitly find the term to be ambiguous before looking to common-law definitions, but noted that dictionary definitions offered by both parties focused on the restoration of property.

In *Wright v. State Farm Mut. Auto. Ins. Co.*, 332 Or 1, 7, 22 P3d 744 (2001), the court examined the family member/household exclusion in an automobile policy and found it similar to the ambiguous exclusion in *N. Pac. Ins. Co. v. Hamilton*, 332 Or 20, 22 P3d 739 (2001)—but even more obtuse. Both opinions found that a policy that merely directed the insured to the Oregon Insurance Code was confusing and ambiguous when the policy expressly provided for coverage exceeding the statutory minimums.

The term “accident” has been especially fruitful. In *St. Paul Fire & Marine Ins. Co.*, 324 Or at 205, the court looked to three cases—*Finley v. Prudential Ins. Co.*, 236 Or 235, 238, 388 P2d 21 (1963); *Botts v. Hartford Accident & Indem. Co.*, 284 Or 95, 101, 585 P2d 657 (1978); and *Ramco, Inc. v. Pacific Ins. Co.*, 249 Or 666, 667, 439 P2d 1002 (1968)—to determine the meaning of the word. The court in *Botts*, 284 Or at 101, admitted, “There are probably not many words which have caused courts as much trouble as ‘accident’ and ‘accidental.’” See also *Chale*, 353 F3d 742 (9th Cir 2003), in which the Ninth Circuit relied on *Fox v. Country Mut. Ins. Co.*, 327 Or 500, 964 P2d 997, 1006 (1998), and *Paulissen v. U.S. Life Ins. Co.*, 205 F Supp2d 1120 (CD Cal 2002), to determine the meaning of the word “accidental” in a mountain climber’s life insurance policy

Other cases in which the court has looked to common law for definitions include *Emplrs Ins. of Wausau v. Tektronix, Inc.*, 211 Or App 485, 508, 156 P3d 105 (2007) (relying on discussion of *sudden and accidental* in *St. Paul Fire & Marine Ins. Co.*); *Farmers Ins. Exch. v. Crutchfield*, 200 Or App 146, 155-156, 113 P3d 972 (2005) (court looked to *Fagg v. Massachusetts Bonding & Ins. Co.*, 142 Or 358, 19 P2d 413 (1933) for definition of *own*); *Smith*, 144 Or App at 448 (noting that none of prior judicial opinions cited found term *watercraft* to be ambiguous).

### §1.2-3(c) Context and Close Scrutiny

If, after applying an internal definition or the ordinary meaning of a term or phrase, there remains only one plausible meaning, courts stop

the analysis and apply that meaning. However, if the term or phrase continues to have more than one plausible meaning, courts examine the particular context in which the term is used within the policy and the broader context of the policy as a whole. *Hoffman Constr. Co. v. Fred S. James & Co.*, 313 Or 464, 470, 836 P2d 703 (1992). Thus, it takes more than an initial showing of multiple plausible interpretations for a term in an insurance policy to be ambiguous. This extra step is done in consideration of the “breadth and flexibility of the English language.” *Hoffman*, 313 Or at 470. “[W]hen two or more competing, plausible interpretations prove to be reasonable after all other methods for resolving the dispute over the meaning of particular words fail, then the rule of interpretation against the drafter of the language becomes applicable, because the ambiguity cannot be permitted to survive. It must be resolved.” *Hoffman*, 313 Or at 470-471.

If a general term or phrase follows or is part of a list of specific things, courts construe the term or phrase to align with other items in that list. *Groshong v. Mutual of Enumclaw Ins. Co.*, 329 Or 303, 313, 985 P2d 1284 (1999) (“this court has stated that ‘the rule of *ejusdem generis* in contracts is peculiarly applicable where specific enumeration precedes the word ‘other’ followed by general words’” (quoting *McGrath v. Electrical Constr. Co.*, 230 Or 295, 307, 364 P2d 604 (1961))). In *Groshong*, 329 Or 306, the court analyzed an insurance policy that covered a business owner who was sued for housing discrimination. The court held that the discrimination was not a covered act of the policy. The court held that the phrase *other invasion of the right of private occupancy* alone may not imply a possessory interest.

However, since a person could not suffer a *wrongful entry or eviction* unless that person occupies or has a possessory interest in the premises, the court held that the parties intended such a similar requirement by the phrase *other invasion of intentional housing discrimination*. Since the original claimant against the insured did not have a possessory interest, the insured was not covered for the housing discrimination claim.

*Groshong*, 329 Or 313–314.

Even when ambiguity of a phrase or term may be found in other jurisdictions, the Oregon court may ignore conflicting common-law definitions if it determines that the term or phrase can be deciphered by analyzing the context in which it was used. *Cimarron Ins. Co. v. Travelers Ins. Co.*, 224 Or 57, 66, 355 P2d 742 (1960) (regarding split of authority on the definition of *the insured*, the court agreed with a California opinion: “[w]e feel, however, that it is not necessary to rely on the authority of any of those cases in determining the question, as it can be decided by an examination of the exclusion clause itself under general principles of insurance law”); *Hoffman Constr. Co.*, 313 Or at 475–477 (rejecting use of cases from other jurisdictions as evidence of ambiguity when phrase had only one plausible interpretation within context of contract as a whole).

Similarly, in *Holloway v. Republic Indem. Co. of Am.*, 341 Or 642, 652–653, 147 P3d 329 (2006), the court was not persuaded by opinions from other jurisdictions that did not follow the *Hoffman* analysis. Furthermore, the anti-assignment clause at issue, when considered in the context of the policy as a whole, was not ambiguous. *Holloway*, 341 Or at 653. In *Andres v. Am. Standard Ins. Co.*, 205 Or

App 419, 426, 134 P3d 1061 (2006), the court refused to adopt definitions of *pickup truck* and *car* from other jurisdictions because none of those definitions “is based on the precise language at issue in this case. And none applies the interpretive principles that we are required to apply under Hoffman.”

Courts may also turn to the broader context of the term or phrase within the policy before finding an ambiguity. In *Sackos v. Great-West Life Assurance Co.*, 213 Or App 298, 160 P3d 1026 (2007), the court analyzed the phrase *A recorded change of beneficiary will take effect as of the date the notice was signed*. The court stated that the phrase itself was not ambiguous, but then looked to the rest of the policy to determine the enforceability of an unrecorded change of beneficiary. In the context of the policy as a whole, the court held that recording the change was intended by the parties to be a condition of enforceability. *Sackos*, 213 Or App at 300, 303–305. *See also Cain Petroleum Inc v. Zurich Am. Ins. Co.*, 224 Or App 235, 242–243, 197 P3d 596 (2008) (rejecting proposed definition that was directly contradicted by express wording of policy).

**§1.2-3(d) If Ambiguity Persists, Construe Against the Drafter (Insurer)**

Courts construe a policy for the insured and against the drafter only if a term remains ambiguous after close scrutiny. *Hoffman Constr. Co. v. Fred S. James & Co.*, 313 Or 464, 470, 836 P2d 703 (1992); *Holloway v. Republic Indem. Co. of Am.*, 341 Or 642, 650, 147 P3d 329 (2006); *Ledford v. Gutoski*, 319 Or 397, 399–400, 877 P2d 80 (1994)

(“Any ambiguity in the complaint with respect to whether the allegations could be covered is resolved in favor of the insured”).

In *N. Pac. Ins. Co. v. Hamilton*, 332 Or 20, 26, 22 P3d 739 (2001), the court pointed out that “a term also can be considered ‘ambiguous’ if its meaning is not comprehensible for some reason, such as indefiniteness, erroneous usage, or form of expression. In such a case, ... the court does not permit the party who drafted the term or phrase to benefit from the obscurity.”

[A] true ambiguity supporting the application of the ‘construe against the drafter’ maxim exists ‘*only* if two or more plausible interpretations of that term withstand scrutiny, i.e., continues to be reasonable, after the interpretations are examined in the light of, among other things, the particular context in which that term is used in the policy and the broader context of the policy as a whole.”

*Gonzales v. Farmers Ins. Co. of Or.*, 210 Or App 54, 64, 150 P3d 20 (2006) (quoting *Hoffman*, 313 Or at 470 (emphasis in original), *affirmed on other grounds*, 345 Or 382 (2008).) *See also Red Lion Hotels, Inc. v. Commonwealth Ins. Co. of Am.*, 177 Or App 58, 65, 33 P3d 358 (2001) (ambiguity in terms involving riprap); *American Hardware Ins. Group v. West One Auto. Group, Inc.*, 167 Or App 244, 248, 2 P3d 413 (2000) (“eviction” as used in policy was not ambiguous); *North Clackamas Sch. Dist. No. 12 v. Oregon Sch. Bds. Ass’n Prop & Cas. Trust*, 164 Or App 339, 344–345, 991 P2d 1089 (1999) (summarizing *Hoffman* analysis).

In Oregon, the standard of interpretation required by the rule is that ambiguous language is viewed “in the sense in which the insured had reason to suppose it was understood.” *Borglund v. World Ins. Co.*,

211 Or 175, 181, 315 P2d 158 (1957). *See also Sch. Dist. v. Mission Ins. Co.*, 58 Or App 692, 698, 650 P2d 929 (1982) (no evidence that school district intended or understood narrow interpretation of errors and omissions policy); *Shadbolt v. Farmers Ins. Exchange*, 275 Or 407, 411, 557 P2d 478 (1976) (insurance policy should be construed "according to its character and its beneficent purposes, and in the sense that the insured had reason to suppose that it was understood") (citations omitted); *Chalmers v. Or. Auto. Ins. Co.*, 262 Or 504, 509, 500 P2d 258 (1972); *Growers Refrigerating Co. v. American Motorists Ins. Co.*, 260 Or 207, 215, 488 P2d 1358 (1971). The determination of what an insured had reason to understand is a question of law. *May v. Chicago Ins. Co.*, 260 Or 285, 292, 490 P2d 150 (1971).

Policy language that merely directs the insured to the Oregon Insurance Code may be ambiguous and construed against the drafter. In *Wright v. State Farm Mut. Auto. Ins. Co.*, 332 Or 1, 8, 22 P3d 744 (2001) (citing *Hamilton*, 332 Or 20), the court held:

The reference in the exclusion to "the limits of liability required by law" does not inform a policyholder what limit, if any, is applicable in a given situation and does not even direct the policyholder to a particular body of law to find out what that limit is. Resort to the context in which the phrase is used in the exclusion, as well as to other provisions of the policy, does not clarify the matter. The exclusion remains inherently ambiguous, if not incomprehensible.

When the court construes policy language against the drafter, the court may extend insurance coverage. "The familiar rule that ambiguities in an insurance contract will be resolved in favor of

extending coverage . . . is a particular application of the general rule of construction that ambiguous terms in a written instrument will be resolved against the party that chose them.” *Perez v. State Farm Mut. Auto Ins. Co.*, 289 Or 295, 299 n 2, 613 P2d 32 (1980); *First Far West Transp., Inc. v. Carolina Casualty Ins. Co.*, 47 Or App 339, 344, 614 P2d 1187 (1980) (“a concession by the court that policy language is ambiguous does not require it to adopt the construction urged by the insured”).

In *Hennessy v. Mut. of Enumclaw Ins. Co.*, 228 Or App 186, 193, 206 P3d 1184 (2009), the policy was held to be ambiguous because of two plausible interpretations of the word *collapse*. Thus, part of the policy was construed against the drafter. *See also Chale v. Allstate Life Ins. Co.*, 353 F3d 742 (9th Cir 2003) (court construed *accident and disease* narrowly to favor insured); *ZRZ Realty Co. v. Beneficial Fire and Cas. Ins. Co.*, 349 Or 117, 241 P3d 710 (2010) (construing the phrase “fixed or moveable things whatsoever” against the drafter and to include a riverbed).

NOTE: Some insurance policies are drafted jointly by industry groups and insurance groups that have equal bargaining power, and many courts hold that in those circumstances ambiguous terms will not be construed against the insurer. For example, some financial institution bonds are drafted jointly by the banking industry and the insurance industry. Although the Oregon courts have not issued opinions on point, many courts hold that ambiguities in financial institution bonds should not be construed against the insurer. *See* 11 COUCH ON INSURANCE §167:44 (1995 &

Supp 2011) (“[d]ue to the fact that a financial institution bond is an industry-standard policy, negotiated between parties of relatively equal bargaining power, the normal rules of insurance contract interpretation do not apply. Consequently, if the terms of the policy are determined to be ambiguous, such terms are to be construed without a presumption in favor of either party,” *citing, Tri City Nat’l Bank v. Fed. Ins. Co.*, 674 NW2d 617 (Wis App 2003)); HOLMES’S APPLEMAN ON INSURANCE, §4.23 (2d ed 1996).

**§1.2-3(d)(1) Exception for Ambiguities in Statutorily Required Language**

The rule that requires ambiguous policy language to be construed in favor of an insured does not apply to language prescribed by statute. The ambiguity then becomes “a problem of statutory construction.” *Perez v. State Farm Mut. Ins. Co.*, 289 Or 295, 299, 613 P2d 32 (1980). *See also Ivanov v. Farmers Ins. Co.*, 344 Or 421, 442, 185 P3d 417 (2008) (relying on *Perez* to avoid construing policy to provide broader coverage than statute provides); *To v. State Farm Mut. Ins.*, 123 Or App 404, 408, 860 P2d 294 (1993), *reversed in part on other grounds*, 319 Or 93 (1994) (“Nothing in the record suggests that the policy was intended to provide broader coverage than the statute requires. Therefore, the trial court was correct in resolving the motion by construing the statute”); *N. Pacific Ins. Co. v. Anderson*, 110 Or App 269, 821 P2d 444 (1991) (without indication that parties intended broader coverage than statute required, court construed *furnished for regular use* narrowly). Although the purpose of the statute may call for a liberal construction, the rule requiring construction in favor of an

insured should not be applied. *P.O.P. Constr. Co. v. State Farm Fire & Cas. Co.*, 328 So 2d 105, 107 (La 1976) (“the phrase should not be construed liberally in favor of the insured, but must be interpreted according to the principles of statutory construction, without leaning toward one side or the other”).

For more on the construction of insurance policies containing statutorily required provisions, see §1.2-3(e).

**§1.2-3(d)(2) Strangers to the Contract**

Generally, the benefit of the rule of construction in favor of an insured can be claimed only by someone who qualifies as an insured under the policy. For example, the rule does not apply in actions between insurers to determine which policy provides coverage. *New Amsterdam Casualty Co. v. Fidelity & Casualty Co. of N.Y.*, 400 F2d 237, 239 (9th Cir 1968) (“there being no contest between insured and insurer, the rule of liberal construction in favor of an insured is not germane”).

There are no Oregon state court cases on point, but see 2 COUCH ON INSURANCE §22:23 for more on this topic.

**§1.2-3(e) Interpreting Statutorily Required Provisions and Terms**

The rules of statutory construction, rather than the rules of contract interpretation, apply to the construction of a statutory term or phrase appearing in a policy. *Moore v. Mutual of Enumclaw*, 317 Or 235, 244–245, 855 P2d 626 (1993) (when provision in insurance contract is required by legislature, intent of legislature controls, not intent of parties). Examples of statutory construction include *Fox v.*

*Country Mut. Ins. Co.*, 327 Or 500, 506, 964 P2d 997 (1998) (construing underinsured and uninsured motorist statutes); *Carrigan v. State Farm Mut. Auto. Ins. Co.*, 326 Or 97, 104, 949 P2d 705 (1997) (construing PIP statute); *To v. State Farm Mut. Ins.*, 319 Or 93, 873 P2d 1072 (1994) (construing “phantom vehicle” statute).

The rules of statutory construction and of contract interpretation may overlap. In *Trus Joist MacMillan v. John Deere Ins. Co.*, 171 Or App 476, 488, 15 P3d 995 (2000), the dissenting judges noted:

We interpret words of common usage found in insurance statutes in accordance with their ordinary meaning. The term “use” is one of common understanding and, when not otherwise defined in an insurance statute, should be given its ordinary meaning. The majority purports to follow these principles, but it overlooks a fundamental synergy between the construction of statutes and insurance policies. At the first levels of statutory construction and insurance policy construction our missions are comparable: We seek to ascertain the ordinary meaning of words. Loading a motor vehicle is a “use” in the ordinary sense contemplated by the omnibus provision of John Deere’s policy.

The basic methodology for interpreting a statute is set forth in *Portland Gen. Elec. Co. v. Bureau of Labor & Indus.*, 317 Or 606, 611-612, 859 P2d 1143 (1993). In interpreting statutes, courts will consider legislative history. ORS 174.020; *State v. Gaines*, 346 Or 160, 171–172, 206 P3d 1042 (2009) (refining methodology set forth in *Portland Gen. Elec. Co.*). See also *Certain Underwriters at Lloyd’s London v. Mass. Bonding & Ins. Co.*, 235 Or App 99, 230 P3d 103 (2010) (determining legislative intent of phrase *is liable or potentially liable* in ORS

465.480(4)); *Progressive Ins. v. Nat'l Am. Ins. Co.*, 201 Or App 301, 305, 118 P3d 836 (2005) (citing *Portland Gen. Elec. Co.*, “we first consider the statute's text in context and, if necessary, its legislative history and other interpretive aids”).

To resolve an ambiguity in policy language prescribed by statute, the court applies general principles of statutory construction to ascertain and give effect to the intent of the legislature. *Perez v. State Farm Mut. Ins. Co.*, 289 Or 295, 613 P2d 32 (1980) (inability to work due to death differs from “disability”); *see also Ivanov v. Farmers Ins. Co.*, 344 Or 421, 442, 185 P3d 417 (2008) (PIP statutes); *Marcilionis v. Farmers Ins. Co.*, 318 Or 640, 871 P2d 470 (1994) (construing *occupying* in ORS 742.504).

Deciphering the ambiguity may involve determining which statute controls when more than one statute may apply to the insurance policy. *Vogelin v. Am. Family Mut. Ins. Co.*, 346 Or 490, 213 P3d 1216 (2009) (ORS 742.502(2)(a) and ORS 742.504(7)(c)). As with general statutory construction, courts use legislative history to determine which statute controls. *Vogelin*, 346 Or at 493.

Examples of statutes prescribing policy language are ORS 742.504 (uninsured motorist coverage) and ORS 742.524 (PIP benefits). Most insurance policy forms and provisions to be delivered or to be issued for delivery in Oregon must be approved by the Director of the Department of Consumer and Business Services. ORS 742.003. This requirement alone does not exempt approved forms and provisions from application of the rule of construction in favor of an insured. *C & J Fertilizer, Inc. v. Allied Mut. Ins. Co.*, 227 NW2d 169, 175 (Iowa 1975);

*see also Hall v. Metropolitan Life Ins. Co.*, 146 Or 32, 28 P 875 (1934); *Gifford v. W. Aviation Ins. Group*, 77 Or App 645, 713 P2d 1085 (1986). Nor does director approval ensure that the policy will comply with the statutes. *Fleming v. United Servs. Auto. Ass'n*, 330 Or 62, 66, 996 P2d 501 (2000).

**§1.2-3(f) Rules Regarding Inconsistencies**

Rules of construction have been developed to resolve inconsistencies between printed policy language and other provisions of the insurance contract. For the most part, these rules do not assume that ambiguities will be resolved in favor of an insured. Rather, by means of arbitrary selection, the rules resolve the conflict ab initio and thereby avoid the ambiguity. These inconsistencies may be treated as ambiguities or may call for rescission of the policy in part or in its entirety. For more information on rescission, see §§1.4-3 to 1.4-3(h).

**§1.2-3(f)(1) Inconsistency with Binder**

The “clear and express terms” of an oral or written binder control over any inconsistent language in either “the usual terms” of the policy contemplated by the binder or the policy actually issued. ORS 742.043(1)–(2). Generally, policy terms that are inconsistent with binder coverage are not enforceable against an insured. *See Stuart v. Pittman*, 350 Or 410, 419, \_\_\_ P3d \_\_\_ (2011) (“as used in the statute, the term ‘clear’ means ‘easily understood’ and the term ‘express’ means ‘directly and distinctly stated, rather than implied or left to inference’”); *Gifford v. Western Aviation Ins. Group*, 77 Or App 645, 650, 713 P2d 1085 (1986); *Avemco Ins. Co. v. Hill*, 76 Or App 185, 188–189, 708 P2d 640 (1985).

For more information on binders, see, §I.1-3 to 1.1-3(c).

**§1.2-3(f)(2) Inconsistency with Application**

Generally, policy language governs over inconsistent terms of an application. For more information on applications, see §1.1-1(a) to 1.1-1(a)(3).

**§1.2-3(f)(3) Inconsistency with Endorsement**

“To the extent of any conflict between the policy and endorsement, the endorsement controls.” *First Far West Transp., Inc. v. Carolina Casualty Ins. Co.*, 47 Or App 339, 344, 614 P2d 1187 (1980); *Waller v. Auto-Owners Ins. Co.*, 174 Or App 471, 476, 26 P3d 845 (2001) (citing *First Far West Transp., Inc.*). The statutory definition of insurance *policy* implies that a single policy may include multiple endorsements. *Pierce v. Allstate Ins. Co.*, 316 Or 31, 36, 848 P2d 1197 (1993) (construing ORS 731.122); *see also Close-Smith v. Conley*, 230 F Supp 411, 417–418 (D Or 1964) (discussing ambiguity created by placement of multiple endorsements).

An insurer’s failure to file an endorsement pursuant to ORS 742.003 (*former* ORS 743.006) does not render the entire policy void. *Gifford Western Aviation Ins. Group*, 77 Or App 645, 649, 713 P2d 1085 (1986) (relying on *Hall v. Metropolitan Life Ins. Co.*, 746 Or 32, 28 P 875 (1934) (refusing to void annuity contract for failure to file)). In *Gifford*, 77 Or App at 649–650, the insured argued that because the insurer had never filed an endorsement that excluded a certain type of loss, the exclusion did not apply. The court reasoned that because Oregon courts have long held that failure to file with the director is not

a ground for voiding a policy, the insurer's failure to file an endorsement that contains a particular exclusion should not disallow application of that exclusion. *See also Baylor v. Cont'l Cas. Co.*, 190 Or App 25, 78 P3d 108 (2003) (discussing the *Gifford* holding on effect of failure to file, but distinguishing between legal effect of binder and certificate of insurance); *Mountain Fir Lumber Co. v. Employee Ben. Ins. Co.*, 296 Or 639, 645-646, 679 P2d 296 (1984) (court refused to enforce oral promise for rebate of premiums); *Progressive Ins. v. Nat'l Am. Ins. Co.*, 201 Or App 301, 303-304, 118 P3d 836 (2005) (unsigned endorsement); *Marsh v. Am. Family Mut. Ins. Co.*, 231 Or App 332, 339-340, 218 P3d 573 (2009) (implying that when endorsement provided that specific exclusion did not apply, then other exclusions did apply).

**§1.2-3(f)(4) Inconsistency Between Printed and Typed Language**

Generally, nonprinted policy language controls over inconsistent printed language found in the policy. *Close-Smith v. Conley*, 230 F Supp 411, 420 (D Or 1964). Nonprinted language includes typewritten, handwritten, and stamped terms and provisions. Generally, typewritten language controls over printed, and handwritten language controls over both typewritten and printed language). *Davis v. Dunigan*, 186 Or 147, 152-153, 205 P2d 839 (1949) (writing prevails over printed language). *See also Ives v. INA Life Ins. Co.*, 101 Or App 429, 790 P2d 1206 (1990) (typewritten copy of application did not vary materially from original handwritten application and constituted a *copy* as required by statute).

**§1.2-3(f)(5) Inconsistency with Statutes**

An insurer may substitute “corresponding provisions of different wording” in place of standard or uniform provisions required by statute if the substitute provisions “are in each instance not less favorable in any respect to the insured.” ORS 742.021(1). The language of acceptable substitute provisions supersedes any inconsistent standard or uniform provisions otherwise required by statute. ORS 742.021(2).

Policy provisions that impose on the insurer a lesser obligation than that required by statute are unenforceable. *Fleming v. United Servs. Auto. Ass’n*, 329 Or 449, 459–460, 988 P2d 378 (1999) (court construed policy as though it did not contain offending clause); *Dowdy v. Allstate Ins. Co.*, 68 Or App 709, 716–717, 685 P2d 444 (1984) (exclusions are unenforceable if they attempt to eliminate coverage required by statute). In such cases, the policy is to be construed and applied according to the conditions and provisions that would have appeared “had such policy been in full compliance with the Insurance Code.” ORS 742.038(2); *Garrow v. Pennsylvania General Ins. Co.*, 40 Or App 23, 25, 594 P2d 415, *aff’d*, 288 Or 215 (1979) (“the extent of personal injury protection coverage is controlled by statute and the policy may not provide lesser coverage than that required by the statute”). The director’s approval of policy forms and provisions pursuant to ORS 742.003 does not cure noncompliance with a statute; the statute controls. *Fleming*, 330 Or at 66 (citing to *Utah Home Fire Ins. Co. v. Colonial Ins. Co.*, 300 Or 564, 573 n 6, 715 P2d 1112 (1986)).

**§1.2-3(g) Sufficiency and Admissibility of Extrinsic Evidence**

As discussed in §§1.2-3(b)(1) to 1.2-3(b)(2), several court of appeals cases have explicitly stated that extrinsic evidence is inadmissible to create or construe an ambiguity in an insurance policy. The Oregon Supreme Court has not been so overt, instead repeating that to construe insurance policies is a matter of law (*Hoffman Constr. Co. v. Fred S. James & Co.*, 313 Or 464, 836 P2d 703 (1992)), without actual mention of the possibility that extrinsic evidence may be admissible. The court may address the issue in *Bresee Homes, Inc. v. Farmers Ins. Exch.*, 227 Or App 587, 206 P3d 1091 (2009), *rev. allowed*, 347 Or 533, 225 P3d 43 (Jan 21, 2010). Since the *Hoffman* opinion did not overrule prior insurance policy construction cases, many pre-*Hoffman* cases regarding extrinsic evidence may still be good law. Sections 1.2-3(g)(1) to 1.2-3(g) (5) outline some areas in which Oregon courts traditionally allowed the admission of extrinsic evidence in insurance policy cases.

NOTE: But attorneys should pay close attention to the court's ruling in *Bresee*, because it may explain how Oregon courts must address some of these extrinsic evidence issues in the future.

**§1.2-3(g)(1) Evidence of Purpose of Policy**

Evidence of the purpose of policy language may be considered in determining the intent of the parties. *A-1 Sandblasting & Steamcleaning Co. v. Baiden*, 293 Or 17, 20, 643 P2d 1260 (1982) (issue of fact remained whether parties intended a list of acids, liquids, and other chemicals to include paint sprayed by insured); *Timberline Equipment Co. v. St. Paul Fire & Marine Ins. Co.*, 281 Or 639, 643, 576 P2d 1244 (1978) (stating similar in dicta); *Insurance Co. of Pennsylvania v. A.J.*

*Zinda Co.*, 49 Or App 589, 598, 620 P2d 504 (1980) (court is not required to interpret policy language to produce nonsense). For example, in *Wyoming Sawmills, Inc. v. Transportation Ins. Co.*, 282 Or 401, 578 P2d 1253 (1978), the purpose of the “injury to products” exclusion found in comprehensive general liability policies was to prevent the insurer from having to pay for repair or replacement of an insured’s defective product, an ordinary business risk more properly retained by the insured. The exclusion did not, however, extend to bodily injury or other property damage caused by the defective product. *See also National Chiropractic Mut. Ins. Co. v. Morgan*, 116 Or App 196, 201, 840 P2d 732 (1992) (“As we have already said, the policy terms are susceptible to alternative reasonable interpretations. Even if we were to consider extrinsic evidence as suggested by the *dictum* in *Timberline Equipment v. St. Paul Fire and Marine Insurance Co.*, . . . there is no relevant evidence to consider” (citations omitted)).

**§1.2-3(g)(2) Evidence of Construction by Parties**

In cases decided before *Hoffman Constr. Co. v. Fred S. James & Co.*, 313 Or 464, 836 P2d 703 (1992), evidence showing that the parties reasonably contemplated that certain risks would be covered by an insurance policy was admissible to establish intent. *First Far West Transp., Inc. v. Carolina Casualty Ins.*, 47 Or App 339, 346–347, 614 P2d 1187 (1980). Such evidence may concern the nature and risks of an insured’s activities. *Ramco, Inc. v. Pacific Ins.*, 249 Or 666, 439 P2d 1002 (1968) (whether loss caused by faulty product was covered “accident”); *A-1 Sandblasting & Steamcleaning Co. v. Baiden*, 53 Or App 890, 632 P2d 1377 (1981), *aff’d*, 293 Or 17 (1982) (whether

overspray damage was covered by policy) . Evidence of an insured's communications with an insurance agent was also admissible under this rule. *A-1 Sandblasting & Steamcleaning Co.*, 53 Or App at 896 (“Defendants were aware from plaintiff's application for the policy of insurance that plaintiff was in the business of bridge sandblasting and painting and that previous overspray claims had been made against plaintiff”).

**§1.2-3(g)(3) Evidence of Meaning of Technical Terms**

Courts have suggested over the years that if technical words, terms of art, or local phrases appear in an insurance policy, evidence of the acquired meaning of that language may be considered in determining the intent of the parties. *Timberline Equipment Co. v. St. Paul Fire & Marine Ins. Co.*, 281 Or 639, 643, 576 P2d 1244 (1978) (construing contract is a question of law; but “if the language of the contract is ambiguous, or if technical words, local phrases or terms of art are used and evidence is properly admitted showing meaning, the question becomes one of fact”); *Boyer Metal Fab, Inc. v. Maryland Casualty Co.*, 90 Or App 103, 750 P2d 1195 (1988) (“The interpretation of an insurance contract is a question of law, unless the language of the contract is ambiguous or technical words or terms of art are used and evidence has been admitted to show meaning”); *see also Farmers Ins. Exch. v. Crutchfield*, 200 Or App 146, 113 P3d 972 (2005) (quoting prior cases on this point).

**§1.2-3(g)(4) Evidence of Custom and Trade**

To ascertain intent, courts have allowed parties to show that in the custom and trade of the insurance industry, certain policy words and

terms are understood to limit or extend coverage in particular situations. *Fireguard Sprinkler Systems, Inc. v. Scottsdale Ins. Co.*, 864 F2d 648, 653 (9th Cir 1988) (applying Oregon law, industry's interpretation of standard form exclusions is "strong evidence of the intent of the parties"); *see also First Far West Transp., Inc. v. Carolina Casualty Ins.*, 47 Or App 339, 344, 614 P2d 1187 (1980) (court may consider situation of parties and circumstances surrounding making of contract); *Hamacher v. Tummy*, 222 Or 341, 358, 352 P2d 493 (1960) ("The implication [of policy terms] would be aided by proof that in the trade certain terms not expressly agreed upon were deemed applicable in the absence of evidence of a contrary intent").

**§1.2-3(g)(5) Evidence of Other Coverages and  
Additional Premium**

An insured sometimes purchases some but not all of the liability coverages offered by the standard policies. The coverages purchased are designated in the declarations page. Evidence that coverages not purchased provide the protection later sought by the insured may be considered on the issue of intent. *Fisher v. California Ins. Co.*, 236 Or 376, 388 P2d 441 (1964) (policy issued clearly indicated which coverage was purchased and which was not); *Saul v. St. Paul Mercury Indem. Co.*, 250 P2d 819, 824 (Kan 1952) (when insured did not purchase insurance for vehicle loss caused by flood, he was not protected from "collision" with rising water). However, strict parol evidence laws govern the admissibility of such evidence if the evidence is contained in an unattached application. *Progressive Ins. v. Nat'l Am. Ins. Co.*, 201 Or App 301, 118 P3d 836 (2005) (because of strict parol

evidence statute, party could not offer as evidence an application that could prove insured had duplicative coverage because insurer did not attach application to policy when issued).

An insurer's failure to include certain available exclusions in the policy may be relevant to the parties' intent to insure against the risks described in the exclusions. *Ranger Ins. Co. v. Culberson*, 454 F2d 857, 861 (5th Cir 1971) ("In viewing the totality of the policy, we observe that omitted form paragraphs are parts of a written document. They serve to explain the intent of the parties"); *contra Parma Seed v. General Ins. Co.*, 496 P2d 281, 285-285 (Idaho 1972) (insured agreed to pay reduced premium for reduced scope of coverage, and thus was not covered for accident). In contrast, evidence that certain coverage was available for an additional premium weighs against a contention that such coverage was intended to be included within the protection purchased by an insured. *First Far West Transp., Inc. v. Carolina Casualty Ins. Co.*, 47 Or App 339, 346, 614 P2d 1187 (1980) ("It is unlikely that defendant intended to expand the coverage of the policy to the extent urged by plaintiff for no extra charge or that plaintiff reasonably expected such wider coverage").

### **§1.2-4 Other Issues in Policy Interpretation**

#### **§1.2-4(a) Statutory Restrictions**

Certain considerations of public policy govern enforceability of insurance contracts, regardless of the intent of the parties in entering into the contract. Although public policy issues often arise from judicial pronouncements, statutory law may also dictate public policy. For example, an insurance policy that covers property that might be used in

violation of a statute may be enforced as long as possession of the covered property is not itself illegal. It is apparently irrelevant that there may be few or no legal uses for the property. *Brown v. New Jersey Ins. Co.*, 140 Or 547, 14 P2d 272 (1932) (fire insurance policy covered “moonshine” paraphernalia sold during Prohibition). In contrast, a policy is void or unenforceable when the ownership of the insured property is itself illegal. *Northwest Amusement Co. v. Aetna Casualty & Surety Co.*, 165 Or 284, 107 P2d 110 (1940) (burglary policy did not cover the theft of slot machines, which were prohibited by city ordinance). *But see Fenter v. General Acci. Fire & Life Assurance Corp.*, 258 Or 545, 550, 484 P2d 310 (1971) (Oregon courts have never held that an interest in property must be legally enforceable to be insurable).

NOTE: The holding in *Fenter* was superseded by statute, as noted in *Avrit v. Forest Industries Ins. Exchange*, 72 Or App 571, 574 n 1, 696 P2d 583 (1985). That statute, ORS 743.033, was renumbered ORS 742.011. See §3.2-1(a) for further discussion of ORS 742.011.

Another example of statutory public policy involves required policy terms. A provision of an insurance policy that is contrary to the statutory requirements mandating certain coverages is void and unenforceable. *See* §§1.1-1(b) to 1.1-1(b)(5).

In 2003, the Oregon Supreme Court cited *Martin v. Ore. Ins. Co.*, 232 Or 197, 206, 375 P2d 75 (1962), *overruled on other grounds by Bunn v. Monarch Life Ins. Co.*, 257 Or 409, 478 P2d 363 (1970), for the proposition that a party to a contract cannot waive benefits of law that

seek to protect the public as well as the individual who purports to waive the benefits. *In re Leisure*, 336 Or 244, 253 n 6, 82 P3d 144 (2003).

### **§1.2-4(b) Public Policy Issues**

Public policy prohibits the enforcement of insurance contracts that constitute “wagers,” when the insured has no legitimate interest in the person or property insured at the time the policy is issued. This rule exists because an insured who has no interest at risk may be inclined toward fraudulent or deceptive conduct. *See* §3.2-1 for further discussion.

“Valued policies,” in which the parties have made the actual value in case of loss irrelevant by agreeing on the value of the property insured, are also prohibited under the common law on public policy grounds. Ordinarily, policies obligate the insurer to pay only the actual cash value at the time of loss; the property value stated in the policy simply establishes a maximum.

Oregon statutes specifically prohibit the issuance of fire insurance policies for an amount greater than “the fair value of the risk insured or of the interest of the insured therein.” ORS 742.200(1).

### **§1.2-4(b)(1) Intentional Torts**

Public policy prohibits insurance coverage for damages that arise from intentionally inflicted injuries. *Eberdt v. St. Paul Fire & Marine Ins. Co.*, 36 Or App 679, 585 P2d 711 (1978) (alienation of affection); *Snyder v. Nelson*, 278 Or 409, 564 P2d 681 (1977) (ramming vehicle into another vehicle); *Isenhardt v. General Casualty Co.*, 233 Or 49, 377 P2d 26 (1962) (assault and battery); *Ledford v. Gutoski*, 319 Or 397,

877 P2d 80 (1994) (malicious prosecution). Thus, if from the allegations of the complaint it appears that the plaintiff's claim is based solely on intentional harm, the carrier is relieved of its obligation to defend as well as its liability for any judgment. An intended act that results in an unintended harm is insurable; the harm itself must be intended before coverage may be denied. *Nielsen v. St. Paul Cos.*, 283 Or 277, 282, 583 P2d 545 (1978). Furthermore, coverage for a partnership for the intentional tort of its servant does not violate public policy unless the acts were committed at the direction of the partners. *Farris v. United States Fidelity & Guaranty*, 273 Or 628, 636–637, 542 P2d 1031 (1975).

The subjective intent of an insured to inflict harm may be established as a matter of law if the insured “engaged in an act so certain to cause a particular kind of harm that the court will say that the insured intended the harm.” *Fox v. Country Mut. Ins. Co.*, 327 Or 500, 514, 964 P2d 997 (1998) (citing *Snyder*, 278 Or at 413,). The question the court asks is whether “the insured intended to cause the particular injury or harm, as opposed to merely intending the act.” *Ledford*, 319 Or at 401.

If the complaint against an insured includes both covered and excluded conduct, the insurer has a duty to defend. In *Abrams v. General Star Indem. Co.*, 335 Or 392, 399-400, 67 P3d 931 (2003), the insurance company unsuccessfully argued that it had no duty to defend because although the complaint stated a claim for conversion, it also included allegations that the insured had converted property with the intent to cause harm to a third party. The court held that *Ferguson v.*

*Birmingham Fire Ins.*, 254 Or 496, 460 P2d 342 (1969), and *Ledford*, 319 Or 397, suggest the following approach to answer any duty-to-defend question when the complaint contains allegations of conduct excluded under the insurance policy:

First, the court must determine whether the complaint contains allegations of *covered* conduct. If it does, as the trespass complaint did in *Ferguson*, then the insurer has a duty to defend, even if the complaint also includes allegations of excluded conduct. If the complaint does not contain allegations of covered conduct, as was the case with the malicious prosecution complaint before the court in *Ledford*, then the insurer has no duty to defend. Accordingly, in *[Abrams]*, because the allegations of intentional conversion included allegations of ordinary conversion, a tortious act that is covered under the policy, [the insurance company] had a duty to defend.

*Abrams*, 335 Or at 399–400.

The financial responsibility law “was not intended to require coverage for intentionally inflicted personal injuries or property damages.” *Snyder*, 278 Or at 415 (construing *former* ORS 486.011 (current ORS chapter 806)); *see also Klamath Pac. Corp. v. Reliance Ins. Co.*, 151 Or App 405, 950 P2d 909 (1997), *aff’d as modified*, 152 Or App 738 (1998) (allegations of injury from intentional infliction of emotional distress covered under policy’s definition of *bodily injury*; employers’ exclusion not applicable to president of corporate employer); *McLeod v. Tecorp Int’l*, 318 Or 208, 865 P2d 1283 (1993) (employer not covered for employee’s claims for wrongful discharge and intentional infliction of emotional distress).

Because liability policies frequently contain an exclusion for “bodily injury that is either expected or intended from the standpoint of

the insured” or similar language, many cases that involve coverage for intentional torts treat the issue as one of interpretation of the insurance policy rather than as a question of public policy. *See, e.g., Mutual of Enumclaw v. Merrill*, 102 Or App 408, 412, 794 P2d 818 (1990) (in sex abuse of child, injurious intent is “necessarily inferred”); *Snyder*, 278 Or at 416 (in vehicle- ramming case, “there is a legitimate question of fact as to whether [the defendant] intended the injuries and damage”).

The court’s application of public policy considerations that preclude coverage for intentional acts often invokes fine distinctions between intentional conduct and unintended consequences. In *Groshong v. Mutual of Enumclaw Ins. Co.*, 143 Or App 450, 923 P2d 1280 (1996), *aff’d on other grounds*, 329 Or 303 (1999), a landlord, as a matter of policy, refused to rent second-floor apartments to people with small children. When a prospective renter filed suit for housing discrimination, the landlord’s insurer denied coverage. The landlord then sued the insurer. The court held that public policy precluded insurance coverage of claims that alleged disparate treatment discrimination. The court distinguished the renter’s “disparate treatment” claim from a “disparate impact” claim, “which asserts that the application of a facially neutral practice or policy has resulted in some discriminatory effect.” *Groshong*, 143 Or App at 461. In *Fox*, 327 Or at 516, the court found that coverage existed based on the premise that determination of whether the consequences of the conduct are intended or unintended was made from the injured person’s point of view. There was no doubt that the driver of the car intended to wreck

his vehicle, but substantial doubt existed that the injured person intended to suffer his injuries.

For a discussion of cases that decide whether the insured acted intentionally as a matter of law, see *ZRZ Realty Co. v. Beneficial Fire & Cas. Ins. Co.*, 222 Or App 453, 478–480, 194 P3d 167 (2008) (*ZRZ I*), *modified on reconsideration*, 225 Or App 247, 201 P3d 912 (2009) (*ZRZ II*), *adhered to as modified*, 349 Or 657 (2011). In *ZRZ I*, 222 Or App at 478-480, the court initially held that the insured’s behavior was not purposeful enough that the *only* inference one could draw was that the insured purposefully caused harm. But on reconsideration, the court stated that given its alternative and independent reason for rejecting the insurer’s assignment of error, it did not need to reach that issue. *ZRZ II*, 225 Or App at 262–263. See also *Drake v. Mutual of Enumclaw Ins. Co.*, 167 Or App 475, 483, 1 P3d 1065 (2000) (whether harm is caused intentionally).

### **§1.2-4(c) Unconstitutionality**

Courts construe clauses to avoid unconstitutionality. In *Molodyh v. Truck Ins. Exchange*, 304 Or 290, 744 P2d 994 (1987), a statute required all fire insurance policies to contain a clause that set forth a permissive appraisal process in the event of a dispute over damages. The Oregon Court of Appeals held that the statute ran afoul of Oregon Constitution article I, §17, because, once the appraisal process was invoked by the demanding party, it became mandatory and deprived the insured of the right to a jury trial. The Oregon Supreme Court affirmed, but did not reach the constitutionality of the statute. Instead it construed the statute as non-binding on the non-demanding party. In *Foltz v. State*

*Farm Mut. Auto. Ins. Co.*, 326 Or 294, 952 P2d 1012 (1998), the court addressed arbitration mandated by a prior version of ORS 742.520(6). Instead of holding that the statute and insurance policy was unconstitutional, the court held that the insured was required to arbitrate pursuant to the statute, but that any resulting award that followed arbitration was non-binding. Otherwise, the insured's right to a jury trial would be violated.

### **§1.3 PROVING EXISTENCE OF POLICIES AND COVERAGE**

Sections 1.3-1 to 1.3-2(c) outline the burdens to prove coverage, applicable standards of proof, and what is required to obtain coverage on a policy that has been lost. Other chapters cover in greater detail the burdens of proof in various types of proceedings, such as actions against insurance agents. *See, e.g.*, §3.3-7 (burden of proof with property insurance); §3.3-22(b) (proof of loss on fire insurance policies); §4.7-1(b) (defense of proof of loss).

NOTE: When discussing burden of proof, the attorney should be aware that the phrase is often used ambiguously and may actually refer to more the precise concepts of "burden of persuasion" or "burden of production." Since 1923, the United States Supreme Court has consistently distinguished between the "burden of proof," which it defined as the burden of persuasion, and a concept increasingly referred to as the "burden of production," meaning "the burden of going forward with the evidence." *See Dir. v. Greenwich Collieries*, 512 US 267, 274, 114 S Ct 2251, 129 L Ed 2d 221 (1994); *see also* OEC 305, 307 (ORS

40.105 and 40.115) (allocation of burden of persuasion and burden of producing evidence).

In *State v. Rainey*, 298 Or 459, 464 n 6, 693 P2d 635 (1985), the court noted, “[b]ecause this opinion spans the transitional period of pre-Oregon Evidence Code and post-Oregon Evidence Code, for clarity we continue to use the now outdated term ‘burden of proof.’” In 2005, the court stated it will use the more precise terms to avoid confusion in future cases. *State v. James*, 339 Or 476, 486, 123 P3d 251 (2005). However, when the parties and prior case law have used the term “burden of proof,” the courts may address the issue with the less precise phrase for convenience. *See Empls Ins. of Wausau v. Tektronix, Inc.*, 211 Or App 485, 509 n 10, 156 P3d 105 (2007); *ZRZ Realty Co. v. Beneficial Fire & Cas. Ins. Co.*, 222 Or App 453, 461 n 5, 194 P3d 167 (2008).

This chapter uses the more general phrase, burden of proof, for convenience.

### **§1.3-1 Establishing Existence and Terms of Lost Policies**

Sometimes an insurance coverage lawsuit is commenced years after the policy at issue has been terminated. In such cases, the policy may have been lost or destroyed. Establishing the existence and terms of the policy then becomes the first issue. Many lost policy cases, however, turn on other issues and the courts only note in passing that some of the policies were missing. *See, e.g., St. Paul Fire & Marine Ins. Co. v. McCormick & Baxter Creosoting Co.*, 126 Or App 689, 698 n 5, 870 P2d 260 (1994), *reversed in part on other grounds*, 324 Or 194 (1996). There

are not many cases in Oregon dealing with lost policies, so it is helpful to turn to other jurisdictions.

Generally, courts permit evidence to prove the existence and terms of a lost policy, provided that the policy was not lost or destroyed in bad faith and the party that seeks to introduce the evidence exercised due diligence in searching for the lost policy. *See* FRE 1004 (original document required); OEC 1002 (ORS 40.555) (same); ORS 465.479 (environmental claims on lost policies). To trigger coverage, the burden to prove the material terms of the policy falls on the insured. In *Dart Indus., Inc. v. Commercial Union Ins. Co.*, 52 P3d 79, 88 (Cal 2002), the court held that “the claimant has the burden of proving (1) the fact that he or she was insured under the lost policy during the period in issue, and (2) the substance of each policy provision essential to the claim for relief, i.e., essential to the particular coverage that the insured claims.”

Typically when the policy has been lost or misplaced, evidence presented must show a substantial part of the policy. *See* 17A COUCH ON INSURANCE §§255.8–255.10 (3d ed 1995 & Supp 2011). However, the insured is not required to prove the specific language of the policy:

Although it is a truism that we look to the language of a contract to ascertain its meaning, it is equally true that when a contract has been lost in good faith, and the actual language is unavailable, the law does not require proof of such language. Rather, . . . , the proponent of the lost document need only prove the relevant substance of the document.

*Dart Indus., Inc.*, 52 P3d at 89. Detailed testimony by a policyholder’s former risk manager regarding the terms of the policies and the period in which the policies were issued has been held to be sufficient to uphold a

jury verdict. *Boston Gas Co. v. Century Indem. Co.*, 529 F3d 8, 37-38 (1st Cir 2008). Evidence concerning coverage may be obtained from custom and practice. *City of Tacoma v. Great Am. Ins. Co.*, 897 F Supp 486, 488 (WD Wash 1995); *see also Savoy v. Harris*, 20 So 3d 1075, 1080 (La Ct App 2009) (insurer failed to produce evidence of nonrenewal); 17A COUCH ON INSURANCE §255.7 (listing factors that influence effect given to evidence of lost policy, the most important of which is how much time has passed since policy was issued).

PRACTICE TIP: In addition to the insured and the insurer, possible sources of information regarding a particular insurance policy include insurance agents, insurance brokers, insurers with related policies, insurance archivists, insurance archaeologists, accountants, lawyers, entities or persons for whom the insured has performed work, the state insurance commissioner, the National Archives, and the Insurance Services Office.

Although the standard of proof in civil cases is typically a preponderance of the evidence, courts have varied widely on the proper standard for lost insurance policies. Some courts require the insured to “prove [the policy’s] former existence, execution, delivery and contents by clear, satisfactory and convincing evidence.” *Boyce Thompson Inst. For Plant Research v. Insurance Co. of North America*, 751 F Supp 1137, 1140 (SDNY 1990). However, other courts have criticized this “heightened standard of proof” and require only that the insured prove the policy’s existence and material terms by a preponderance of the evidence. *Remington Arms Co. v. Liberty Mut. Ins. Co.*, 810 F Supp 1420, 1423 (D Del 1992); *Gold Fields Am. Corp. v. Aetna Cas. & Sur.*

*Co.*, 661 NYS2d 948, 950 (NY Sup Ct 1997) (stating that correct standard in New York is by preponderance of evidence). At least one court has said a “more likely than not” standard is appropriate. *Employers Ins of Wausau v. Duplan Corp*, 1999 US Dist LEXIS 15368, \*79 (SDNY Oct 20 1999). For a discussion of this debate, see *Dart Indus., Inc.*, 52 P3d at 79.

Once the insured proves the existence and material terms of the policy, the burden then shifts to the insurer to prove any applicable exclusions. See *State Farm Fire & Casualty Co. v. Reuter*, 299 Or 155, 159 n 3, 700 P2d 236 (1985); *Paxton-Mitchell Co. v. Royal Indem. Co.*, 279 Or 607, 614, 569 P2d 581 (1977).

### **§1.3-1(a) Environmental Cleanup Assistance Act and Lost Policies**

In 2003, the Oregon Legislature amended the Environmental Cleanup Assistance Act (ECAA) by enacting ORS 465.479, which imposes on insureds and insurers an obligation to search for lost policies. Under the statute, after the policyholder has performed a diligent search of its own records to determine the existence of a policy, the policyholder may provide the insurer with a lost-policy notice, which triggers the insurer’s duty to investigate. The statute provides in part:

If, based on the information discovered in an investigation of a lost policy, the insured can show by a *preponderance of the evidence* that a general liability insurance policy was issued to the insured by the insurer, then if:

(a) The insured cannot produce evidence that tends to show the policy limits applicable to the policy, it shall be assumed that the minimum limits of coverage, including any exclusions to coverage,

offered by the insurer during the period in question were purchased by the insured.

(b) The insured can produce evidence that tends to show the policy limits applicable to the policy, then the insurer has the burden of proof to show that a different policy limit, including any exclusions to coverage, should apply.

ORS 465.479(6) (emphasis added). *See also Fireman's Fund Ins. Co. v. Ed Niemi Oil Co., Inc.*, 436 F Supp2d 1174, 1181 (D Or 2006), *rev'd on other grounds*, 317 Fed Appx 623 (9th Cir 2008) (citing ECAA and noting parties' settlement was not unreasonable in light of fact that policies had been lost),

The ECAA governs environmental claims under general liability insurance policies and specifically excludes motor vehicle and homeowner policies. ORS 465.475(2). It is unclear to what extent Oregon courts may apply the specific statutory requirements and standard of proof for lost policies under the ECAA to other types of insurance.

When the question concerns which defendant pays the plaintiff's defense cost, the issue of a lost policy is for the defendant to raise, not the plaintiff, unless the plaintiff is able to show that existing coverage is insufficient. *Schnitzer Inv. Corp. v. Certain Underwriters at Lloyd's of London*, 341 Or 128, 139, 137 P3d 1282 (2006) (see also court of appeals decision for discussion of genuine issue of material fact concerning lost policies, *Schnitzer*, 197 Or App 147, 161-163 (2005)).

For more discussion of lost policies and burdens of proof, see Tod Zuckerman & Mark Raskoff, ENVTL INS LITIG L AND PRAC §34:2 (2010).

### §1.3-2 Burden of Proof

The initial burden of proving coverage is on the insured. *Lewis v. Aetna Ins. Co.*, 264 Or 314, 316, 505 P2d 914 (1973). For example, the beneficiary of a life insurance policy has the burden of establishing that the death resulted from an accident within the meaning of the policy. *In Stuart v. Occidental Life Ins. Co.*, 156 Or 522, 527–528, 68 P2d 1037 (1937), for example, the beneficiary had the burden to establish that her husband’s death resulted from an accidental injury. *See also Coburn v. Utah Home Fire Ins. Co.*, 233 Or 20, 375 P2d 1022 (1962) (insured required to prove that boat’s sinking while moored was caused by “peril of the sea”); *La Barge v. United Ins. Co.*, 209 Or 282, 300, 306 P2d 380 (1957), *overruled on other grounds in Perry v. Hartford Acci. & Indem. Co.*, 256 Or 73, 82 (1970) (insured proved that arthritis was not cause of accident).

The insured’s duty of proving that the cause of the loss was an insured peril also extends to proving that the policy was in effect when the loss occurred. *American Federal Sav. & Loan Asso. v. Rice*, 76 Or App 635, 639–640, 711 P2d 150 (1985); *see also Kalgin Packing Co. v. Fire Asso. of Philadelphia*, 67 F2d 569 (9th Cir 1933); *Heipershausen Bros., Inc. v. Continental Ins. Co.*, 25 F Supp 1010 (SDNY 1938).

When the insured brings a claim against agents of an insurer, the insured has the burden to show that the agents were authorized to act as such. *Williams v. International Harvester Co.*, 172 Or 270, 141 P2d 837 (1943), *overruled on other grounds, Rogue Valley Mem’l Hosp. v. Salem Ins. Agency, Inc.*, 265 Or 603, 510 P2d 845 (1973).

**§1.3-2(a) Proving Applicable Exclusions**

Once the insured proves the existence and material terms of the policy, the burden then shifts to the insurer to prove that the policy excludes coverage. *See State Farm Fire & Casualty Co. v. Reuter*, 299 Or 155, 159 n 3, 700 P2d 236 (1985); *Stanford v. American Guaranty Life Ins. Co.*, 280 Or 525, 527, 571 P2d 909 (1977), *appeal after remand*, 281 Or 325 (1978); *Paxton-Mitchell Co. v. Royal Indem. Co.*, 279 Or 607, 614, 569 P2d 581 (1977); *see also Royal Indem. Co. v. John F. Cawrse Lumber Co.*, 245 F Supp 707, 709–710 (D Or 1965) (applying Oregon law).

For example, after the insured presents prima facie evidence of ownership of an automobile for purposes of auto insurance, that evidence may be rebutted with the insurer's evidence of another person's control over the vehicle. *Barber v. George*, 144 Or App 370, 372–373, 927 P2d 140 (1996) (plaintiffs failed to show that defendants, not their son, owned vehicle). Evidence of another person's control may indicate that someone other than the titled owner has an ownership interest in a vehicle. *See Weber v. State Farm Mut. Auto. Ins. Co.*, 216 Or App 253, 258–259, 172 P3d 660 (2007) (partial payment of the purchase price, possession and control of car, and purchase of insurance may create issue of fact regarding ownership).

In the case of a life insurance policy, the insurer carries the burden of proving suicide. *Hildebrand v. United Artisans*, 50 Or 159, 162, 91 P 542 (1907). However, when an action is brought on the double indemnity provisions of an insurance policy that provides recovery for death by accident, the plaintiff has the burden of proving

that the insured's death was by accident. *United States Nat'l Bank v. Underwriters at Lloyd's, London*, 239 Or 298, 323, 382 P2d 851, 396 P2d 765 (1964).

In a class action suit, in order to establish a factual issue for a jury regarding whether the insured was injured by the insurer's denial, the plaintiffs were not required to prove that they actually paid the medical expenses that the insurer had denied as unreasonable. *Strawn v. Farmers Ins. Co. of Or.*, 228 Or App 454, 467, 209 P3d 357 (2009), *reversed on other grounds*, 2011 Ore LEXIS 444 (May 19, 2011).

### **§1.3-2(a)(1) Misrepresentations**

When an insurer seeks relief from its responsibilities under an insurance contract, it has the burden to prove the elements necessary for rescission or avoidance. *Santilli v. State Farm Life Ins. Co.*, 278 Or 53, 57, 562 P2d 965, (1977) (burden on insurer to prove materiality of misrepresentations); *Crawford v. Standard Ins. Co.*, 49 Or App 731, 735, 621 P2d 583 (1980) (burden on insurer to prove reliance on insured's fraud).

For fire insurance, "In order to use any representation by or on behalf of the insured in defense of a claim under the policy, the insurer must show that the representations are material and that the insurer relied on them." ORS 742.208(3).

An insurer makes out a prima facie case of reasonable reliance on a misrepresentation if the insurer shows that it approved the policy in the ordinary course of business, it would not have issued the policy but for the false representations, and it had a right to rely on the application. *Story v. Safeco Life Ins. Co.*, 179 Or App 688, 694, 40 P3d 1112 (2002);

*see also Mutual Life Ins. Co. v. Muckler*, 143 Or 327, 331, 21 P2d 804 (1933) (reliance requires insurer to prove that insured knowingly made false statements in application for life insurance policy); *Progressive Specialty Ins. Co. v. Carter*, 126 Or App 236, 241, 868 P2d 32 (1994) (insurer failed to prove reliance on insured's false representations, which were material to decision to insure); *Mutual of Enumclaw Ins. v. McBride*, 295 Or 398, 400, 667 P2d 494 (1983) (measure of proof is preponderance of evidence).

An insured's misrepresentation on an application for health insurance could be material even if not related to the condition for which a claim was later made. In *Reisen v. Blue Cross Blue Shield*, 115 Or App 396, 402, 839 P2d 729 (1992), the court held that a misrepresentation is material as a matter of law if its disclosure would have made the insurer unwilling to accept the risk.

For more on rescission, material misrepresentation, and reliance, see §§1.4-3 to 1.4-3(h).

### **§1.3-2(a)(2) Noncooperation**

For an insurer to argue noncooperation as a defense, "the insurance company has the burden to plead and prove that it has suffered prejudice as a result" of the insured's noncooperation. *Bailey v. Universal Underwriters Ins. Co.*, 258 Or 201, 219, 474 P2d 746 (1970).

In *Ivanov v. Farmers Ins. Co. of Or.*, 344 Or 421, 185 P3d 417 (2008), the court construed ORS 742.524(1)(a), the statute governing PIP claims. "Claims for those statutorily mandated benefits are presumed to be reasonable and necessary" at the time they are submitted to an insurer. *Ivanov*, 344 Or at 428. Once the presumption is

established, the burden shifts to the insurer to challenge the validity of the claims. Furthermore, an insurer that denies PIP claims must establish that its denials were based on reasonable investigations “sufficient to support a decision to deny a medical expense claim” that meets the statutory presumption. *Ivanov*, 344 Or 421..

An insurer that denies a claim based on an insured’s failure to give immediate notice of a possible claim has the burden to show prejudice. *Lusch v. Aetna Casualty & Surety Co.*, 272 Or 593, 597, 538 P2d 902 (1975); *Carl v. Oregon Auto. Ins. Company/North Pac. Ins. Co.*, 141 Or App 515, 520-521, 918 P2d 861 (1996); *but see United Pacific Ins. Co. v. Mazama Timber Products, Inc.*, 270 Or 242, 527 P2d 259 (1974) (when insured claimed oral notice was given to agent that later died, insurer was not required to negate all other possibilities of notice and did not have to prove that no notice of any kind had been given).

Whether the insurer suffered prejudice may be a matter of law or a question of fact. *See Empls Ins. of Wausau v. Tektronix, Inc.*, 211 Or App 485, 494-501, 156 P3d 105 (2007) (discussing cases on this issue). An insurer may not be entitled to judgment as a matter of law if a reasonable juror could find from the evidence that the insurer has not been prejudiced because the insurer had access to information that would have allowed it to conduct an adequate investigation or protect its and the insured’s interest. *North Pac. Ins. Co. v. United Chrome Prods., Inc.*, 122 Or App 77, 81-82, 857 P2d 158, *modified on reconsideration on other grounds*, 123 Or App 536 (1993). Likewise, if a reasonable juror could conclude that the insurer would not have taken advantage of

any additional opportunities to investigate or otherwise protect its interest and that of the insured, the insurer is not entitled to judgment as a matter of law. *Halsey v. Fireman's Fund Ins. Co.*, 68 Or App 349, 354, 681 P2d 168 (1984).

The insurer also has the burden to show that the insured either knew or had reason to know, a substantial period of time before giving notice, that there was a likelihood that the tort-feasor lacked coverage. *General Acci. Fire & Life Assurance Corp. v. Shasky*, 266 Or 312, 319-322, 512 P2d 987 (1973).

For more on notice and proof of loss, see §§4. 7-1(a) to 4.7-1(b).

### **§1.3-2(b) Proving Exceptions to Exclusions**

Analytically, an exception to an exclusion has the effect of providing coverage that otherwise would not exist under the exclusion. Thus, the burden of proof returns to the insured to establish an exception to a standard exclusion. *Empls Ins. of Wausau v. Tektronix, Inc.*, 211 Or App 485, 514, 156 P3d 105 (2007) (“Tektronix seeks the benefit of the exception to the pollution exclusion. For that reason, it is appropriate that Tektronix bear the burden of proving that the exception is applicable”).

### **§1.3-2(c) Standard of Proof**

Many lawyers and scholars confuse the term “standard of proof” with “burden of proof.” The standard of proof is the measure of conviction that a party must achieve in the mind of the trier of fact in order to meet the burden of persuasion. *State v. James*, 339 Or 476, 485, 123 P3d 251 (2005). In *Addington v. Tex.*, 441 US 418, 423, 99 S Ct 1804, 60 L Ed 2d 323 (1979), the court said that the standard of proof

operates to “instruct the factfinder concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions for a particular type of adjudication.”

In *Mutual of Enumclaw Ins. v. McBride*, 295 Or 398, 667 P2d 494 (1983) the court enunciated a test for determining when a statutory action, although characterized as civil, requires proof by the higher clear and convincing standard rather than the preponderance of the evidence standard. When a statute creates a civil cause of action and is silent as to the degree of proof required, the civil preponderance standard normally applies. When the consequences of fraud or misrepresentation are solely the forfeiture of a contractual benefit, the stakes are financial. “While the loss of anticipated insurance benefits may be a severe blow, it is no more severe than the consequences attaching to many disputes in tort or contract. For those reasons, insurance fraud or false swearing is a purely civil dispute” and the preponderance standard applies. *McBride*, 295 Or at 407. However, “[t]here are occasions where a statutory cause of action, although characterized as civil, requires proof by the higher clear and convincing standard,” because of the quasi-criminal sanctions attached. *McBride*, 295 Or at 405. See also *Mut. Life Ins. Co. v. Muckler*, 143 Or 327, 331, 21 P2d 804 (1933) (applying preponderance of evidence standard to whether insured made false statements in application for life insurance policy).

The court in *McBride* construed ORS 743.612 governing fire insurance policies, and did not explicitly resolve whether the same rule applies to statutes that govern other kinds of insurance policies. Therefore, it is unsettled to what degree courts will apply the *McBride*

test to various insurance policy cases. In *Stuart v. Pittman*, 350 Or 410, 416 n 4, \_\_\_ P3d \_\_\_ (2011) for example, which was a dispute concerning an oral binder as governed by ORS 742.043, the court noted that “[t]he Court of Appeals' disposition of the case did not require that it reach the issue [of standard of proof]. Because defendant conceded the existence of the oral binder, we need not address whether the trial court erred in failing to instruct the jury regarding the heightened standard of proof.”

In rescission cases, the Oregon Court of Appeals has applied the preponderance of the evidence standard to cases that involve motor vehicle and life insurance policies. See *Progressive Specialty Ins. Co. v. Carter*, 126 Or App 236, 868 P2d 32 (1994) (insurer had to prove by preponderance of evidence that it issued motor vehicle policy in reliance on insured's false representations, which were material to decision to insure).; *Story v. Safeco Life Ins. Co.*, 179 Or App 688, 694, 40 P3d 1112 (2002). (in life insurance case, “[t]o meet its burden of persuasion, the insurer must . . . establish by a preponderance of the evidence that it had no such knowledge or at least that its failure to discover the true facts was attributable to mere negligence”).

But when the parties seek reformation, equity will not reform an insurance policy unless the alleged mistake is established by clear and satisfactory evidence. In *Boardman v. Insurance Co. of Pennsylvania*, 84 Or 60, 164 P 558 (1917), the partnership of Boardman & Bartle brought suit to reform an insurance policy after striking the words “Boardman & Miller” and inserting “Boardman & Bartle” as the name of the insured. The supreme court held that “the testimony as to the real

contract intended by the parties must be clear and convincing,” and “if it is at an equal balance either as to what the agreement was or as to the mutuality of the mistake,” reformation would not be allowed.

*Boardman*, 84 Or at 69. See also *Epstein v. State Ins. Co.*, 21 Or 179, 181, 27 P 1045 (1891) (in addition to ordinary burden of proof, there is, in reformation cases, additional burden of overcoming presumption created by the contract itself).

The presumption that a binder includes the terms of the policy must be overcome by the clear and express terms of the binder. In *Stuart*, 350 Or at 418, an oral binder to provide a “safety net” of coverage “in all instances that something goes wrong” and provide some type of coverage for “faulty work” was not vague or obscure. “Rather, those terms, in the context in which they were used, were easily understood and were not implied or left to inference, and thus were sufficient under the ‘clear and express’ requirement in ORS 742.043(1)” to provide coverage under the insurance binder. *Stuart*, 350 Or at 420.

The insured makes out a case if the factfinder finds that the preponderance of the evidence favors any one of the causes insured against, even though it may be impossible to say which of the several causes alleged was the actual or “proximate” cause of the loss. See, e.g., *Automobile Ins. Co. v. Central Nat’l Bank, Sav. & Trust Co.*, 20 F2d 619, 620-621 (6th Cir 1927).

If, however, the factfinder can only speculate whether the loss was caused by an insured peril or some other cause not covered by the policy, or the evidence is in equipoise, the insured has failed to sustain the burden of proof, and recovery on the policy must be denied. *Coburn*

*v. Utah Home Fire Ins. Co.*, 233 Or 20, 375 P2d 1022 (1962); *Wood v. Great America Insurance Co.*, 289 F Supp 1014 (ED Wis 1968); *Northwestern Mut. Life Ins. Co. v. Linard*, 498 F2d 556, 561 (2d Cir 1974).

### **§1.4 TERMINATION OF POLICIES**

The right to abort an insurance contract—whether by termination, cancellation, rescission, reformation, or an abandonment in some other form—has several sources. These sources include state statutes, federal statutes, judicial doctrines, policy provisions, and other agreements between the insured and insurer. Attorneys should take care to look beyond the Oregon insurance statutes, especially when an insurance policy has been issued in connection with a government benefit or other statutory scheme, or when the insured whose coverage is being terminated is a member of a statutorily protected class.

Sections 1.4-1 to 1.5-6 focus on terminations of insurance policies. Sections 1.4-1 to 1.4-3(h) outline judicial doctrines and generally applicable Oregon statutes, briefly detailing some basic principles of termination. The specific doctrines of cancellation (§§1.4-2 to 1.4-2(e)), rescission (§§1.4-3 to 1.4-3(h)), and reformation (§§1.5 to 1.5-6) are covered. Treatise authors agree that there is some misuse and confusion with these terms. *See* 2 COUCH ON INSURANCE §30.3 (3d ed 1995 & Supp 2011). These terms may invoke different sets of doctrines and procedures, and the practicing attorney should use and understand the correct terminology.

The attorney should be aware that many types of insurance have their own section in the ORS, which often contain unique provisions

governing the rights and procedures of cancellation. For example, fire insurance policies must contain provisions detailing that the policy terminates at 12:01 a.m. on a specific day (ORS 742.206), but other types of insurance have no such requirement regarding the precise minute of cancellation.

Because statutes often add detail or limitations to court decisions, some sections in this chapter overlap. For example, the statutes governing termination of motor vehicle insurance policies for misrepresentation, ORS 742.560–742.57, overlap with the judicial doctrine of rescission.

#### **§1.4-1 Introduction**

Cancellation and termination are distinct terms, but sometimes the demarcation is not clear. Cancellation is the termination of a policy before its expiration, and a party to an insurance contract has the right to cancel when it has the “right to terminate a policy prior to its expiration.” 2 COUCH ON INSURANCE §30.1 (3d ed 1995 & Supp 2011). Termination, however, is ending a policy through the lapse of the policy period. When terms of the policy specify that coverage terminates on the occurrence of specified events, “the termination of coverage is not a matter of cancellation but is merely a question of the duration of the risk provided by the policy.” 2 COUCH ON INSURANCE §30.2.

The Oregon Insurance Code, however, does not always use these definitions uniformly and sometimes applies slightly different definitions of cancellation. For example, “cancellation” as used in motor vehicle insurance policies is “termination of coverage by an insurer, other than termination at the request of the insured, during a policy period.” ORS 742.560 This means that an insured cannot “cancel” a motor vehicle

insurance policy, but may “terminate” it on request. On the other hand, although “cancellation” is not defined as used in fire insurance policies, an insured with a fire insurance policy may “cancel” the policy at any time. ORS 742.224(1).

It may be helpful to think of cancellation as a type of termination, usually induced by one or both of the parties before the expiration date of the policy, while a termination is not always a cancellation. When a party cancels a policy, the policy is terminated; when a policy lapses at its expiration date or because of its own terms, it is terminated but not necessarily canceled. For the purpose of this chapter, termination refers to the general ending of an insurance contract, whether from lapse of its original term, cancellation, rescission, or some other method. Cancellation is used when referring to the ending of a contract prior to its own terms, usually due to the action of one of the parties.

Ultimately, this distinction is not frequently litigated in Oregon and, when it is, it usually involves issues of notice. *See* §1.4-2(b); *Nelson v. Oregon Ins. Guaranty Ass’n*, 102 Or App 125, 794 P2d 1 (1990) (notice not required when policy is cancelled at insured’s request) ; 2 COUCH ON INSURANCE §§ 30.1, et seq. for more on the distinction.

However, the demarcation between cancellation and rescission has much greater legal ramifications. Although the terms will be explored more fully in the following sections, it is important to note initially that the primary distinction between the two is that rescission avoids the policy ab initio, whereas cancellation terminates the policy at the time the cancellation becomes effective. 2 COUCH ON INSURANCE §30.3.

Reformation, on the other hand, is an equitable remedy that permits a court to correct a written instrument to conform to the original agreement that the parties intended and desired to put into writing. In the insurance context, a suit to reform the policy is usually brought by the insured on the ground that the written policy issued by the insurer did not conform to the agreement reached between the two parties due to either a mutual mistake or fraud by the defendant. Unlike with termination, cancellation, and rescission, an insurance contract continues to exist after reformation. Reformation is discussed in greater detail in §§1.5 to 1.5-6.

Over the past several decades, termination of insurance policies has become increasingly governed by Oregon statutes, particularly for types of insurance that protect individuals or implicate public interests, such as motor vehicle insurance, fire insurance, health insurance, and life insurance. As with the general principle of the supremacy of statutes over contracts, a policy provision is void when it is contrary to a statutory provision. 2 COUCH ON INSURANCE §30.6.

#### **§1.4-2 Cancellation of Policies**

Both cancellation and rescission are methods of ending an insurance policy before it expires. Cancellation and rescission cut off all rights of the insured and rule out recovery on the policy for any future event. Rescission avoids the policy ab initio, usually because of a material misrepresentation by the insured, and places the parties in the position as if a contract was never formed. Cancellation terminates the policy at the time the cancellation becomes effective. 2 COUCH ON INSURANCE §30.3 (3d ed 1995 & Supp 2011). Under an occurrence-based policy, the insurer should still provide coverage for a loss that occurred

during the term of the policy even if the claim is brought after the cancellation of the policy became effective.

Statutes governing grounds and procedures for “cancellation” of insurance contracts, although ambiguous as to whether they encompass unilateral “rescission,” may be interpreted to regulate both. 2 COUCH ON INSURANCE §30.3. Motor vehicle insurance may be cancelled for fraud or material misrepresentation (ORS 742.562(2)), both of which have been held to be grounds for rescission. *See, e.g., Ives v. INA Life Ins. Co.*, 101 Or App 429, 790 P2d 1206 (1990) (insurer denied claim on life insurance policy because of insured’s misrepresentation on application).

Cancellation and rescission are closely related matters and a fair degree of overlap exists between the two topics. Sections 1.4-2(a) to 1.4-2(e) on cancellation cover some general cancellation concepts, statutory authority, and case law. Some of the discussion must include rescission since the concepts are so intertwined. Sections 1.4-3 to 1.4-3(h) on rescission, however, focus the elements of rescission and the courts’ interpretation of those elements.

### **§1.4-2(a) Rights of Cancellation**

The insurer’s right to cancel an insurance policy is the “right to terminate a policy prior to its expiration.” 2 COUCH ON INSURANCE §30.1 (3d ed 1995 & Supp 2011). Cancellation should be distinguished from the lapse of a policy, the expiration of the policy according to its terms, and the failure of negotiations to establish the insurance contract in the first place. 2 COUCH ON INSURANCE §30.1. Once the insurer begins cancellation proceedings, it cannot deny the existence of a valid policy. 2 COUCH ON INSURANCE §30.1. Likewise, if an insurer intends to rescind a

contract, due to some fraudulent statement for example, but terms its actions as a cancellation, the insurer may be liable for a specific claim made on the policy. 2 COUCH ON INSURANCE §30.22. Furthermore, an insurer may be estopped from denying the existence of a policy and should make a determination early on whether it intends to terminate the policy going forward, deny coverage for a previous loss based on a policy provision, or deny the very existence of a policy. For more on this distinction, see §1.4-3(h).

The right to cancel must arise from statutory authority, the terms of the contract, mutual consent, or by some breach that justifies the cancellation. 2 COUCH ON INSURANCE §30.1. Statutory language is especially important when a party seeks to unilaterally effect cancellation of a policy, in which case “strict compliance by insurer with the policy’s cancellation provisions is necessary.” 2 COUCH ON INSURANCE §30.17. When the party is a listed driver but is not a named insured or policyholder, it follows that the party would not ordinarily have authority to amend or cancel the policy. *Laird v. Allstate Ins. Co.*, 232 Or App 162, 170-171, 221 P3d 780 (2009) (“policyholder” referred to named insureds, not listed drivers, because ordinary purchaser of insurance would not interpret listed driver as having authority to amend or cancel the policy).

The Oregon Insurance Code provides unique grounds for cancellation of certain types of insurance. For example, an insurer may cancel a motor vehicle insurance policy if the insured’s license becomes suspended at any time during the term of the policy. ORS 742.562(1)(c). An insurer may also cancel an individual health insurance policy for

excessive coverage if the insured has duplicative health coverage by the same insurer. ORS 743.472(2).

Some types of policies typically contain provisions relating to rescission and cancellation by either party, such as property and liability insurance contracts. However, life insurance policies rarely do and instead rely on the insured's ability to stop or neglect payment, which effectively cancels or abrogates the policy. 2 COUCH ON INSURANCE §30.1.

Consistent with basic contract principles, the parties to an insurance contract have the right to cancel by mutual agreement or consent, even if the policy does not contain such cancellation provisions. 2 COUCH ON INSURANCE §§31.47, 31.51. A failure to pay premiums is generally interpreted as consent to cancellation. 2 COUCH ON INSURANCE §31.56. However, courts may be more lenient in interpreting reinstatement provisions following a cancellation for nonpayment. In *SAIF Corp. v. Bowers*, 215 Or App 30, 168 P3d 263 (2007), for example, the insurer negotiated the insured's check for overdue premiums and the agent represented that workers' compensation coverage would be reinstated. The court held that those actions were sufficient to reinstate coverage after cancellation for overdue payment.

In Oregon, most insurance policies must provide that the policy may be canceled for nonpayment of premiums after a grace period, fraud or misrepresentation, or some other violation of the terms and conditions. The Oregon Insurance Code contains many statutes that require that the policy itself include specific terms of cancellation. *See, e.g.*, ORS 742.560 (motor vehicle insurance); ORS 742.702 (commercial liability

insurance). The language of these provisions is crucial and may vary based on insurance type. When statutes prescribe particular language, the policy should conform. For example, in *Traders & Gen. Ins. Co. v. Freeman*, 81 F Supp2d 1070, 1078–1079 (D Or 2000), a provision in a property insurance policy voided coverage if “any insured” intentionally concealed or misrepresented a material fact. The court held that this provision conflicted with the fraud clause in the Oregon standard fire policy specified by ORS 742.208, which uses “the insured.” The policy had to be rewritten to conform to the statute to carry out the legislature’s “intent to establish a public policy that an innocent co-insured should not be denied coverage for the bad acts of someone else, even another named insured.” *Freeman*, 81 F Supp2d at 1079. The court, however, refused to extend this holding to the policy’s intentional-act exclusion because other statutes do not prescribe any particular intentional-loss language.

#### **§1.4-2(b) Notice**

The insurer must provide notice to the insured of cancellation. In cases involving mutual consent, however, relevant notice requirements are often not applicable. 2 COUCH ON INSURANCE §31.52 (3d ed 1995 & Supp 2011). For most types of insurance, 30 days’ notice is required; but only 10 days’ notice if cancellation is due to nonpayment of premiums. Failure to provide notice may result in the continuation of the policy. *See, e.g.*, ORS 743.560(5) (group health insurance).

If the policy provides notice provisions that are more favorable to the insured, courts enforce the stricter requirements as provided in the policy. In *Chrysler Credit Corp. v. Mid-Century Ins. Co.*, 110 Or App 343, 346-347, 822 P2d 744 (1991), the court held that, when the loss-

payable provision of an automobile insurance policy promised to “give the lienholder advance notice” of the insurer’s cancellation of the policy, cancellation was not effective as to the lienholder until the lienholder actually received the notice.

When a policy makes no provision for a change of address, an insurer may comply literally with the terms of the contract by providing notice to the insured’s address as written in the policy. In *Morrow v. Red Shield Ins. Co.*, 212 Or App 653, 662, 159 P3d 384 (2007), the court held that the duty of good faith and fair dealing, applicable to all contracts, imposed an obligation on the insurer to take action or to follow up on a change of address notice because it was within the parties’ reasonable expectations to do so. However, an obligation to process an address change form is not necessarily implied from the terms of the policy because an address change form concerns an entirely new policy, while courts cannot impose entirely new provisions into a policy that fall outside the scope of the policy. *Morrow*, 212 Or App at 660–662.

For additional discussion of the duty of good faith and fair dealing, see §1.4-2(e).

**§1.4-2(c) Effect of Cancellation**

Once a policy is canceled, the cancellation cuts off all rights of the insured and duties to pay premiums, and bars recovery for any subsequent accidents. 2 COUCH ON INSURANCE §§30.22-30.23 (3d ed 1995 & Supp 2011). Cancellation does not act retroactively; the insurer may still be liable for claims on losses that occurred during the term of the policy. 2 COUCH ON INSURANCE §30.25. See *Progressive Ins. v. Nat’l Am. Ins. Co. of Cal.*, 201 Or App 301, 118 P3d 836 (2005) (insurer could

not retroactively cancel coverage and avoid loss, even though insured had duplicative vehicle insurance).

It may be unclear at what point the policy is canceled. For example, in *Eifert v. Fortis Benefits Ins. Co.*, 128 Or App 359, 361, 876 P2d 343 (1994), the insured requested a “cash surrender request form” from the insurer under his whole-life policy, and then completed and mailed the form back to the insurer. The form provided that, in exchange for the cash surrender value, the insured “relinquishes all right, title, interest and claim in or under the policy.” *Eifert*, 128 Or App at 361. Three weeks later, the insured was killed in a trucking accident before receipt of the check for the cash surrender value that the insurer had deposited in the mail the previous day. In the personal representative’s action to recover benefits under the policy, the trial court entered summary judgment for the insurer. The court of appeals affirmed. The insured’s request for the cash surrender value was not an offer to rescind the policy, but was an assertion of his right to that value in exchange for relinquishing his remaining rights under the policy, and had the effect of canceling the policy when the insurer received the request. *Eifert*, 128 Or App at 361–364.

However, an important distinction should be made between the effects of cancellation on “occurrence” and “claims-made” policies. For an occurrence policy, the insured is covered for losses that occur during the policy period, even if the claim is made after the termination of the policy. For a claims-made policy, coverage is provided only if the claim is made during the term of the policy. Thus, if a claims-made policy is terminated and replaced by an occurrence policy, there may exist a risk

period when the insured will not be covered for a claim brought after the termination of the claims-made policy on a loss that occurred before the commencement of the occurrence policy. Attorneys should advise clients on this risk and negotiate special provisions to cover such claims.

Cancellation also terminates an insurer's liability to potential third parties, who are creditors of the insured and who may bring attachment or garnishment proceedings. A third party may be entitled to notice of cancellation, and failure to do so may lead to problems for the insurer. 2 COUCH ON INSURANCE §30.24.

### **§1.4-2(d) Modifications**

Both insureds and insurers should be careful when negotiating policy modifications. Modifications to an insurance policy may be deemed a cancellation of a previous policy, followed by the establishment of a new policy, which may have undesirable results for the insured. In *Pierce v. Allstate Ins. Co.*, 316 Or 31, 36–37, 848 P2d 1197 (1993), the Oregon Supreme Court held that the issuance of a renewal for an additional period or to modify a policy by adding or deleting vehicles covered under the policy does not create a separate, new policy and does not trigger the statutory requirement that requires insurers to offer uninsured motorist coverage to all new policies. But the court of appeals has held that when an insured requested that a term life policy be converted to a whole life policy, the conversion had the effect of canceling the term life policy. *Nolan v. Jackson Nat'l Life Ins. Co.*, 155 Or App 420, 429–430, 963 P2d 162 (1998).

### **§1.4-2(e) Duty of Good Faith and Fair Dealing**

The duty of good faith and fair dealing is implied by law into insurance contracts, regardless of whether one party has some discretion in the performance of the provision at issue, and breach of the implied duty may be the basis for a claim. *McKenzie v. Pacific Health & Life Ins. Co.*, 118 Or App 377, 380–381, 847 P2d 879 (1993); *Eggiman v. Mid-Century Ins. Co.*, 134 Or App 381, 895 P2d 333 (1995). Presumably, this implied duty also applies to unilateral decisions to terminate insurance contracts, at least when the decision to terminate is not supported by the express terms of the insurance contract. *See Uptown Heights Assocs. Ltd. v. Seafirst Corp.*, 320 Or 638, 644–648, 891 P2d 639 (1995) (foreclosure of construction loan).

In *Richardson v. Guardian Life Ins. Co. of Am.*, 161 Or App 615, 624, 984 P2d 917 (1999), the court held that any implied covenant of good faith and fair dealing must be consistent with the terms of a contract. *But see Morrow v. Red Shield Ins. Co.*, 212 Or App 653, 159 P3d 384 (2007) (discussed in §1.4-2(b)).

### **§1.4-3 Rescission of Policies**

Rescission is sought in order to cancel out an insurance policy ab initio and to place the parties in the position as if the contract had never been made. 2 COUCH ON INSURANCE §30.3 (3d ed 1995 & Supp 2011).

In line with the basic principles of contract law, the parties to an insurance contract have the right to cancel or rescind by mutual agreement or consent, as long as the rights of a third party are not injured by the agreement, even if no such right is expressly reserved in the contract. 2 COUCH ON INSURANCE §31.47. It should be noted that

although a unilateral act to repudiate a contract does not automatically trigger a mutual rescission or cancellation, it may be interpreted as an offer, which can place the power to accept a mutual rescission or cancellation in the hands of the other party. 2 COUCH ON INSURANCE §31.47.

More frequently, however, rescission cases are brought by a party claiming the other party misrepresented a material fact. These misrepresentations may provide grounds for an insurer to deny coverage and rescind the entire policy (or, in the rare case, for an insured to rescind). Rescission is generally allowed when there has been a misrepresentation of a material fact, the misrepresentation was made to be relied on, and has in fact been relied on. 2 COUCH ON INSURANCE §31.81. Accordingly, the misrepresentation must be material to the risk to constitute the basis for avoidance of the policy. And if it is material, the fact that the misrepresentation was made innocently and in good faith is irrelevant. 2 COUCH ON INSURANCE §31.81.

Rescission may be either affirmatively brought in order to cancel the policy or argued as a defense or counterclaim. 2 COUCH ON INSURANCE §31.66. As long as the contract for insurance is not entire and indivisible, rescission may be partial. 2 COUCH ON INSURANCE §31.69. Because rescission is a drastic remedy, courts often are reluctant to grant it. 2 COUCH ON INSURANCE §31.70. But it is important to distinguish from the outset whether a party seeks denial of coverage based on a policy provision of forfeiture, or denies the existence of policy coverage in the first place.

The Oregon statute that provides the general basis for rescission claims on insurance policies is ORS 742.013, which provides in its entirety:

- (1) All statements and descriptions in any application for an insurance policy by or in behalf of the insured, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealments of facts and incorrect statements shall not prevent a recovery under the policy unless the misrepresentations, omissions, concealments of fact and incorrect statements:
  - (a) Are contained in a written application for the insurance policy, and a copy of the application is indorsed upon or attached to the insurance policy when issued;
  - (b) Are shown by the insurer to be material, and the insurer also shows reliance thereon; and
  - (c) Are either:
    - (A) Fraudulent; or
    - (B) Material either to the acceptance of the risk or to the hazard assumed by the insurer.
- (2) This section does not apply to surety insurance.

Because the Oregon Insurance Code defines statements in any insurance application or claim as representations and not warranties, a misrepresentation or omission is generally not a ground for cancellation unless it meets the above requirements. This statute applies to all insurance policies except for wet marine and transportation, reinsurance, and surplus line insurance policies, ORS 742.001, and surety insurance, ORS 742.013(2). However, the Oregon Legislature has enacted many similar provisions specific to particular types of insurance, and attorneys should read the language of these provisions carefully as some may differ from ORS 742.013.

**§1.4-3(a) Copy of Written Application**

Misrepresentations, omissions, concealments of fact, or incorrect statements will not prevent recovery unless they “[a]re contained in a written application for the insurance policy, and a copy of the application is indorsed upon or attached to the insurance policy when issued.” ORS 742.013(1)(a). The purpose of the writing requirement is to prevent proof problems that may arise if an insurer were permitted to deny a claim based on an alleged oral misrepresentation. In *Ives v. INA Life Ins. Co.*, 101 Or App 429, 433, 790 P2d 1206 (1990), the court explained that the statutory requirement that a “copy” of the application be attached provides the insured with the entire agreement of the parties; a signed, typewritten copy that does not differ materially from the original, signed handwritten copy of the original application complies with the statute. *Ives*, 101 Or App at 433.

A signed application not attached to the policy does not satisfy the statutory requirements. In *Brock v. State Farm Mut. Auto. Ins.*, 195 Or App 519, 98 P3d 759 (2004), the court held that an unattached, signed application that contained omissions of the insured’s driving history was not sufficient. The court went on to say that a copy of the application is “indorsed upon” the policy when it is recreated in a memorandum or an explanation inscribed on the policy. *Brock*, 195 Or App at 524–529.

CAVEAT: Attorneys should be cautious when they rely on *Brock* for anything more than the premise that an unattached, signed application is not enough to satisfy the statute. At least one trial court has noted that the court in *Brock* decided only whether an unattached, signed application satisfied the statutory

requirement of ORS 742.013, not what may constitute a copy of the application. In *James River Ins. Co. v. Breitenbush Hot Springs & Conf. Ctr.*, 2005 WL 1278942 (D Or May 25, 2005), the court denied declaratory judgment for the insurer when the defendant's application was not attached to the policy when issued. The signed application included the words "HOTELS/MOTELS-NO-POOLS-LESS 4 STORIES", and a box for "no" was checked next to the question "Is there a swimming pool on the premises?" The policy, however, merely contained the classification information "Hotels and Motels-Without Pools or Beaches Less Than Four Stories."

#### **§1.4-3(b) Materiality**

To prevail on a rescission claim, an insurer must establish that the insured made a misrepresentation or omission that was material to the insurer's decision to issue the policy. ORS 742.013(1); *Seidel v. Time Ins. Co.*, 157 Or App 556, 561–562, 970 P2d 255 (1998) (health insurance). A false answer in an application for an insurance policy is material when "the insurer would not have accepted the application had a truthful answer been given." *Bunn v. Monarch Life Ins. Co.*, 257 Or 409, 412, 478 P2d 363 (1971). Similarly, other jurisdictions essentially ask whether the insurer would have issued the policy "but for" the fraud and, when the mistake is not material, rescission is not an available remedy. 2 COUCH ON INSURANCE §§31.74, 31.77 (3d ed 1995 & Supp 2011).

Separate rules often apply to avoiding insurance on the basis of misrepresentations in policy applications, as distinguished from misrepresentations in making claims. When the misrepresentation is made in the context of an investigation of a claim, the misrepresentation

is material if it is “relevant and germane to the insurer’s investigation as it was then proceeding.” *Callaway v. Sublimity Ins. Co.*, 123 Or App 18, 23, 858 P2d 888 (1993), quoting *Fine v. Bellefonte Underwriters Ins. Co.*, 725 F2d 179, 183 (2d Cir 1984). The materiality of an overvaluation is a fact-sensitive issue, however, and only a slight increase of the claimed value over the actual value of the lost property may not be relevant and germane to the insurer’s investigation. In *Allstate Ins. Co. v. Breeden*, 216 Fed Appx 655 (9th Cir 2007), the court construed a fire insurance statute, ORS 742.208(3), which is similar to ORS 742.013, to require the insurer to show that the insured’s representations were material. In *Breeden*, the insured “bumped up” the claimed values of property lost during a fire, but questions of fact remained as to the degree of misrepresentation. Uncontested “bumping up” is not enough. The court stated that if the insured’s “couch were worth \$5,000 and he had claimed a value of \$5,001,” that misrepresentation probably would not have been material. *Breeden*, 216 Fed Appx at 659.

The insurer has the burden of proving the materiality and the falseness of the insured’s answer. *Bunn*, 257 Or at 412. Although materiality is normally a question of fact, sometimes the court may find the misrepresentations to be material as a matter of law. *Santilli v. State Farm Life Ins. Co.*, 278 Or 53, 57, 562 P2d 965 (1977) (backdated life insurance policy). Materiality is “a question for the jury when reasonable minds can differ as to its existence.” *Mayflower Ins. Exchange v. Gilmont*, 280 F2d 13, 17 (9th Cir 1960).

To prevail on a directed verdict regarding a rescission claim, an insurer must show that there was no evidence from which a jury could

conclude either (1) that the insured did not make any misrepresentations or omissions or (2) that any misrepresentations or omissions made were not material. *Seidel*, 157 Or App at 562.

**§1.4-3(c) Reliance**

To prevail on a rescission claim, the insurer must show that it relied on the representations or omissions made by the insured. ORS 742.013(1)(b). Reliance in the insurance context requires “some evidence of detrimental action or change in position” by the insurer, such as calculating risk, offering coverage, or incurring additional investigation expenses. *Eslamizar v. American States Ins. Co.*, 134 Or App 138, 146, 894 P2d 1195 (1995) (insurer offered no evidence that it changed its position in any way, offered coverage, calculated its risk, or incurred additional expenses in conducting its investigation because of plaintiff’s misrepresentations).

To prove reliance, the insurer must show (1) reliance in fact, (2) reliance that was justified in light of the facts known to the insurer at the time, and (3) the right to rely on the representations. *Crawford v. Standard Ins. Co.*, 49 Or App 731, 735, 621 P2d 583 (1980) (discussing burden of establishing insured’s fraud in life insurance application pursuant to *former* ORS 743.042(1)(a) (current ORS 742.013(1)(a)). Reliance in fact and justified reliance are questions of fact; right to rely is a question of law. *Crawford*, 49 Or App at 736.

When the insurer did not change its position or it acted independently of, or in contradiction to, the insured’s factual assertions, the insurer did not rely. In *Leavenworth v. State Farm Fire & Cas. Co.*,

297 Fed Appx 602 (9th Cir 2008), the court applied Oregon fire insurance law and concluded that the insurer did not prove reliance.

The insurer is not obligated to investigate an insurance applicant's representations before relying on those representations. (See the discussion of justifiable reliance in §1.4-3(c)(2)). In *Story v. Safeco Life Ins. Co.*, 179 Or App 688, 40 P3d 1112 (2002), the insurer claimed that, had it known of the insured's treatment for coronary artery disease, it would have issued the insured's life insurance policy at a higher premium. The insured contended that it was not reasonable for the insurer to rely on the insured's misrepresentations of good health in his application for life insurance because the insurer could have only come to one plausible conclusion—coronary artery disease-- with all the accurate information provided to the insurer, such as the insured's age, weight, cholesterol level, and family history for heart disease. The court held that although the information put the insurer on notice that the insured had many risk factors associated with coronary artery disease, that information did not put the insurer on notice that the insured actually had coronary artery disease. In the absence of information that gives an insurer notice that an applicant has misrepresented facts, the insurer has no obligation to investigate an applicant's representations. *Story*, 179 Or App at 696.

### **§1.4-3(c)(1) Reliance in Fact**

Reliance in fact is a question of fact. *Crawford v. Standard Ins. Co.*, 49 Or App 731, 735-736, 621 P2d 583 (1980). That is, the insurer must prove actual reliance on the insured's misrepresentations. *Eslamizar v. American States Ins. Co.*, 134 Or App 138, 143, 894 P2d 1195 (1995)

(ORS 742.208(3), which governs standard fire insurance policies and is similar to ORS 742.013, requires that insurer show insured's representations are material and that insurer relied on them). The term *reliance* means ordinary reliance requiring "some evidence of a detrimental action or change in position." *Eslamizar*, 134 Or App at 146.

An insurer may meet the burden of showing reliance in fact by presenting evidence that, had the insured not misrepresented the facts, the insurer would have issued the policy at higher premiums or not issued it at all. *Story v. Safeco Life Ins.*, 179 Or App 688, 694, 40 P3d 1112 (2002) (discussed in §1.4-3(c)).

Merely fulfilling a duty to investigate is not sufficient to satisfy reliance in fact. *See Allstate Ins. Co. v. Breeden*, 216 Fed Appx 655, 659-660 (9th Cir 2007) (when insurer submitted no evidence to show that it incurred greater investigative costs than it would have absent the misrepresentations, insurer had not met its burden to establish reliance as a matter of law).

#### **§1.4-3(c)(2) Justifiable Reliance**

Whether the insurer justifiably relied on the insured's alleged misstatements is a question of fact. *Crawford v. Standard Ins. Co.*, 49 Or App 731, 736, 621 P2d 583 (1980). (construing life insurance under mortgage insurance policy).

The insurer can make out a prima facie case for the element of justified reliance on misinformation in an application by showing (1) that it approved the policy in the ordinary course of business; (2) that the application contained misrepresentations "but for which the insurer would not have issued the policy"; and (3) that the insurer had a legal

right to rely on the application information. The insured then must establish that the insurer had, or was chargeable with, knowledge of facts that revealed the falsity of the representations before the insurer's reliance. *Crawford*, 49 Or App at 736.

Putting the insurer on notice of risk factors does not equate to putting the insurer on notice of the falsity of the representations and does not preclude justifiable reliance. *Story v. Safeco Life Ins. Co.*, 179 Or App 688, 696, 40 P3d 1112 (2002) (discussed in §1.4-3(c)).

After the insurer presents prima facie evidence of reasonable reliance, the burden shifts to the plaintiff to show that defendant "knew facts that revealed the falsity of the insured's representations or that should have led it to learn that the representations were false." *Story*, 179 Or App at 696.

QUERY: In the *Story* case, the insured applied for life insurance and died less than one year later. What if the policy is in effect for many years? See 2 COUCH ON INSURANCE §31.79 (3d ed 1995 & Supp 2011), which discusses the courts' willingness to analyze the degree of fault of the mistaken party in failing to ascertain the truth and suggests that, at a certain point, the law of equity will not decree the rescission of the insurance contract, especially when the policy has been in effect for so long due largely to the insurer's failure to investigate.

Mere negligence in failing to ascertain the truth of an insured's representations is not enough to preclude justifiable reliance. *Crawford*, 49 Or App at 736 ("insurer must then establish by a preponderance of the evidence ...at least that its failure to discover the true facts was

attributable to mere negligence”) However, for discussion to what degree the insurer must investigate the accuracy of the insured’s statement, see §§1.4-3(c)(3) and 1.4-3(c)(f) below.

**§1.4-3(c)(3) Right to Rely**

Only “reliance where there is a right to rely will relieve a contracting party from the fraud of another.” *Kubeck v. Consolidated Underwriters*, 267 Or 548, 554–555, 517 P2d 1039 (1974) (construing former ORS 743.042(1), current ORS 742.013(1)). The right to rely is a question of law. *Crawford v. Standard Ins. Co.*, 49 Or App 731, 736, 621 P2d 583 (1980) (construing life insurance under mortgage insurance policy). In *Kubeck*, the insured misrepresented on his car insurance policy that his car was a standard Ford, not a high-performance Cobra. The court held that the insurer’s failure to check the vehicle serial number, which would have revealed that the vehicle was actually a high-performance model that the insurer would not have insured, was negligent—but not negligent enough to overcome the insured’s fraud. Fraud protection laws were designed to favor the vigilant, as well as to provide protection for the “foolishly credulous, as against the machinations of the designedly wicked.” *Kubeck*, 267 Or at 555 (quoting *Johnson v. Cofer*, 204 Or 142, 150, 281 P2d 981 (1955)).

However, limitations on the insurer’s right to rely depend on the extent to which the insurer must investigate the accuracy of the insured’s statements. *Johnson*, 204 Or at 150 (“The rule of law is one of policy. Is it better to encourage negligence in the foolish, or fraud in the deceitful?”); *Heverly v. Kirkendall*, 257 Or 232, 237, 478 P2d 381, 383 (1970) (“negligence on the part of the party to whom the

misrepresentation was made is not a defense to a claim for rescission”). See 2 TORTS §23.12 (OREGON CLE 2006), discussing the duty to investigate.

**§1.4-3(d) Either Fraudulent or Material to the Risk**

In addition to materiality and reliance, the insured’s misrepresentations in general must be either (1) fraudulent or (2) material either to the insurer’s acceptance of the risk or to the hazard assumed by the insurer. ORS 742.013(1)(c). By its terms, ORS 742.013 provides the insurer with the right to rescind a policy if the misrepresentation is found to be either of those. *Kraus v. Prudential Ins. Co.*, 799 F2d 502, 504 (9th Cir 1986) (*former* ORS 743.042(1) (current ORS 742.013(1)) “gives an insurer the right to rescind or avoid a policy where incorrect statements, misrepresentations, omissions or concealments of facts are done fraudulently or are material to the risk”). See also *Knight v. Continental Casualty Co.*, 259 Or 46, 51, 485 P2d 403 (1971) (holding that misrepresentation is “material as matter of law,” without mentioning any degree of mens rea, under *former* ORS 741.150 (repealed in 1967)); *Martin v. Pacific Hosp. Ass’n*, 101 Or App 37, 42, 788 P2d 1029 (1990) (insured’s failure to disclose breast condition was material to insurer’s acceptance of risk of subsequent cancer; fraud was not at issue); *Reisen v. Blue Cross Blue Shield*, 115 Or App 396, 405, 839 P2d 729 (1992) (insured’s misrepresentations in health policy application were material as matter of law under ORS 742.013(1); insurer did not contend that insured committed fraud).

These opinions mean, that in a literal interpretation of the statute, an insurer may rescind a policy without having to establish scienter,

which is the speaker's knowledge of the falsity of his or her statements and is an element of common-law fraud. *See* 2 TORTS §§23.2, 23.9 (OREGON CLE 2006); *Conzelmann v. Northwest Poultry & Dairy Products Co.*, 190 Or 332, 350, 225 P2d 757 (1950) (listing elements of "actionable fraud").

However, judicial opinions interpreting ORS 742.013 have held that for rescission, the insurer must show that the false representations were made recklessly without any knowledge of their truth or made knowingly. In *Progressive Specialty Ins. Co. v. Carter*, 126 Or App 236, 868 P2d 32 (1994), the insurer sought to rescind a motor vehicle liability insurance policy on the ground that the insured made material misrepresentations in the policy application. The trial court precluded rescission pursuant to ORS 742.013 because the application containing the alleged misrepresentations was not physically attached to the policy. The appellate court did not address the statutory basis for the trial court decision because it agreed that the insurer failed to prove any misrepresentations under the following test:

To establish a right to rescind its insurance policy, [the insurer] must prove . . . that it issued the policy in reliance on [the insured's] false representations, which were material to the company's decision to accept the risk. *Crawford v. Standard Ins.*, 49 Or App 731, 735–736, 621 P2d 583 (1980), *review denied* 290 Or 652 (1981). Scienter must be proven by evidence that [the insured] either knowingly made false representations, or recklessly made false representations without any knowledge as to whether they were true or false. *Kentner v. Gulf Ins.*, 297 Or 470, 476, 686 P2d 339, *modified* 298 Or 69, 689 P2d [955] (1984) [holding scienter standard applicable to *former* ORS 743.042(1) (current ORS 742.013) for "insurance fraud" is "reckless

indifference,” same standard required to establish scienter in common-law fraud].

*Progressive Specialty Ins. Co.*, 126 Or App at 241–242.

Thus, the court essentially adopts the same mens rea as for fraud and applies it to actions seeking rescission, even though the statute appears literally to allow for rescission claims against purely innocent misrepresentations that are material to the risk. *See United States Nat’l Bank v. Fought*, 291 Or 201, 220–221, 630 P2d 337 (1981) (“knowledge of its falsity or ignorance of its truth”).

In a footnote in *Holman v. Pacific Health & Life Ins. Co.*, 136 Or App 260, 264 n 2, 902 P2d 106 (1995), the court suggested in dicta that it would follow *Progressive Specialty Ins. Co.* on the scienter issue. *See also Northwestern Mut. Life Ins.Co. v. Wiggins*, 15 F2d 646, 647 (9th Cir 1926) (insured’s answers in life insurance application, if true, gave all necessary information required to determine acceptance of risk by insurer; to avoid risk or cancel policy, insurer had to show insured’s answers were false and known by insured to be false); *Mutual Life Ins. Co. of N.Y. v. Muckler*, 143 Or 327, 331, 21 P2d 804 (1933) (in action on life insurance policy for false representations, insurer must show not only that insured’s statements were false, but also that statements “were made knowingly”).

The opinions in *Progressive Specialty Ins. Co.* and *Holman* arguably eliminate the alternatives set forth in ORS 742.013, that a material and relied-on misrepresentation may be either fraudulent, thereby requiring proof of scienter, or material to the risk, which presumably should not require proof of scienter. However, the Oregon Supreme Court finds the term *fraud* confusing: “There has been a good

deal of overlapping of theories, and no little confusion, which has been increased by the indiscriminate use of the word `fraud,' a term so vague that it requires definition in nearly every case.” *Fought*, 291 Or at 213 n 13 (quoting Prosser, LAW OF TORTS 684 (4th ed 1971)). The court concluded: “Our own use of the word ‘fraud’ in this opinion will disclose that it has been in quotation marks. We do this because we agree with Professor Prosser that the word has no precise referent.” *Fought*, 291 Or at 213 n 13.

In the broader contract sense, Oregon recognizes an action for “innocent” misrepresentation, which provides an equitable basis for rescinding a contract. The party seeking to rescind must allege that the representations at issue were false, that they were material, and that they were reasonably relied on. *See* 2 TORTS §§23.33-23.35 (Oregon CLE 2006). In certain situations, Oregon also recognizes the tort of negligent misrepresentation. *See Onita Pac. Corp. v. Trs. of Bronson*, 315 Or 149, 843 P2d 890 (1992).

#### **§1.4-3(e) Burden of Proof**

“To meet its burden of persuasion, the insurer must . . . establish by a preponderance of the evidence that it had no such knowledge or at least that its failure to discover the true facts was attributable to mere negligence.” *Story v. Safeco Life Ins. Co.*, 179 Or App 688, 694, 40 P3d 1112 (2002) (quoting *Crawford v. Standard Ins. Co.*, 49 Or App 731, 736, 621 P2d 583 (1980) (citations omitted)).

Thus, once an insurer makes a prima facie showing of reasonable reliance, the burden shifts to the insured to present evidence that the insurer either knew or can be charged with knowing that the

representations on which the insurer relied were false. *See, e.g., Progressive Specialty Ins. Co. v. Carter*, 126 Or App 236, 241, 868 P2d 32 (1994) (in rescission of motor vehicle liability insurance policy, insurer had to prove by preponderance of evidence that it issued policy in reliance on insured's false representations, which were material to decision to insure); *Mutual of Enumclaw Ins. Co. v. McBride*, 295 Or 398, 407, 667 P2d 494 (1983) (pursuant to statutory concealment and fraud provision in standard fire policy (*former* ORS 743.612, current ORS 742.208), insured's fraud or misrepresentation need only be shown by preponderance of evidence, not clear and convincing evidence). *See also Mutual Life Ins. Co. v. Muckler*, 143 Or 327, 331, 21 P2d 804 (1933) (applying preponderance of evidence standard to whether insured made false statements in application for life insurance policy).

### **§1.4-3(f) Duty to Investigate Misrepresentations**

Pursuant to ORS 742.013, an insurer generally does not have a duty to investigate possible misrepresentations or omissions on the insured's application for insurance when the application is "incomplete on its face." *Kraus v. Prudential Ins. Co.*, 799 F2d 502, 505 (9th Cir 1986) (applying Oregon law). *Cf. Verex Assur., Inc. v. John Hanson S&L*, 816 F2d 1296, 1305 (9th Cir 1987) (applying Oregon law) (when mortgage guaranty insurer assumed active role in sale of loans and insurance certificates, extent of insurer's knowledge was question of fact pursuant to claims of negligent failure to inspect correctness of insurance applications) (distinguishing *Kraus*). However, the insurer has a duty to investigate when "the omissions are so obviously material that reliance on the incomplete application would be reckless." *Kraus*, 799 F2d at 505.

The insured, on the other hand, has no duty to read the application and policy when they are returned to him or her and to report to the insurer any material misrepresentations made by the insurer's agent in the application. *Bunn v. Monarch Life Ins. Co.*, 257 Or 409, 419–420, 478 P2d 363 (1971), *overruling Comer v. World Ins. Co.*, 212 Or 105, 318 P2d 916 (1957); *Reserve Life Ins. Co. v. Howell*, 225 Or 71, 357 P2d 400 (1960); *Martin v. Ore. Insurance Co.*, 232 Or 197, 375 P2d 75 (1962). The *Bunn* decision is in accord with the rule prevailing in the majority of jurisdictions. *See* Annot, *Insurance Application-False Answers*, 26 ALR3D 6 (1969 & Supp). *See also Franklin v. Western Pacific Ins. Co.*, 243 Or 448, 453, 414 P2d 343 (1966) (in breach of contract to procure insurance, when insurance agent is also insured's agent, insured has no duty to read policy; insured is entitled to assume agent performed his or her duty). *Compare Martini v. Beaverton Ins. Agency*, 314 Or 200, 207, 838 P2d 1061 (1992) (in action against agent for negligent failure to procure insurance, insurer could raise insured's failure to read policy as specification of comparative fault).

When the insured makes representations of facts that are peculiarly within his or her knowledge, and that may disclose his or her state of health, the insured must make a good-faith full disclosure in answering the insurer's direct questions. *Leigh v. Consumers Nat'l Life Ins. Co.*, 240 Or 290, 293–294, 401 P2d 46 (1965). The law recognizes the insured's failure to answer such questions as fraud, thereby vitiating the policy. *Leigh*, 240 Or at 294.

When an insurance contract is made pursuant to a written application, "if the insurer delivers a copy of such application with the

policy,” the application becomes part of the policy. ORS 742.016(1). Moreover, any application that is not delivered according to the statutory terms “shall not be a part of the insurance policy and the insurer shall be precluded from introducing such application as evidence in any action based upon or involving the policy.” ORS 742.016(1). Thus, the insurer apparently is not required to send to the insured a copy of the application.

However, RCW 48.21.060, which governs every policy of group or blanket disability insurance, mandates that the copy of the application, if any, “shall be attached to the policy when issued.” In *Manz v. Cont’l Am. Life Ins.*, 119 Or App 31, 35, 849 P2d 549 (1993), the Oregon Court of Appeals, construing the Washington statute under Washington law, held that “the insured has a duty to read the insurance application when it is received with the policy and to call any inaccuracies to the attention of the insurer. . . . The statute is intended to facilitate the fulfillment of that obligation.”

### **§1.4-3(g) Rescission by Insured**

Although the insured typically is advantaged when the policy is enforced, rarely an insured may use the remedy of rescission when the insurer is guilty of fraud or misrepresentation.

In *Bollenback v. Continental Casualty Co.*, 243 Or 498, 414 P2d 802 (1966), the court held that when the insurer wrongfully repudiated the insured’s coverage under a group health and accident policy due to a willful mistake about the status of premium payments, the insured was entitled to rescind the contract and receive a refund of premiums paid, minus the value of coverage received. *See also Albertus v. Icoa Life Ins.*

*Co.*, 247 Or 618, 431 P2d 264 (1967) (insurer's fraud in inception of life insurance policies).

**§1.4-3(h) Distinction Between Scope of Coverage and Conditions of Forfeiture**

An important initial question often is whether an insurer has denied coverage based on a policy provision for forfeiture of coverage or because there was no policy coverage in the first place. The topics covered in this section are not exclusively a rescission issue, but are discussed under the rescission heading because many forfeiture-of-coverage cases are the result of an alleged act by the insured that forfeits either the entire coverage of the policy or coverage for a particular type of loss.

The specific parol evidence rule set forth in ORS 742.016(1) provides that “every contract of insurance shall be construed according to the terms and conditions of the policy.” Therefore, the law governing the scope of coverage and conditions of forfeiture in insurance contracts varies significantly from laws governing contracts generally. *See Bennett v. Farmers Ins. Co.*, 332 Or 138, 158, 26 P3d 785 (2001); CONTRACT LAW IN OREGON §12.5 (Oregon CLE 2003 & Supp 2008) (discussing estoppel).

The basic axiom is that an insured cannot expand the scope of coverage of a policy through the argument of estoppel. *ABCD Vision, Inc. v. Fireman's Fund Ins. Cos.*, 304 Or 301, 307, 744 P2d 998 (1987). However, when coverage existed in the first place but an act by the insured forfeits that coverage, the insurer may be estopped from denying coverage if it represents that the insured will be covered for a particular

loss. *ABCD Vision, Inc.* 304 Or at 306–307; *Day-Towne v. Progressive Halcyon Ins. Co.*, 214 Or App 372, 381, 164 P3d 1205 (2007) (“A condition forfeiting coverage exists when there is insurance coverage for the loss in the first place, but acts of the insured work to lose that coverage (e.g., making a false statement, failing to protect the insured property”).

In representations to the insured, the insurer does not need to preserve an argument that a particular claim is outside the scope of, or specifically excluded in, the insurance contract. In *ABCD Vision, Inc.*, the insured obtained a commercial property policy that covered physical loss by external causes. The policy contained a condition of forfeiture for failure to safeguard. It also contained several exclusions, two of which became germane to the case: (1) losses due to electrical or mechanical breakdown resulting in fire and (2) losses due to repairing or adjusting equipment. Two instances of arcing and fire damage occurred with the electronic equipment and, after the first incident, the insured adjusted the equipment. In a letter to the insured, the insurer initially denied coverage based on failure to safeguard without mentioning any conditions of exclusion, and the parties agreed to delay appraisal until after litigation of coverage. The trial court held that the insurer was estopped from denying coverage based on the exclusion, but the supreme court reversed. The court held that the policy provisions describing loss caused by mechanical or electrical breakdown or failure and loss resulting from repair and maintenance as “perils excluded” were “exclusions of coverage,” which the insurer could not be estopped from later adding as

additional defenses against coverage. *ABCD Vision, Inc.*, 304 Or at 307.

The supreme court reasoned:

When an insurer's assertion of policy defenses is challenged by claiming that policy exclusions have been lost through estoppel, the correct procedure is to determine first whether the provisions upon which the insurer relies are conditions of forfeiture that are subject to estoppel or, instead, are matters relating to the scope of coverage. Estoppel cannot be invoked to expand insurance coverage or the scope of an insurance contract. . . .

When there is forfeiture of coverage being effected, there is insurance coverage for the loss in the first place, but acts of the insured nullify the coverage, such as the filing of a false statement of loss.

*ABCD Vision, Inc.*, 304 Or at 307.

In an earlier case, however, the court held that estoppel was available to preclude the insurer from asserting that no coverage was available. In *Paulson v. Western Life Ins. Co.*, 292 Or 38, 636 P2d 935 (1981), an employer, who was also an agent by function and the holder of a group insurance policy, told a new employee that he did not need to apply for medical insurance for six months, when in fact the deadline was 31 days. The employee's daughter incurred medical charges after the 31-day deadline, and the insurer denied benefits. The court held that even though an express provision denied coverage, the doctrine of estoppel applied to grant coverage for losses that occurred essentially before the policy was established. "In this case, the employee clearly met the eligibility requirements, and but for the mistaken representation made by his employer, the plaintiff might have seasonably obtained the coverage, thus avoiding this dispute." *Paulson*, 292 Or at 53.

Although the Oregon Court of Appeals has discussed the possibility that the estoppel doctrine could be used to expand policy coverage when the insurer's conduct at issue occurs before the loss, *see, e.g., Kabban v. Mackin*, 104 Or App 422, 429–431, 801 P2d 883 (1990), the Oregon Supreme Court has noted it would require “exceptional circumstances,” *DeJonge v. Mutual of Enumclaw*, 315 Or 237, 242–243, 843 P2d 914 (1992).

In *DeJonge*, the insured had orally requested complete coverage for a grocery store and received a written policy. The insured was unaware for three years of coverage of a written provision that excluded bodily injury caused by a sale of alcohol to a minor. When the insured was sued on that ground, the insurer denied coverage. The court held that estoppel could not be used to negate an unambiguous exclusion in a written policy of insurance when the insurer did not dissuade the insured from reading or understanding the exclusion. The court distinguished *Paulson* and *ABCD Vision*, based on whether the oral representations were made pre-policy or post-policy. The court noted that in *Paulson* no policy had issued but that the insured had never received a written policy, and did not have the ability to read the exclusions of coverage. The court ruled that even conduct of the insurer occurring before the loss but after issuing the policy cannot support the use of estoppel to “negate an express exclusion in an insurance policy” and expand coverage beyond the terms of the policy. *DeJonge*, 315 Or at 245.

COMMENT: Three justices dissented in the *DeJonge* case, arguing that the court should draw distinctions between pre-loss and post-loss, not merely pre-policy and post-policy losses. *See*

*DeJonge*, 315 Or at 246 (dissent). The dissent would bring estoppel doctrine in insurance cases in line with general contract cases. No supreme court cases have expanded on the pre-loss/post-loss distinction in insurance cases since *DeJonge*, so it is unclear if the court would consider overturning *DeJonge*. Several court of appeals cases have followed *DeJonge* and *ABCD Vision* in ruling on insurance estoppel cases.

For other cases discussing estoppel, see *Farmers Ins. Co. v. Munson*, 127 Or App 413, 418, 873 P2d 370 (1994) (summarizing these rules); *Richardson v. Guardian Life Ins. Co. of Am.*, 161 Or App 615, 984 P2d 917 (1999) (court rejected insured dentist's contention that "covered expense" provision in business overhead disability policy was condition of forfeiture that could be defeated by estoppel, because expenses incurred after sale of business were not business-continuation expenses); *Strawn v. Farmers Ins. Co.* 228 Or App 454, 473, 209 P3d 357, 370, *reversed in part on other grounds*, 350 Or 336 (2011) (insurer was estopped from raising new ground for denying payment of the benefits at that point in the case); *Or. Schs. Activities Ass'n v. Nat'l Union Fire Ins. Co.*, 279 Fed Appx 494, 496 (9th Cir 2008) ("notice under a claims-made-and-reported policy is the very act that triggers coverage" and is a defense that cannot be waived); *Day-Towne*, 214 Or App at 381-383 (insurer's letter, which stated that insurer accepted coverage regarding insured's underinsured-motorist claim and consented to submit case to binding arbitration if case could not be resolved, did not expand insurance coverage by estoppel because it would expand scope of insurer's contractual obligations).

“A suit limitation provision... does not nullify insurance coverage. Rather, it precludes an insured from starting an action against its insurer once the limitation period has passed, regardless of the extent of coverage.” *Herman v. Valley Ins. Co.*, 145 Or App 124, 131, 928 P2d 985 (1996). When the insurer represents to the insured that a claim was covered, even if the claim is brought after the allotted time in the suit-limitations provision, the insurer may waive the defense (i.e., be estopped from asserting it). In *Wright v. State Farm Mut. Auto. Ins.*, 223 Or App 357, 368-369, 196 P3d 1000 (2008), the court compared waiver and estoppel and held that the insurer may waive a suit-limitation defense when it represented to the insured that a claim was covered even though the claim was brought three years after the allotted time to bring the claim according to the terms of the policy. However, in *Herman*, 145 Or App at 126, the insurer did not receive notice of the insured’s action until after the suit-limitations period set forth in the policy. The court refused to estop the insurer from asserting the defense because the insured had not complied with the policy provision.

Estoppel has been used to reach results similar to reformation, discussed in §1.5

### **§1.5 REFORMATION OF POLICIES**

Reformation is an equitable remedy designed to permit a court to correct a written instrument to conform to the original agreement that the parties intended and desired to put into writing. In the insurance context, the insured usually brings a suit to reform the contract of insurance on the ground that the written policy issued by the insurance company did not conform to the agreement reached between the insured and the

company's agent. *See, e.g., Gregan v. Northwestern Nat'l Ins. Co.*, 83 Or 278, 163 P 588 (1917) (discussed in §1.5-1); *Leavens v. Northwestern Mut. Ins. Co.*, 249 Or 418, 439 P2d 17 (1968) (trial court properly reformed policy when plaintiff established that insurance agent and insured intended to insure contents of house).

The complaint in a suit for reformation must (1) clearly state the original agreement of the parties, (2) point out with precision where there was a misunderstanding, and (3) allege that either the mistake was mutual and did not arise from the plaintiff's gross negligence or that the misconception was caused by the defendant's fraud. *Peninsula Lumber Co. v. Royal Indem. Co.*, 93 Or 684, 689, 184 P 562 (1919). When the insured or the insurer seeks to reform the insurance policy as an alternative to an action pursuant to the written policy itself, the elements of reformation must be specifically pleaded and proved. *Avemco Ins. Co. v. Hill*, 76 Or App 185, 190-191, 708 P2d 640 (1985).

For further discussion of reformation, see CONTRACT LAW IN OREGON ch 5 (Oregon CLE 2003 & Supp 2008).

### **§1.5-1 Mutual Mistake**

A court will reform a contract that, by reason of mutual mistake, does not express the real agreement of the parties, as long as the mistake did not arise from the plaintiff's gross negligence. *Peninsula Lumber Co. v. Royal Indem. Co.*, 93 Or 684, 689, 184 P 562 (1919); *Schaffner v. Oregon Cent. Credit Union*, 63 Or App 118, 124, 663 P2d 1275 (1983) ("Plaintiffs' negotiation of the check [on advice of agent] before the correction of the written agreement may not have been the most prudent action, but their negligence, if any, was not so gross and inexcusable as to

justify a denial of reformation”). A showing that the contract does not express the intent of one of the parties, while conforming to that of the other, is not enough. *Boardman v. Insurance Co. of Pennsylvania*, 84 Or 60, 64, 164 P 558 (1917) (lack of mutuality of mistake when insured struck out “Boardman & Miller” on contract and wrote “Boardman & Bartle,” and insured did not allege, nor did facts support, that insurer originally agreed to enter into contract with Bartle instead of Miller).

To justify reformation after a mutual mistake, it is not enough that the parties would have come to a certain agreement had they been aware of the actual facts; “it is necessary that the parties . . . shall have previously reached a complete mutual understanding with respect to all of the essential terms of their agreement, for otherwise there would be no standard by which the writing could be reformed.” *Manning Lumber Co. v. Voget*, 188 Or 486, 500, 216 P2d 674 (1950). The mutual mistake “must have been in the *drafting* of the instrument, not in the *making* of the contract. *Interior Elevator Co. v. Limmeroth*, 278 Or 589, 597, 565 P2d 1074 (1977) (emphasis in original). A contract “will not be reformed because of a mistake of fact which, if known, probably would have induced the making of a different contract.” *King v. Talcott*, 80 Or App 701, 704, 723 P2d 1058 (1986).

A court may reform a written agreement based on an earlier oral agreement. In *Mock v. Glens Falls Indem. Co.*, 210 Or 71, 309 P2d 180 (1957), the plaintiff, a used car dealer, contacted an insurance agent and orally requested liability insurance to cover automobiles purchased in other cities and driven to plaintiff’s place of business. The defendant’s agent advised plaintiff on March 7 that he could obtain such insurance for

plaintiff and from that moment on such risk was covered. After this conversation, the agent had some difficulty placing the policy with the defendant because of the extrahazardous nature of the risk. However, a general comprehensive liability policy was finally written with the defendant and dated July 3. The plaintiff paid no attention to the date of the policy and later was advised of an accident occurring on June 30. The trial court reformed the date of the policy to read March 7. The Oregon Supreme Court affirmed the ruling because the oral agreement with an effective date of March 7 between the plaintiff and the defendant's agent was sufficiently definite to be valid but, through mistake, it was not so written.

The plaintiff's mere failure to read the written policy of insurance does not amount to gross negligence that deprives the plaintiff of the requested equitable relief. In *Gregan v. Northwestern Nat'l Ins. Co.*, 83 Or 278, 282, 163 P 588 (1917), the plaintiff was a contract purchaser, not the sole owner, of certain real property. The defendant's agent agreed to furnish fire insurance. The policy provided that the plaintiff must be the sole owner of the insured property. After a loss by fire, the plaintiff brought suit to reform the policy by eliminating the sole-ownership clause. The trial court reformed the policy, and the supreme court affirmed. The defendant intended to issue a valid policy, and the mistake was therefore mutual. The plaintiff's right to relief was not barred by his failure to read the policy.

That the plaintiff was somewhat careless in not examining the policies issued more carefully is, perhaps, true; but this negligence should not prevent relief. There are few, if any, cases where the aid of equity is asked to reform mistakes in written instruments in which

there is not disclosed some degree of negligence by the injured party, and this is particularly true as to insurance policies. The average person insured describes his property to the agent, pays his premium, receives his insurance policy, and goes on his way rejoicing, usually not reading it, and not understanding half of it if he does read it.

*Carlton Lumber Co. v. Lumber Ins. Co.*, 81 Or 396, 403–404, 158 P 807, 159 P 969 (1916).

### §1.5-2 Fraud

The mistake of one party coupled with fraud on the part of the other party is sufficient to justify reformation. *See Peninsula Lumber Co. v. Royal Indem. Co.*, 93 Or 684, 689, 184 P 562 (1919). However, fraud is never presumed. *Gregan v. Northwestern Nat'l Ins. Co.*, 83 Or 278, 281, 163 P 588 (1917).

### §1.5-3 Burden of Proof

Equity will not reform an insurance policy unless the alleged mistake is established by clear and satisfactory evidence. *Boardman v. Ins. Co. State of Pa.*, 84 Or 60, 69, 164 P 558 (1917). In addition to the ordinary burden of proof that rests on every litigant asserting a particular issue, there is, in this class of cases, the additional burden of overcoming the presumption created by the contract itself. *Epstein v. State Ins. Co.*, 21 Or 179, 181, 27 P 1045 (1891).

### §1.5-4 Defenses

Because reformation is an equitable doctrine, the full range of equitable defenses is available to the defendant. For example, if the plaintiff has unreasonably delayed in bringing the suit, the defense of laches is available. In *Woodriff v. Ashcraft*, 263 Or 547, 553, 503 P2d

472 (1972), the court applied the 10-year limitations period set forth in ORS 12.140—the “catchall” statute of limitations—as a general yardstick for determining the reasonableness of the delay.

### **§1.5-5 Supplemental Relief**

Courts have awarded money judgments in the amount of the loss under the policy should the policy be reformed as requested, as well as additional attorney fees. *See Mock v. Glens Falls Indem. Co.*, 210 Or 71, 309 P2d 180 (1957) (court affirmed money judgment and awarded plaintiffs additional attorney fees on appeal).

### **§1.5-6 Alternative Legal Remedies**

Many reformation cases involve a claim that the written policy of insurance did not conform with the oral agreement between the insured and the insurer’s agent. *See Mock v. Glens Falls Indem. Co.*, 210 Or 71, 309 P2d 180 (1957). Accordingly, if the written policy of insurance was not delivered before the loss for which coverage is claimed, the insured can simply bring an action on the oral contract of insurance. *See Frontier Ins. Agency, Inc. v. Hartford Fire Ins. Co.*, 262 Or 470, 477, 499 P2d 1302 (1972) (“In this case the court was asked, in effect, to enforce the written policy of insurance, as amended by oral agreement, to include additional coverage”); *Bird v. Central Mfrs. Mut. Ins. Co.*, 168 Or 1, 7, 120 P2d 753 (1942) (insured had “plain, speedy and adequate remedy at law” to enforce oral contract, and it was unnecessary to seek reformation of policy because there was no mutual mistake).

Equitable estoppel has been used occasionally to reach results similar to the results achieved in a suit for reformation. Although the insurance policy technically remains unchanged under this doctrine, the

insurer is estopped from asserting some particular provision of the policy because it would be inequitable to do so. Although estoppel is largely a creature of equity, the law courts, on adopting it, proceeded to enforce it under the rules that govern legal remedies. *Comer v. World Ins. Co.*, 212 Or 105, 121, 318 P2d 916 (1957), *overruled on other grounds*, *Bunn v. Monarch Life Ins. Co.*, 257 Or 409, 420, 478 P2d 363 (1971). The question of estoppel is normally an issue of fact for the jury. *Hayes Truck Lines, Inc. v. Investors Ins. Corp.*, 269 Or 565, 572, 525 P2d 1289 (1974).

Equitable estoppel has most often been asserted as a defense to the insurer's claim that the policy should be canceled or voided due to the insured's misstatements or nondisclosures in the policy application process. Estoppel has been successful when the insured could show that the insurer's own agent was responsible for the misstatements on a policy application.

The insurer will not be permitted to avoid the policy by taking advantage of any misstatement, misrepresentation or concealment, of a fact material to the risk, which is due to the mistake, fraud, negligence or other fault of its agent and not to fraud or bad faith on the part of the insured.

*Williams v. Pacific States Fire Ins. Co.*, 120 Or 1, 10, 251 P 258 (1926). *See also Mercer v. Germania Ins.*, 88 Or 410, 171 P 412 (1918) (insurer estopped to assert sole-ownership clause in policy because its agent had represented to insured that both she and former husband were covered by policy).

In *Bunn*, 257 Or at 420, the court overruled its holding in *Comer* that the insured was under a duty to read his or her own policy

application because a copy was required by statute to be attached to the policy sent to the insured. Although the court in *Comer*, 212 Or at 121, criticizes equitable estoppel as a “short cut to equitable reformation,” the continuing force of that pronouncement is questionable in light of the *Bunn* court’s overruling of the *Comer* holding and subsequent cases applying the equitable estoppel doctrine. See, e.g., *Paulson v. Western Life Ins. Co.*, 292 Or 38, 636 P2d 935 (1981) (estoppel applied to medical insurance claim).

In another context, the Oregon courts have limited the scope of the insured’s use of estoppel to recover against the insurer. An insurer may be estopped to assert “conditions of forfeiture,” but estoppel cannot be used to expand the essential scope of coverage, whether that coverage is in the basic policy provisions or in exclusions to the policy. See the discussion of conditions of forfeiture in §1.4-3(h).

The scope of equitable estoppel in insurance cases remains unclear. The court attempted to clarify this area of the law in *Bennett v. Farmers Ins. Co.*, 332 Or 138, 26 P3d 785 (2001), which was an employment case brought against an insurance company by one of its district managers. The court specifically rejected the idea that estoppel was not available to the plaintiff to defeat the terms of the written employment agreement. The court limited its holding to the contrary (set forth in *DeJonge v. Mutual of Enumclaw*, 315 Or 237, 843 P2d 914 (1992)), to “disputes in the interpretation of express insurance policies.” *Bennett*, 332 Or at 158. The court pointed out that express contracts of insurance are subject to the statutory parol evidence rule set forth in ORS 742.016(1) and concluded that “[i]n the absence of a superseding statute, however,

estoppel is available to a party to a contract that was led to rely upon a perceived waiver of a contract provision.” *Bennett*, 332 Or at 158.