21-1830

IN THE

United States Court of Appeals

FOR THE SECOND CIRCUIT

ANDREW NITKEWICZ, as Trustee of THE JOAN C. LUPE FAMILY TRUST on behalf of himself and all others similarly situated,

Plaintiff-Appellant,

—against—

LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK,

Defendant-Appellee.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

BRIEF AND SPECIAL APPENDIX FOR PLAINTIFF-APPELLANT

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Rules

JURISDICTIONAL STATEMENT

The district court had subject-matter jurisdiction under 28 U.S.C. § 1332(d) because this is a class action with diversity between at least one class member and Defendant, and the aggregate damages exceed $5,000,000. JA10, Compl. ¶ 11. On July 2, 2021, the United States District Court for the Southern District of New York (Cronan, *J.*) dismissed the Complaint with prejudice under Rule 12(b)(6) and without leave to amend. JA325. Plaintiff timely filed a Notice of Appeal on July 28, 2021. JA374. This Court has jurisdiction under 28 U.S.C. § 1291 because this is an appeal from the district court's final judgment dismissing the Complaint.

STATEMENT OF THE ISSUE

New York requires that life insurance companies not charge insureds for insurance after they are already dead. N.Y. Ins. Law § 3203(a)(2) provides: "[I]f the death of the insured occurs during a period for which the premium has been paid, the insurer shall add to the policy proceeds a refund of any premium actually paid for any period beyond the end of the policy month in which such death occurred . . . . This paragraph shall not apply to single premium or paid up-policies."

Plaintiff purchased a $1.5 million universal life insurance policy from Defendant, paid an annual premium of $53,877.72 on May 7, 2018, and the insured died on October 6, 2018. That policy was not a single-premium or paid-up policy.

The issue presented is whether N.Y. Ins. Law § 3203(a)(2) requires Defendant to refund the portion of the annual premium for this policy that was paid for the period after the insured died in October 2018.

STATEMENT OF THE CASE

In 2011, Plaintiff-Appellant Andrew Nitkewicz, as successor trustee of the Joan C. Lupe Family Trust, purchased a life insurance policy for the Trust from Defendant-Appellee, Lincoln Life & Annuity Company of New York ("Lincoln Life"). JA8-9, Compl. ¶¶ 4, 9. Plaintiff's policy (the "Policy") is a "flexible premium adjustable" (aka "universal") permanent-life insurance policy with a $1.5 million death benefit. JA8, Compl. ¶ 4; JA62.

Every year since 2011, Plaintiff paid the Policy's annual premium of $53,877.72; the last annual premium payment of $53,877.72 was made on May 7, 2018. JA11, Compl. ¶ 18. The insured died on October 6, 2018 – with seven months remaining on his May 2018 annual premium. *Id.*

In situations like this, N.Y. Ins. Law § 3203(a)(2) requires the insurer to refund to the policyholder the portion of the annual premium that corresponds to the period after the insured's death; here, the 7 months after October 2018. Section 3203(a) provides:

> All life insurance policies, except as otherwise stated herein, delivered or issued for delivery in this state, shall contain in substance the following provisions, or provisions which the superintendent deems more favorable to policyholders: . . .

> (2) that if the death of the insured occurs . . . during a period for which the premium has been paid, the insurer shall add to the policy proceeds a refund of any premium actually paid for any period beyond the end of the policy month in which such death occurred, provided such premium was not waived under any policy provision for waiver of premiums benefit. This paragraph shall not apply to single premium or paid-up policies.

It is undisputed that that Policy here was not a single premium or paid-up policy.[1] The Policy was instead a universal "permanent life" insurance policy.[2]

The insured here passed away on October 6, 2018—with seven months remaining on the annual premium that was paid in May 2018. JA11, Compl. ¶ 18. Lincoln Life paid the Policy's death benefit, but did not refund the portion of the May 2018 annual premium paid for the months after the insured's death in October 2018. JA7-8, Compl. ¶¶ 1, 4. Lincoln Life's refusal stands in stark contrast to what other New York insurers do in similar circumstances. For example, in parallel circumstances, Athene Life Insurance Company of New York ("Athene

[1] Single premium and paid-up policies are akin to annuities; the insured essentially pays one (very large) lump sum amount at the outset, and in return, obtains a set amount of insurance on his life for the duration of the policy. *See generally* Note, *Combined Annuity and Single Premium Life Insurance Under the Estate Tax: Effect of Assigning the Insurance*, 62 Yale L.J. 822 (1953).

[2] *See Buck v. Am. Gen. Life Ins. Co.*, 2018 WL 5669173, at *1 (D.N.J. Oct. 31, 2018) ("Universal life insurance is a form of permanent life insurance . . . . This type of insurance is meant to give a policyholder coverage for her entire lifetime . . . .").

Life") promptly paid the balance of the annual planned premium owed under the statute for a universal life policy covering the same insured. JA9, Compl. ¶ 7.

Plaintiff sued Lincoln Life for breach of contract, seeking the prorated refund of his $53,877.72 annual premium. JA7. Plaintiff seeks to represent three classes of policyholders whose premium refunds were likewise withheld. Lincoln Life moved to dismiss the claim under Rule 12(b)(6). JA27.

The United States District Court for the Southern District of New York (Cronan, *J.*) granted Lincoln Life's motion and dismissed the Complaint with prejudice and without leave to amend, asserting that N.Y. Ins. Law § 3203(a)(2) did not apply to Plaintiff's annual premium payment as a matter of law and any proposed amendment would be futile. *See* JA325.; *Nitkewicz v. Lincoln Life & Annuity Co. of N.Y.*, 20-Civ-6805 (JPC), 2021 WL 2784551 (S.D.N.Y. July 2, 2021). Plaintiff now timely appeals the district court's judgment, seeking reversal.

SUMMARY OF ARGUMENT

New York requires insurers to "refund []any premium actually paid for any period beyond the end of the policy month in which [the insured's] death occurred." N.Y. Ins. Law § 3203(a)(2) (the "Statute"). Plaintiff paid his policy's annual "premium" of $53,877.72 on May 7, 2018, and the insured died on October 6, 2018. JA8, Compl. ¶ 4. Since the insured died within a year of payment of the $53,877.72 annual premium, the plain language of the Statute required Lincoln

Life to refund that portion of the $53,877.72 annual premium that was for the seven months after the insured died in October 2018. But Lincoln Life did not do so. That is a breach of contract. It violates Section 3203(a)(2). *See Terry v. UNUM Life Ins. Co. of Am.*, 394 F.3d 108, 110 (2d Cir. 2005) ("[W]here a policy provision is less favorable to the insured than the provision required by New York Insurance Law, the statutory provision controls.").

The district court admitted that Plaintiff's arguments "certainly appear compelling at first blush." JA335, Op. at 11. The court should have trusted its first instinct. This is not a complicated case.

"Interpretation begins with the text of the statute. If the text is unambiguous, [the court's] task is at an end unless the text produces a manifestly absurd result, an exceptionally rare occurrence." *In re Dubroff*, 119 F.3d 75, 76 (2d Cir. 1997). The text of the Statute says that (1) if a policyholder pays the premium for a year, but (2) the insured dies before the year is up, (3) the insurer must refund that portion of the premium that was for the period after the insured was dead. The Complaint indisputably alleges that here: (1) the policyholder paid an annual premium of $53,877.72 on May 7, 2018 (as he did), (2) the insured died on October 6, 2018 (as he did), and yet (3) the insurer did not refund that portion of the premium that was for after the insured died in October 2018 (as it didn't). That states a claim.

The district court's contrary conclusion mainly rests on its misunderstanding of the "practical reality" described in this paragraph:

> Some of Plaintiff's arguments certainly appear compelling at first blush. But a close reading of the statutory text and the Policy reveal that, for a universal life insurance policy crafted like the one at issue here, a Planned Premium simply is not paid for any specific "period." For instance, a Planned Premium can be less than or greater than the monthly cost of insurance. *See* Policy at 3 ("The Planned Premium may need to be increased to keep this policy and the coverage in force; payment of the Planned Premium may not prevent th[e] Policy from terminating."). A paid Planned Premium ***may not necessarily*** "prevent th[e] policy from terminating," and "[f]ailure to pay a Planned Premium will not, in itself, cause th[e] policy to terminate." *Id.* at 8. The Policy will only terminate if it enters the grace period, *i.e.*, if "the Cash Surrender Value is less than the monthly deduction due"—unless, as discussed above, the CPGR applies—and the Owner fails to cure in the manner required by the Policy. *Id.* at 8-9.
>
> None of Plaintiff's arguments otherwise are able to overcome this practical reality.

JA335-36, Op. at 11-12 (emphasis added).[3]

This analysis rests on three independent errors, each of which (at a minimum) raises factual issues that cannot be resolved on the pleadings. ***First***, while the phrase "specific period" is not found in the Statute, Plaintiff's annual premium was indeed paid for a specific period – a year. It is called an "ANNUAL" premium in all caps in the Policy. JA65.

[3] Unless otherwise indicated, all emphases are added.

PLANNED PREMIUM: $53,877.72 ANNUAL

Similarly, the application specifies an "Annual" premium mode:

23. Premium Mode: ☑ Annual ☐ Semi-Annual

24a. Modal Planned Premium: $ 53,878

JA100. The Policy describes the annual payment as the payment the policyholder "intend[s]" to pay every year,[4] and Plaintiff paid it every year. JA11, Compl. ¶ 18. The Policy also says the insurer will send out "Planned Premium payment reminder notices" when due – here, every year.[5] At the very least, it is a fact question whether in those circumstances, the annual premium is "paid for a specific period" – i.e., a year.

Second, the district court erred by inserting words into the Statute that are not there. The district court improperly held that Plaintiff's annual premium payment cannot count under the Statute because an annual payment "*may not necessarily*" be enough to keep the policy in force for a year (which is irrelevant and not true for this specific annual premium). But the Statute does not say – as the district court assumed – that a premium is refundable only if it is actually paid "for any period *of guaranteed coverage*." Rather, the Statute simply says that a

[4] *See* JA75 ("The Premium Frequency is how often You *intend* to pay the Planned Premium.").

[5] *See* JA75 ("We will send You Planned Premium payment reminder notices.").

premium is refundable if it is paid "for any period." Plaintiff's "annual" premium payment clearly meets that minimal statutory test: it was an "ANNUAL" payment, due after the insurer sent an annual "payment reminder notice," and the policyowner paid the billed annual premium exactly once each year.

Even if the district court were factually correct that this specific annual payment "*may not necessarily*" be enough to keep the Policy in force for a year (which is not true on these facts), that would not matter: it is still payment for a year of coverage, even if the payment did not necessarily guarantee a full year of coverage in the event something unexpected happened. By way of comparison, if a season ticket holder pays for a year's worth of ballet tickets, it is still payment "for a year" of tickets even if there is a clause saying that the season ticket holder may need to pay slightly more in the event something unexpected happens (like a famous guest star joining the cast or an extra show being added during the year), or slightly less (like the prima ballerina getting sick). The very first dictionary definition of the word "for" – which is used in both the statutory clauses at issue – is "[u]sed to indicate the object, aim, or purpose of an action." *See American Heritage Dictionary*, https://www.ahdictionary.com/word/search.html?q=for. Here, the purpose of the annual payment is to make that annual premium payment once per year over the life of the Policy – the Policy explicitly says that's the "intent." JA75. The words "guaranteed" and "coverage" do not appear in the

Statute, and nothing about the word "for" suggests that they should be read into the statute.

Third, even if the words "of guaranteed coverage" were improperly inserted into the Statute, Plaintiff would still easily state a claim. While it is true, as the district court observed, that an annual premium payment "***may*** not necessarily" be enough to keep a generic policy in force for a year in unusual circumstances, it is far more often the case and is indisputably the case here – that the planned premium ***was enough*** to ensure that the Policy would stay in force for a year.[6] Determining whether Plaintiff's 2018 annual premium payment was sufficient to ensure coverage for a year, or for some lesser period that is entitled to a refund, is a disputed factual question that cannot be resolved on the pleadings against the Plaintiff. Resolution of that issue requires discovery of, amongst other things, Lincoln Life's cost of insurance rates and conducting mathematical calculations that the district court did not even purport to conduct. Further, the planned annual premium was indisputably sufficient to keep Plaintiff's Policy in force in each of the preceding seven policy years, and so the plausible inference is that it was also sufficient to do the same through May 2019—resolution of which is a

[6] The Policy recognizes this reality by negative implication. As is factually true in this case, the planned premium often does **not** "need to be increased to keep … the coverage in force." *See* JA64 ("The planned premium **may** need to be increased to keep this Policy and the coverage in force.").

quintessential fact question that cannot be resolved on the pleadings adverse to Plaintiff. In elevating its own view of the "practical reality" above the plain text of the Statute and the Legislature's judgment, the district court misapplied these relevant pleading standards.

Further, under the Coverage Protection Guarantee Rider ("CPGR"), *see* JA87, the payment of the planned premium on this Policy satisfied the fact-specific CPGR test, and therefore the payment of the annual premium **guaranteed** that the Policy would stay in effect for the following year under the CPGR. So even under the strictest version of the district court's expanded statutory test, the premium payment was a payment "for a year" because it guaranteed coverage for a year under the CPGR test. The district court failed to grasp the import of the CPGR, dismissing its relevance in a short footnote, and improperly denied leave to amend to plead further facts on this issue. JA336, Op. at 12 n.4.[7]

STANDARD OF REVIEW

This Court "review[s] the grant of a motion to dismiss under Rule 12(b)(6) *de novo*, construing the complaint liberally, accepting all factual allegations in the complaint as true, and drawing all reasonable inferences in the plaintiffs favor."

[7] *See Oliver Sch., Inc. v. Foley*, 930 F.2d 248, 253 (2d Cir. 1991) ("Where the possibility exists that the defect can be cured and there is no prejudice to the defendant, leave to amend at least once should normally be granted as a matter of course.").

Elias v. Rolling Stone LLC, 872 F.3d 97, 104 (2d Cir. 2017) (emphasis in original) (internal quotation marks omitted). This Court similarly "review[s] *de novo* whether the district court correctly interpreted the statute." *Perry v. Dowling*, 95 F.3d 231, 235 (2d Cir. 1996) (emphasis in original).

ARGUMENT

I. The District Court Disregarded the Plain Meaning of the Policy and the Statute.

"To make out a viable claim for breach of contract a complaint need only allege (1) the existence of an agreement, (2) adequate performance of the contract by the plaintiff, (3) breach of contract by the defendant, and (4) damages." *Eternity Glob. Master Fund Ltd. v. Morgan Guar. Tr. Co. of N.Y.*, 375 F.3d 168, 177 (2d Cir. 2004) (citation omitted). The only element in dispute is breach, namely, whether Lincoln Life breached the Statute's refund requirement, which is incorporated into the Policy. *See Terry v. UNUM Life Ins. Co. of Am.*, 394 F.3d 108, 110 (2d Cir. 2005) ("[W]here a policy provision is less favorable to the insured than the provision required by New York Insurance Law, the statutory provision controls."). The court wrongly concluded that Lincoln Life did not.

"Interpretation begins with the text of the statute. If the text is unambiguous, [the court's] task is at an end unless the text produces a manifestly absurd result, an exceptionally rare occurrence." *In re Dubroff*, 119 F.3d 75, 76 (2d Cir. 1997). The Supreme Court has likewise instructed "time and again that courts must presume

that a legislature says in a statute what it means and means in a statute what it says there." *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-254 (1992). The Statute provides that for "[a]ll life insurance policies"—excluding two irrelevant types—"the insurer shall add to the policy proceeds a refund of any premium actually paid for any period beyond the end of the policy month in which [the insured's] death occurred." N.Y. Ins. Law § 3203(a)(2).

The upshot is that (1) if a policyholder "actually" pays the "premium" for a period, and (2) the insured dies before the period is up, then (3) the insurer must refund that portion of the premium that was for the period after the insured was dead. Here, the Complaint indisputably alleges (1) the policyholder actually paid an annual premium of $53,877.72 on May 7, 2018, (2) the insured died on October 6, 2018, and yet (3) the insurer did not refund the portion of the premium that was for after the insured died in October 2018. The Statute squarely applies to these facts. Indeed, another life insurance company, Athene Life, promptly complied with the Statute by refunding the pro-rated portion of the same Trust's "annual" premium for a flexible-premium policy in parallel circumstances. JA9, Compl. ¶ 7. The district court's opinion does not even mention this undisputed fact about industry practice that favors Plaintiff's interpretation of a similar "annual" premium payment provision. *See Int'l Multifoods Corp. v. Com. Union Ins. Co.*,

309 F.3d 76, 83 (2d Cir. 2002) (noting that industry "practices" are relevant to contract interpretation).

The district court began by correctly recognizing that Plaintiff's annual premium "was a 'premium'" under the Statute, and that Lincoln Life did not dispute this fact. JA333, Op. at 9. The court nonetheless erred by reasoning that this $53,877.72 annual premium was not "actually paid for any period." Instead, according to the court, only the Monthly Cost of Insurance charge deducted from the cash value of the Policy was potentially refundable under the Statute. *See* JA336, Op. at 12 ("It is still the monthly deductions that actually pay for the insurance"). The court's reasoning contradicts the plain language of both the Policy and the Statute.

A. The Policy's "Annual" "Premium" Was Paid for an Annual Period.

The district court overlooked provisions in the Policy which plainly state that Plaintiff's annual premium was paid for a specific period: one year. The Policy specifies an "ANNUAL" "PREMIUM" of $53,877.72.

INSURED:	JOAN C LUPE
POLICY NUMBER:	LJ7197774
FORM NUMBER:	UL 5049N
PLANNED PREMIUM:	$53,877.72 ANNUAL
MINIMUM SPECIFIED AMOUNT	$100,000

JA65. Similarly, the application for the Policy asked Plaintiff to indicate whether the premium would be "Annual," "Semi-Annual," "Quarterly," or "Monthly."

JA10, Compl. ¶ 15, JA100. As the district court recognized, Plaintiff expressly elected "Annual." JA331, Op. at 7. Further, the Policy describes the annual premium as the payment the policyholder "intend[s]" to pay every year,[8] and the Policy promises that Lincoln Life will send out "Planned Premium payment reminder notices" when due – here, every year.[9]

A reasonable insured would understand the Policy's specified "ANNUAL" premium to be paid for an "annual" period. "When interpreting terms in insurance policies, we are to construe the language at issue as would the ordinary [person] on the street or ordinary person when he [or she] purchases and pays for insurance . . . ." *First Invs. Corp. v. Liberty Mut. Ins. Co.*, 152 F.3d 162, 167 (2d Cir. 1998) (alterations in original and internal quotation marks omitted) (quoting *Michaels v. City of Buffalo*, 85 N.Y.2d 754, 757 (N.Y. 1995)). An ordinary person would assume that an "annual" premium is paid for an annual period.

The district court jumped through hoops to avoid these simple conclusions, suggesting that "annual" merely refers to "the anticipated recurrence of payment," as opposed to a "specific period of coverage." JA339, Op. at 15. This is a distinction without a difference. There is no meaningful difference between (a) a

[8] *See* JA75 ("The Premium Frequency is how often You *intend* to pay the Planned Premium.").

[9] *See* JA75 ("We will send You Planned Premium payment reminder notices.").

premium payment that is due and paid once per year over the life of the Policy, and (b) a premium payment that is paid for a year. The Policy states that the annual premium is the amount the insured intends to pay every year, and that Lincoln Life will send "payment reminder notices" each year before the payments are due. By Policy design, the policyholder was supposed to pay the annual premium once per year over the life of the policy. In other words, each annual payment was designed to cover the next year's worth of insurance, until the next annual payment became due. Had Plaintiff elected quarterly payments, the amount would have been $13,469.43 ($53,877.72 divided by four) and been for a period of three months. Had Plaintiff elected monthly payments, the amount would have been $4,489.81 ($53,877.72 divided by twelve) and been for a period of one month. The district court's conclusion, as a matter of law, that the period of coverage is automatically and necessarily divorced from the timing of payments is contrary to both (a) how a policyholder would understand the policy terms "according to common speech and consistent with the reasonable expectation of the average insured", *Dean v. Tower Ins. Co. of New York*, 19 N.Y.3d 704, 708 (N.Y. 2012), and (b) the Statute's reference to "a period for which the premium has been paid."

If there were any doubt about whether the Policy's inclusion of the words "ANNUAL" premium, and similar provisions, connotes that the payment was "for" a year, that must be resolved in favor of the insured. *See Westview Assocs. v.*

Guar. Nat'l Ins. Co., 95 N.Y.2d 334, 340 (N.Y. 2000) ("[I]f the language of the policy is doubtful or uncertain in its meaning, any ambiguity must be resolved in favor of the insured and against the insurer.").

B. The District Court Erred in Its Interpretation of the "For Any Period" Statutory Language.

The district court also erred by inserting words into the Statute that are not there, effectively holding that a refund is required only if a premium is "for any period" . . . *of coverage guaranteed by the premium payment*. The italicized words are found nowhere in the Statute. And they are critical to the district court's holding: the court said that annual premiums don't fall within the meaning of the Statute, as a matter of law, because an annual premium payment "**may not necessarily** prevent" the policy from lapsing. JA335, Op. at 11. That contention only makes sense if the Statute *requires* that the premium payment "necessarily prevent" the Policy from lapsing.

But there is zero statutory support for inserting those words into the Statute. Rather, the Statute simply says that a premium that is "actually paid for any period" beyond the death of the insured must be refunded – like the annual premium payment here. The Court improperly read the words "guaranteed coverage" into the statute.

Similarly, on the other side of the coin, the district court appears to have been concerned with the fact that an annual premium payment may be *more* than

what is *required* to cover the insurance charges. *See* JA335, Op. at 11 (noting that the premium "can be . . . greater than the monthly cost of insurance"). Again, that question is not relevant under the statutory text, but even if it were, it would simply go to the amount of damages owed, not to whether a breach has been pled. For example, on the merits and after discovery is concluded, a defendant might argue that damages could be limited to the balance of the portion of the annual premium that actually covers the insurance charges for a year (or less), rather than the balance of the entire annual premium amount (if the latter is proven to be greater than the former).

"'Every exercise in statutory construction must begin with the words of the text,'" and "the language of the statute cannot be simply brushed aside." *Gibbons v. Bristol-Myers Squibb Co.*, 919 F.3d 699, 705-06 (2d Cir. 2019) (quoting *Saks v. Franklin Covey Co.*, 316 F.3d 337, 345 (2d Cir. 2003)). The Supreme Court has similarly instructed that "respect for [the Legislature's] prerogatives as policymaker means carefully attending to the words it chose rather than replacing them with others of our own." *Murphy v. Smith*, 138 S. Ct. 784, 788 (2018). By contrast, here, the district court "simply brushed aside" the Legislature's decision to not limit the Statute to premiums that guarantee coverage, *Gibbons*, 919 F.3d at 706, and replaced the Legislature's wording "with others of [its] own," *Murphy*, 138 S. Ct. at 788.

Using the plain meaning of the words in the Statute, the annual "planned premiums" were clearly "for" a period of one year. The very first dictionary definition of the word "for" – which is used in both the statutory clauses at issue – is "[u]sed to indicate the object, aim, or purpose of an action." *See American Heritage Dictionary*, https://www.ahdictionary.com/word/search.html?q=for. The aim of the annual premium was to pay it once per year – the contract says that – until the next payment became due. Whether there might be scenarios in which that premium would be insufficient to guarantee coverage for an entire year is simply irrelevant under the plain language of the Statute. Indeed, there is not a single dictionary definition of the word "for" that supports the district court's conclusion that a "period for which the premium has been paid" means "period for which coverage is guaranteed."

The district court also failed to grapple with how "actually paid" undermines its interpretation of "for any period." The court initially (and correctly) admitted that the phrase "actually paid" supports Plaintiff. *See* JA341, Op. at 17 ("Admittedly, the phrase 'actually paid,' in the abstract, might not be enough to make clear that Planned Premiums are not covered by this provision."). Yet the court went on to read the phrase right out of the Statute. *United States v. Kozeny*, 541 F.3d 166, 168 (2d Cir. 2008), which the district court cited, JA341, Op. at 17, illustrates the problem with the district court's analysis. In *Kozeny*, this Court

explained that "[w]e will not adopt a statutory interpretation that would render superfluous" a neighboring provision. *Id.* at 174. Yet here, the district court's interpretation of "for any period" makes "actually paid" superfluous. If only monthly deductions could be paid for any period, there would be no need to write "actually paid" into the Statute. Unlike premiums, which can be due but not actually paid, monthly deductions are automatically taken from the policy value *by the insurer*. *See* JA327, Op. at 3 ("Lincoln NY deducts money from the Policy Account to pay for the insurance coverage. This is referred to as the 'monthly deduction.'" (citations omitted)).

The practical consequence of the district court's ruling is to do what New York's Legislature *decided not to do*: exempt flexible-premium universal life policies from the scope of the Statute. Under the district court's reasoning, the Statute could never apply to flexible-premium policies because, according to the district court, such premiums – even annual premiums – are never "actually paid for the period" because they are flexible. But the Legislature clearly understood how to exempt specific types of life insurance policies from the scope of the Statute where a premium refund would be illogical or impractical. N.Y. Ins. Law § 3203(a)(2) ("This paragraph shall not apply to single premium or paid-up policies."). The Legislature made no such exemption for flexible-premium policies.

And there is no question that the Legislature understood the nuances specific to flexible-premium life insurance: in the Statute's immediately preceding subsection, the Legislature singled out "policies in which the amount and frequency of premiums may vary" for a longer grace period, N.Y. Ins. Law § 3203(a)(1). In determining that Plaintiff's reading of the Statute, despite appearing "compelling at first blush," should be disregarded because of the district court's own view of "practical reality," the district court did nothing more than substitute its own judgment for that of the Legislature's. JA335-36, Op. at 11-12. This was error. Again, the district court "simply brushed aside" the Legislature's decision to apply the refund requirement to flexible-premium policies. *Gibbons*, 919 F.3d at 706.

The district court's interpretation of the Statute to effectively exempt flexible-premium policies from its reach not only conflicts with the statutory text (and its two express exclusions), but would also impute arbitrary and irrational intentions to the Legislature. Under the district court's reasoning, the buyer of a term policy who paid (for example) an annual premium of $12,000 a year, but died 32 days after the policy was purchased, would be entitled to the policy proceeds plus a refund of the $10,000 for the ten months remaining on the annual premium. By contrast, the buyer of an otherwise identical flexible-premium policy who did the exact same thing – paid an initial annual premium of $12,000 for a year but

died 32 days after buying the policy, would be entitled to *only* the policy proceeds, with no refund at all.

The cash value of Plaintiff's Policy is indisputably forfeited upon the insured's death, and only the face value of the Policy is paid out (also called the death benefit). JA340. Thus, in the example, were the respective term and flexible-premium policies to each have a face value of $100,000, the term policyholder would recover $110,000, but the flexible-premium policy holder only $100,000. There is zero indication that the Legislature intended such a bizarre and irrational disparate treatment of term and flexible-premium policies, particularly given its decision not to include flexible-premium policies from the list of policies exempted from the Statute's "Return the $10,000" reach.

The same is true for a policyholder who purchased a term policy with an annual premium of $12,000 and who died (as here) five months later – or who purchased a term policy with the same $12,000 annual premium, paid it (as here) for seven straight years, and then (as here) died five months into his final year. It is undisputed that the term policyholder would get a refund of $7,000 in each of these situations, and yet the district court insists that an identically situated flexible-premium policyholder would get no refund at all. The policies have the same face value. The policies cost the same every year. Yet, according to the district court, one is exempt from the Statute, and the other is not. That is an

absurd result, and there is no reason whatsoever why the Legislature – which exempted only single-premium and paid-up policies from the Statute's reach – would have intended it. And there is zero indication the Statute calls for that result.

The district court also seems to have been led astray by the fact that the permanent life policy at issue here was ostensibly paid for by the cash value of the policy and would purportedly be cancelled only if that cash value was insufficient to cover the monthly cost-of-insurance charge. *See* JA336, Op. at 12 (reasoning that "[i]t is still the monthly deductions that actually pay for the insurance"). But the cash value of the policy came directly from the $53,877.72 annual premiums paid by the insured. This makes sense; where else, after all, could it possibly come from? The policyholder paid an annual $53,877.72 annual premium, the vast majority of which was added to the cash value of the Policy, and then that cash value was reduced every month to pay for the insurance. Not only was the $53,877.72 the premium, and actually paid, but it also paid for the insurance.

It is a distinction without a difference that the annual premium was first turned into a "cash value" and then that latter item used to pay the cost of the insurance. Imagine a term policy in which the insured paid an annual premium of $12,000, the insurer placed that money in the bank, and the insurer then deducted $1,000 a month from that $12,000 premium as the cost of insurance. There is no

question whatsoever that an insured who died five months after paying the premium would be entitled under the Statute to a refund of $7,000. Similarly, it would be of no moment were the insured to pay an annual premium of $12,000, the insurer then used that money to buy twelve different $1000 certificates of deposit (or twelve gold bars, or whatever), and then every month used one of the CDs (or gold bars) to pay for the insurance. The insured who died seven months later would be entitled under the Statute to a refund of the seven remaining months. That the policy might have created an intermediate step in the payment of the costs of insurance would be of absolutely no moment.

So too here. The insured actually paid a premium of $53,877.72 every single year. That premium was, in fact, enough to pay for the cost of insurance (and it wouldn't even matter if it wasn't), and every month, Lincoln Life deducted from that premium – which had been added to the cash value of the Policy – the cost of insurance. Yes, the cash value of the Policy was forfeited upon the insured's death; so, for example, the previous seven years of premium payments were gone, just as the exact same result would be true for the buyer of a term insurance policy who had paid seven prior years of annual premiums. But both the term and permanent-life policyholder are equally entitled under the Statute to a return of the seven months remaining after the insured's death. That the insurer might, with either policy, only deduct those expenses every month (e.g., the

$1,000/month), or deduct them with an intermediate step (cash value or gold bars), is irrelevant. The text, plain meaning, and purpose of the Statute situate both insureds identically. As the Complaint here properly pleads, a partial refund is due to both.

II. Even Under the District Court's (Erroneous) Interpretation of the Statute, Reversal Is Warranted Because of Disputed Fact Questions and Because of the Coverage Protection Guarantee Rider.

Even if the Statute were somehow interpreted to require a refund only for premium payments that *guaranteed coverage* for a specific period (words nowhere found in the Statute), the district court still erred in granting the motion to dismiss for three independent reasons.

First, the district court ignored the significance of the Coverage Protection Guarantee Rider ("CPGR"). The Coverage Protective Guarantee Rider is what it sounds like: a *guarantee* of *coverage*. As a factual matter (which is inapropriate to resolve against the pleader on a motion to dismiss), the CPGR and annual premiums were set up in a way for this Policy to ensure that coverage would remain in effect so long as Plaintiff timely paid his annual planned premium, thus transforming his premiums into payments that guaranteed and extended coverage for a full year. If necessary, in an amended complaint that the district court improperly denied leave to file, Plaintiff would allege that the Annual Statement sent each year explicitly states that if the "Planned Premiums" are timely "Paid"

each year on this Policy, then this Policy is projected to continue "to death of the insured," even on a "Guaranteed" basis (i.e., no matter whether the interest, Administrative Charges and Cost of Insurance rates change). The CPGR's upshot is that Plaintiff's premium payment passes muster even under the district court's (incorrect) view that payments are only "for any period" insofar as they guarantee coverage for that period. The district court erred by declining to permit Plaintiffs to amend to elaborate on this issue, which Plaintiffs requested leave to do. JA285, 299. "Where the possibility exists that the defect can be cured and there is no prejudice to the defendant, leave to amend at least once should normally be granted as a matter of course." *Oliver Sch., Inc. v. Foley*, 930 F.2d 248, 253 (2d Cir. 1991); *see also Goney v. SuttonPark Capital LLC*, 2021 WL 5071867, at *2 (2d Cir. Nov. 2, 2021) ("hold[ing] that the district court erred in denying the [plaintiffs] leave to amend their complaint").

The Policy explains how the CPGR works. JA87. The CPGR references an "alternate" policy value made up of premium payments less monthly deductions. *Id.* These monthly deductions, unlike the monthly cost-of-insurance deductions applied to the Policy's actual account value, are based on fixed charges and interest rates that are guaranteed not to increase up to the specified death benefit. *See* JA89 ("The cost of insurance rates and the interest rates described in the Coverage Protection Guarantee Provisions are fixed and guaranteed for the Initial Specified

Amount and are not subject to change."). The CPGR remains in effect provided that this alternate account value remains above zero. JA87. Electing the CPGR "can ensure that Your coverage will continue even if the Cash Surrender Values are insufficient to cover the monthly deductions." *Id.* Most importantly, the "initial planned premim" can be designed to "satisfy the Coverage Protection Gurantee Test"—i.e., ensure that the alternate CPGR value remains above zero and that the Policy never enters the grace period. *Id.* That's exactly what happened here as a factual matter: payment of the annual premium ensured that the Policy would remain in force for the following year.

The district court misunderstood the CPGR. In a footnote, the court rejected Plaintiff's reliance on the CPGR because the CPGR "is simply not a premium paid 'for any period' of coverage." JA336, Op. at 12 n.4. But the district court elsewhere reasoned that a planned premium is not paid for any period precisely because "payment of the Planned Premium may not prevent th[e] Policy from terminating." JA335, Op. at 11 (alteration in original and internal quotation marks omitted). In the present case, however, due to the CPGR, payment of the Planned Premium did *indeed* "prevent th[e] Policy from terminating." Reversal is therefore warranted even under the district court's (erroneous) standard for whether something is paid "for any period."

Second, determining whether Plaintiff's 2018 annual premium payment was sufficient to ensure coverage for a year, or for some lesser period that is entitled to a refund, is a disputed factual question that cannot be resolved on the pleadings against the Plaintiff. As noted, in every preceding policy year, the annual premium payment paid by Plaintiff was sufficient to provide coverage for at least a year. And it is therefore plausible to infer that the 2018 premium payment was likewise sufficient to provide coverage for at least a year, even on a "Guaranteed" basis.[10] Instead of allowing those facts to be developed in discovery, the district court relied on the theoretical possibility that an annual premium might not be sufficient to secure coverage for a full year. This was error. *See State Emps. Bargaining Agent Coal. v. Rowland*, 494 F.3d 71, 91 (2d Cir. 2007) (affirming denial of a motion to dismiss in light of "a disputed question of fact that must be resolved after discovery"). Those are factual and damages questions that cannot be resolved adverse to the Plaintiff on the pleadings.

Third, the court declined to draw a (more than) reasonable inference that the paid premium payments were revenue to Lincoln Life and thus paid for the insurance it provided. Plaintiff's opposition brief pointed out that Lincoln Life

[10] Once again, if necessary, more facts would be pled in an amended complaint to support this. The Annual Statement sent by Lincoln Life explicitly states that the Policy would continue in force through the end of the policy year without any further premium payments, even on a guaranteed basis.

claims to use premiums to offset the death benefits paid to policyholders. JA289 (citing JA49). In response, the district court acknowledged that Lincoln Life "may be able to benefit from the Planned Premium," but somehow determined that this "does not mean these funds 'actually pay' for any period of insurance." JA342, Op. at 18. But, at a minimum, this too is a disputed issue of fact, and it cannot resolved adverse to Plaintiff as a matter of law at the pleading stage.

III. The District Court Erred In Concluding that the 15% Load Charge Applied to the Annual Premium Does Not Pay for Insurance.

The district court also erred by dismissing the relevance of the 15% load charge that Lincoln Life skims off the top of all premium payments (here, $8,081.66). The load charge taken annually from the annual payments confirms that the annual payments were for a year of insurance. The Policy expressly explains that this load charge is "applied to **cover the company's cost of insurance** and other expenses." JA62.

> Monthly Cost of Insurance and Administrative Charges: These charges are assessed against your Policy Value **or in the case of a net premium factor** assessed against the premium before it is applied to the Policy value. **These charges are applied to cover the company's cost of insurance** and other expenses. These charges will be detailed in Your annual Statement of Account.

JA62.[11] This load charge, which is deducted once per year directly from the annual premium, contradicts the court's conclusion that only "the monthly deductions . . . actually pay for the insurance." JA336, Op. at 12. Rather, as common sense dictates, the insurance is paid for not only by the monthly cost of insurance charge, but instead by *all* of the charges annually imposed by the insured, including but not limited to the "Annual" "Premium" and the 15% load that Lincoln Life charges on this amount.

Rather than apply the plain meaning of the load charge provisions, the district court somehow found that the "more natural reading" of the load charge is that it does not cover insurance, but rather only covers "other expenses." JA336, Op. at 12. But the Policy text expressly says otherwise, and if it's deemed ambiguous, that must be resolved in favor of the Plaintiff, especially on a motion to dismiss. The relevant policy provision refers to "monthly cost of insurance and administrative charges" and explains that "[t]hese charges" "cover the company's cost of insurance *and other expenses*." JA62. The term "and" is a coordinating conjunction that does not allow the district court to ignore the "company's cost of insurance" clause. At a minimum, discovery is necessary to sort out whether the various charges, including but not limited to the 15% load charge on the annual

[11] *See also* JA65 (defining the "guaranteed net premium factor" as 85% of premium paid).

premium, covers Lincoln Life's cost of insurance, as opposed to some other (unstated and unallocated) service that Lincoln Life provides.

The district court further erred by assuming that even if the load charge covers Lincoln Life's cost of insurance in some way, "there is nothing to indicate that the load charge covers any specific period of coverage." JA336, Op. at 12. Surely it is plausible to conclude that the $8,081.66 load charge must have covered some period; moreover, since it was charged once a year, every year on the $53,877.72 annual premium, it is hardly implausible that it in fact covered a year. Nothing in the Policy suggests that the $8,081.66 load charged by Lincoln Life every year only covered one month; indeed, that would be exorbitant. Yet the district court assumed without any discovery that no portion of the charge was paid for the period after the insured's death. At worst, even if "and" somehow means "or," the motion should have been denied so the parties can "resolve the issue in discovery or, if necessary, before a trier of fact." *Eternity Global Master Fund Ltd.*, 375 F.3d at 186.

IV. The District Court's Parade of Horribles Is Misguided and Does Not Support Dismissal.

The district court suggested that "myriad issues . . . would result from interpreting a Planned Premium as being 'for' a specific period." JA336, Op. at 12. The court did not describe "myriad" examples, and instead ignored the *real world* example of Athene Life paying the refund in parallel circumstances. The

district court discussed just two examples. Both of these examples assumed facts not alleged in the Complaint, and both of them were also irrelevant to the Policy at issue here.

First, the court was concerned about how to account for "an unplanned deposit into the Policy Account," as opposed to a scheduled "annual" premium, wondering whether the former should "also be interpreted to cover some period of time." JA337, Op. at 13. But that question is divorced from the facts of this case and irrelevant to the decision here. The Complaint alleges that Plaintiff timely paid the scheduled "annual" premium every year, including on May 7, 2018. JA8,11, Compl. ¶¶ 4, 18. The Complaint does not demand a refund to Plaintiff of any "unplanned" premium payments, nor does a Court ruling on motion to dismiss need to decide how that refund should be calculated.

The court's analysis of the hypothetical was also misguided. There are plenty of "logical clues" to assess scenarios and payments that may not be as straightforward as the facts alleged here. JA337, Op. at 13. The most logical approach is to compare a policy's specified annual premium with the actual payment – for example, payment of half the annual payment amount is payment for half a year. In any event, that other scenarios may prove more difficult to resolve provides no basis to dismiss Plaintiff's claim. *See, e.g.*, *Eternity Global Master Fund Ltd.*, 375 F.3d at 178 (citation omitted) ("[A] contract may be

ambiguous when applied to one set of facts but not another; if a contract is ambiguous as applied to a particular set of facts, a court has insufficient data to dismiss a complaint for failure to state a claim.").

Second, the district court's concern about an alleged "irreconcilable tension" between Plaintiff's argument and another part of the Statute is equally misguided. JA337, Op. at 13. This other statutory provision states: "if the death of the insured occurs within the grace period provided in the policy, the insurer may deduct from the policy proceeds the portion of any unpaid premium applicable to the period ending with the last day of the policy month in which such death occurred." The court worried that crediting Plaintiff's interpretation of the refund requirement would allow insurance companies, under this other provision, to deduct an unpaid planned premium from policy proceeds, thus transforming an "optional statement[] of intent" into a "binding promise." JA338, Op. at 14. But this other provision only applies when "the death of the insured occurs within the grace period," and it turns on the special rules governing the payment of premiums during the grace period, which has no application to the facts here since this Policy was not in a grace period.

More fundamentally, the district court erred by assuming that this other provision is also incorporated into the Policy. Not so. The statutory requirement controls only "where a policy provision is less favorable to the insured than the

provision required by New York Insurance Law." *Terry*, 394 F.3d at 110. Here, vis-à-vis the Statute's grace-period deduction provision, as interpreted by the court, the Policy is more favorable because, according to the court, the Policy precludes Lincoln Life from deducting an unpaid planned premium from the proceeds. There was nothing for the court to worry about.

Finally, the district court's brief discussion of the Option I death benefit is misguided. *See* JA340, Op. at 16. To be sure, "Plaintiff here could have elected the Option II benefit, pursuant to which Lincoln NY would have paid out both the Policy Account [value] and the Specified Amount." *Id.*; *see also* JA77 (listing the two death benefit options). Plaintiff instead chose the Option I benefit, which only paid out a specified death benefit. But to apply the Statute here would not, as the district court suggested, "invalidate Plaintiff's election." JA340, Op. at 16. The prorated refund that Plaintiff seeks is not equivalent to the Option II death benefit. Option II pays out the full Policy value on top of the specified amount, which is *far greater* than a prorated portion of one annual premium.

In any event, "where a policy provision is less favorable to the insured than the provision required by New York Insurance Law, the statutory provision controls." *Terry*, 394 F.3d at 110. The district court's logic reads this rule out of the Statute. An insurer could always argue that the insured made an "election" under a policy, and that it would be inappropriate for the court to "invalidate" that

election by honoring the more favorable statutory provision. But New York law says otherwise. Plaintiff's selection of the Option I death benefit accordingly provides no grounds for dismissal.

CONCLUSION

For the foregoing reasons, this Court should reverse the district court's July 2, 2021 judgment dismissing the Complaint, and the case should proceed to discovery.

In the alternative, this Court should vacate the district court's July 2, 2021 judgment dismissing the Complaint with prejudice and denying leave to amend the Complaint, so that Plaintiff may be granted leave to file a first amended complaint.

Dated: November 10, 2021

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CERTIFICATE OF COMPLIANCE

1. This brief complies with Local Rule 32.1(a)(4), including because this brief contains 7,943 words, excluding the parts of the document exempted by Fed. R. App. 32(f).

2. This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the typestyle requirements of Federal Rule of Appellate Procedure 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Office Word in Times New Roman 14-point font.

/s/ Seth Ard
Seth Ard

CERTIFICATE OF SERVICE

I hereby certify that on November 10, 2021, I caused the foregoing Brief for Plaintiff-Appellant to be filed with the Clerk using the appellate CM/ECF system. All counsel of record are registered CM/ECF users, and service will be accomplished by the CM/ECF system.

/s/ Seth Ard
Seth Ard

SPECIAL APPENDIX

TABLE OF CONTENTS

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

ANDREW NITKEWICZ, AS TRUSTEE OF THE JOAN C. LUPE FAMILY TRUST, *on behalf of himself and all others similarly situated*, Plaintiff, -v- LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK, Defendant.	20 Civ. 6805 (JPC) OPINION AND ORDER

JOHN P. CRONAN, United States District Judge:

Plaintiff Andrew Nitkewicz as successor trustee of the Joan C. Lupe Family Trust, on behalf of himself and all others similarly situated, brings this putative class action for breach of contract arising from a universal life insurance policy (the "Policy") issued by Defendant Lincoln Life & Annuity Company of New York ("Lincoln NY"). Plaintiff paid a "Planned Premium" on May 7, 2018, which, pursuant to the Policy, largely went into an interest-bearing account associated with the Policy. Monthly deductions were made from that account to cover the cost of insurance and administrative charges. Plaintiff argues that New York law requires Lincoln NY to refund a portion of that Planned Premium to cover a period that followed the insured's death on October 6, 2018.

Lincoln NY has moved to dismiss under Rule 12(b)(6) of the Federal Rules of Civil Procedure. Because the Court concludes that the Planned Premium was not "actually paid for any period beyond the end of the policy month" of the insured's death, N.Y. Ins. Law § 3203(a)(2), the Court grants Lincoln NY's motion to dismiss.

I. Background

A. Facts

The following facts, which are assumed true for purposes of this motion, are taken from the Complaint and from the Policy, which is integral to the Complaint. *See Chambers v. Time Warner, Inc.*, 282 F.3d 147, 152 (2d Cir. 2002) (noting that at the motion to dismiss stage, a court may consider "any written instrument attached to [the complaint] as an exhibit or any statements or documents incorporated in it by reference" as well as any documents "integral" to the complaint, *i.e.*, "where the complaint 'relies heavily upon [the document's] terms and effect'" (quoting *Int'l Audiotext Network, Inc. v. Am. Tel. & Tel. Co.*, 62 F.3d 69, 72 (2d Cir. 1995))); *Pastor v. Woodmere Fire Dist.*, No. 16 Civ. 892 (ADS), 2016 WL 6603189, at *4 (E.D.N.Y. Nov. 7, 2016) ("[C]ourts within this Circuit routinely consider copies of relevant policy documents in connection with insurance disputes."); *see also* Dkt. 26 at 1 (Plaintiffs agreeing that the Court may consider the Policy at this stage).

On April 4, 2011 (the "Policy Date"), Lincoln NY issued a Flexible Premium Adjustable Life Insurance Policy, Dkt. 23, Exh. A ("Policy"), to the Joan C. Lupe Family Trust to insure the life of Joan C. Lupe. Compl. ¶¶ 4, 9.[1] A Flexible Premium Adjustable Life Insurance Policy is Lincoln NY's "generic name for universal life insurance." Policy at 2. There are two main facets of the Policy: insurance coverage and an interest-bearing account with cash value (the "Policy Account" or the "Policy Value"). Policy at 2-5, 7-15; *see* Dkt. 22 ("Motion to Dismiss") at 1.

The Policy allows the Policy owner (the "Owner") to pay flexible premiums. *See* Policy at 2 ("'Flexible premium' means that You may pay premiums by any method agreeable with Us,

[1] Plaintiff Andrew Nitkewicz is the current trustee of the Trust. Compl. ¶ 9. Another individual, Robert Wakeman, appears to have been the trustee at the time of Ms. Lupe's death. *See id.*

at any time prior to the Insured's Attained Age 121 and in any amount subject to certain limitations. 'Adjustable life insurance' means that You, with Our agreement, can change the death benefit to meet Your changing needs."). This includes a so-called "Planned Premium." "The Planned Premium is the amount of premium [the Owner] intend[s] to pay." *Id.* at 8. The "Premium Frequency," in turn, "is how often [the Owner] intend[s] to pay the Planned Premium." *Id.* "Payment of the Planned Premium is [the Owner's] option," with both the amount and the timing of any Planned Premium largely left to the discretion of the insured. *Id.*; *see also id.* at 5.

When the Owner pays Lincoln NY a premium, including a Planned Premium, Lincoln NY deposits the net premium into the Policy Account. Policy at 2, 4, 11-14. The net premium is based on the "Guaranteed Net Premium Factor" stated in the Policy, which is "assessed against a premium before it is applied" to the Policy Account. *See id.* at 2. The Policy lists net premium factors as part of "Monthly Cost of Insurance and Administrative Charges," which are "applied to cover the company's cost of insurance and other expenses." *Id.* Here, the Guaranteed Net Premium Factor was 85% of the premium paid. *Id.* at 4. Thus, for example, if a policy owner paid a premium of $100, $85 would go to the Policy Account and Lincoln NY would retain $15.

The Policy Account then earns interest, *id.* at 2, 11, and the Owner can also take out a loan against that account, *id.* at 14. The Owner can access the money in the Policy Account by partially or totally surrendering the Policy. *See id.* at 12; *see also id.* at 5, 11.

On the Monthly Anniversary Day, which corresponds to "the same day in each month as the Policy Date," *id.* at 5, Lincoln NY deducts money from the Policy Account to pay for the insurance coverage, *id.* at 9, 11-12. This is referred to as the "monthly deduction." *Id.* at 11. Because here the Policy Date was April 4, 2011, these deductions occurred on the fourth of each month. There are two parts to the monthly deduction: (1) the "cost of insurance" ("COI") charge

and (2) "administrative charges." *Id*. at 11. The COI charge is directly proportional to the "net amount at risk" for Lincoln NY, which, in simple terms, is based on the potential payout at the time of the insured's death. *Id.* at 11-12 ("The net amount at risk for the Policy Value calculation is computed as (1) minus (2) where: (1) is the death benefit for the month before reduction for any Debt, discounted to the beginning of the month at the guaranteed interest rate[, and] (2) is the Policy Value at the beginning of the month after subtracting all parts of the monthly deduction other than the cost of insurance.").

If there is insufficient money in the Policy Account on the Monthly Anniversary Day to cover that month's deduction, the Policy enters a grace period. *Id.* at 9 ("If on a Monthly Anniversary Day the Cash Surrender Value is less than the monthly deduction due, Your policy will enter the grace period."); *see also id.* at 5 (defining the Cash Surrender Value as the "Cash Value," *i.e.*, "[t]he Policy Value as of the date of surrender less the charge, if any, for full surrender," minus any "Debt," *i.e.*, "[t]he principal of a policy loan together with interest due"). The Policy may then lapse if the Owner does not pay "the minimum amount needed to continue th[e] policy" within sixty-one days. *Id.* at 9. "If the amount specified is not paid within the grace period, th[e] policy will terminate without value at the end of such period." *Id.* The insured may, within five years of the date of termination, make an application to reinstate the Policy, which includes "pay[ing] an amount that results in a Cash Surrender Value on the date of reinstatement that is sufficient to keep th[e] policy in force for at least two (2) months." *Id.*

The Policy also allows for the Owner to select an optional Coverage Protection Guarantee Rider ("CPGR") add-on.[2] If the Owner opts into the CPGR add-on, the Coverage Protection Guarantee premium is taken from the Policy Account each month as part of the monthly deduction.

[2] The CPGR is located at the end of the Policy. Dkt. 23, Exh. A at 29-33 ("CPGR").

Id. at 2 ("We deduct the cost of providing the coverage (the cost of insurance) plus the cost of any additional benefits and/or riders and administrative charges from th[e Policy Value] each month as a 'monthly deduction.'"). Lincoln NY applies the Coverage Protection Guarantee Net Premium Factor to any such deductions, and allocates the net premium remaining to specified Coverage Protection Accounts. *Id.* The Coverage Protection Guarantee Net Premium Factor is similar to the 85% guaranteed net premium factor discussed above, except that it varies depending on the Policy Year during which the premium is paid. *Id.* at 4.

The CPGR is designed to "ensure that [the Owner's] coverage will continue even if the Cash Surrender Values are insufficient to cover the monthly deductions." CPGR at 1. The Policy explains how this works:

> The guarantee references an "alternate" value (Coverage Protection Value) calculated by utilizing monthly deduction charges and credited interest rates. All charges and interest rates used in the Coverage Protection Value calculation are fixed and are guaranteed not to increase or decrease for the Initial Specified Amount. You will be notified of any increase in Coverage Protection Guarantee charges due to an increase in Specified Amount. The Coverage Protection Value is not used in determining the actual Policy Value, it is simply a reference value used to determine whether the Coverage Protection Guarantee is in effect.

Id. Specifically, the CPGR establishes the Coverage Protection Guarantee Test (the "CPG Test"), which creates a "reference value." *Id.* The CPG Test is satisfied when the reference value is positive; this occurs when the amount in the Coverage Protection Accounts equals or exceeds Debt. *Id.*; Policy at 5 (defining "Debt" as "[t]he principal of a policy loan together with interest due"). When the CPG Test is satisfied, a policy does not enter the grace period, even if the funds in the Policy Account are insufficient to cover the monthly deduction. CPGR at 4. In other words, "[t]he addition of the Coverage Protection Guarantee Rider to the policy provides that the policy and all riders will continue in force as long as either the Cash Surrender Value is sufficient to cover the monthly deduction or the total of the Coverage Protection Accounts equals or exceeds Debt." *Id.*

"If neither amount is sufficient and no additional premiums are paid, the policy will terminate according to the Grace Period Provision." *Id.* Here, Plaintiff opted for the CPGR add-on. *See* Policy at 4; Dkt. 25 ("Opposition") at 4.

The Policy provides for two death benefit options. Under Option I, the Policy will pay out, upon the insured's death, either the "Specified Amount" that the Owner has selected or, if higher, the value of the Policy Account multiplied by a factor under an Internal Revenue Code schedule.[3] Policy at 9-10; *see also* Motion to Dismiss at 5. By electing this option, the insured generally pays lower monthly COI deductions because the value of the Policy Account reduces the net amount at risk. *See* Policy at 11 ("The cost of insurance is determined on a monthly basis as the cost of insurance rate for the month multiplied by the net amount at risk for the month."); *id.* (defining the net amount at risk as (1) "the death benefit for the month before reduction for any Debt, discounted to the beginning of the month at the guaranteed interest rate," minus (2) "the Policy Value at the beginning of the month after subtracting all parts of the monthly deduction other than the cost of insurance"); *see also* Opposition at 5. In contrast, under Option II, Lincoln NY pays out both the Policy Account and the Specified Amount upon the insured's death. Policy at 10. Under this option, higher monthly COI charges are therefore deducted from the Policy Account. *See id.* at 11; *see also* Motion to Dismiss at 6. Any death benefit is reduced by any Debt as of the date of death. Policy at 10.

[3] This factor, termed the "Corridor Factor," is relevant to ensuring that the Policy meets the Internal Revenue Code's requirements for a "life insurance contract" and that the death benefit qualifies for the Federal Income Tax exclusion. *See* Policy at 10; 26 U.S.C. § 7702; *see also Webber v. Comm'r*, 144 T.C. 324, 371 (2015) ("Under section 7702(a), a policy will be treated as a 'life insurance contract' only if it satisfies either the 'cash value accumulation' test or both the 'guideline premium' test and the 'cash value corridor' test. These tests require complex calculations involving the relationships among premium levels, mortality charges, interest rates, death benefits, and other factors.").

Here, Plaintiff elected the Option I benefit. The Policy had a Specified Amount of $1.5 million. Compl. ¶¶ 4, 9; Policy at 3; *see* Motion to Dismiss at 4-5. The application for the Policy gave Plaintiff the option of various premium frequencies: "Annual," "Semi-Annual," "Quarterly," "Monthly (EFT)," and "Other." Dkt. 23, Exh. A at 42. Plaintiff selected "Annual." *Id.* On May 7, 2018, Plaintiff paid an "Annual Planned Premium" of $53,877.72. Compl. ¶¶ 4, 18.

Ms. Lupe passed away five months later, on October 6, 2018. *Id.* Lincoln NY paid the Specified Amount, *id.* ¶ 4, but declined to refund any portion of the Planned Premium on the basis that "annual planned premiums paid increased the policy value, earned interest, w[ere] accessible for a policy loan, withdrawal or cash surrender, and could have been used to cover future policy expenses," and therefore "there was no 'unearned premium' and no refund of premium was payable," *id.* ¶¶ 4, 5. Plaintiff contends that Lincoln NY's refusal to issue a proportionate refund of the Planned Premium to cover the period from November 2018 (*i.e.*, the month after Ms. Lupe's death) through May 7, 2019 violated New York Insurance Law.

B. Procedural History

On August 24, 2020, Plaintiff commenced this action, bringing a single claim of breach of contract. *Id.* ¶¶ 27-31. This case was originally assigned to the Honorable Paul G. Gardephe, but was reassigned to the undersigned on September 29, 2020. *See* Dkt. 11. On November 13, 2020, Lincoln NY moved to dismiss the Complaint. Motion to Dismiss. Lincoln NY also has requested that the Court take judicial notice of publicly available Product Outlines from the New York State Department of Financial Services ("NYDFS"), which Lincoln NY argues support its reading of New York Insurance Law. Dkt. 24.

II. Legal Standard

In considering a motion to dismiss under Rule 12(b)(6), courts assess whether the complaint "contain[s] sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). A claim is plausible "when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* A complaint's "[f]actual allegations must be enough to raise a right to relief above the speculative level." *Twombly*, 550 U.S. at 555. In making such determination, the Court must "accept[] as true the factual allegations in the complaint and draw[] all inferences in the plaintiff's favor," *Biro v. Conde Nast*, 807 F.3d 541, 544 (2d Cir. 2015), but need not accept "legal conclusions" as true, *Iqbal*, 556 U.S. at 678 (citing *Twombly*, 550 U.S. at 555).

To state a claim for breach of contract under New York law, a "complaint need only allege (1) the existence of an agreement, (2) adequate performance of the contract by the plaintiff, (3) breach of contract by the defendant, and (4) damages." *Eternity Glob. Master Fund Ltd. v. Morgan Guar. Tr. Co. of N.Y.*, 375 F.3d 168, 177 (2d Cir. 2004) (quoting *Harsco Corp. v. Segui*, 91 F.3d 337, 348 (2d Cir. 1996)). "The provisions of the parties' agreements establish the rights of the parties and prevail over conclusory allegations in the complaint." *Spinelli v. Nat'l Football League*, 96 F. Supp. 3d 81, 131 (S.D.N.Y. 2015) (citing *805 Third Ave. Co. v. M.W. Realty Assoc.*, 58 N.Y.2d 447, 451 (1983)).

III. Discussion

The issue before the Court is whether Lincoln NY breached its obligations under the Policy because New York law requires it to refund a portion of the Planned Premium following the insured's death. The Court begins with the text of section 3203(a) of the New York Insurance

Law. "If the text is unambiguous, [the court's] task is at an end unless the text produces a manifestly absurd result, an exceptionally rare occurrence." *In re Dubroff*, 119 F.3d 75, 76 (2d Cir. 1997).

Under section 3203(a)(2), all insurance policies "delivered or issued for delivery in this state, shall contain in substance" a provision requiring that: (1) "if the death of the insured occurs within the grace period provided in the policy, the insurer may deduct from the policy proceeds the portion of any unpaid premium applicable to the period ending with the last day of the policy month in which such death occurred," and (2) "if the death of the insured occurs during a period for which the premium has been paid, the insurer shall add to the policy proceeds a refund of any premium actually paid for any period beyond the end of the policy month in which such death occurred." N.Y. Ins. Law § 3203(a). The latter provision forms the basis of the claims here. "[W]here a policy provision is less favorable to the insured than the provision required by New York Insurance Law, the statutory provision controls." *Terry v. Unum Life Ins. Co. of Am.*, 394 F.3d 108, 110 (2d Cir. 2005).

Both parties seem to agree, at least for the purposes of this motion, that the Planned Premium paid on May 7, 2018 was a "premium" under section 3203(a). *See* Motion to Dismiss at 2 n.1. They differ, however, on whether the other requirements of the statute were met. Plaintiff argues that Lincoln NY must refund a prorated portion of the "annual planned premium" that Plaintiff paid on May 7, 2018, covering the period of time starting in the month after Ms. Lupe's death. Therefore, it appears that Plaintiff seeks a prorated refund of the $53,877.72 Planned Premium to cover November 2018 through May 2019. Compl. ¶ 4 ("Plaintiff paid an annual planned policy premium of $53,877.72 on May 7, 2018 . . . . The insured passed away five months later, on October 6, 2018. Lincoln NY paid the death benefit but did not include the premium

refund for any of the months for which the Plaintiff paid an annual planned premium after the policy month of the insured's death." (emphases omitted)). In moving to dismiss, Lincoln NY argues that this Planned Premium was not, under the terms of the Policy, "actually paid for any period," and thus was not covered by section 3203(a).

A. "For Any Period"

The Court first looks to the import of section 3203(a)'s language, "for any period." Lincoln NY argues that Plaintiff's Annual Planned Premium was not actually paid for "any period" because the Planned Premium itself did not extend the insured's coverage. Motion to Dismiss at 11-13. Instead, Lincoln NY argues that "only the monthly [COI] deduction pays for insurance coverage 'for any period.'" *Id.* at 9. As explained above, these monthly COI deductions were drawn from the Policy Account.

Plaintiff responds that "premiums" and "deductions" are distinct, and that the law and the Policy, on their plain terms, mandate that insurers refund any overpaid "premiums." *See* Opposition at 6 ("The Statute and Policy use the same word: 'premium.' [Lincoln NY's] lead argument is that 'premium' (as used in Statute) does not mean 'premium' (as used in Policy), but instead means only 'monthly deduction' (as used in the Policy)."). Plaintiff correctly notes that the New York legislature has distinguished elsewhere in the statute between deductions and premiums. *Id.*; *see, e.g.*, N.Y. Ins. Law § 3203(a)(11) (referring to "charges deducted from any premium paid or from the policy value"); *id.* § 3203(a)(16) (referring to "the amount of cost of insurance or other expense charges deducted under the policy"). Plaintiff also points to various other provisions of the Policy that it contends "contradict [Lincoln NY's] claim that 'only the monthly [COI] deduction pays for insurance coverage "for any period."'" Opposition at 11 (second alteration in original) (quoting Motion to Dismiss at 9). For instance, Plaintiff highlights

what it calls the "15% load charge," *i.e.*, the charge that Lincoln NY keeps based on the 85% "guaranteed net premium factor," discussed above. *Id.* at 3, 11-12, 14; Policy at 2, 4. Plaintiff argues that because the Policy states that this "charge" is "applied to cover the company's cost of insurance and other expenses," Policy at 2, it cannot be that only the COI deduction pays for insurance coverage. Opposition at 11. Plaintiff also references the provision requiring the insured to "pay an amount . . . that is sufficient to keep this policy in force for at least two (2) months" to reinstate the Policy following termination. Policy at 9; Opposition at 11. Finally, Plaintiff looks to the Policy's CPGR, arguing that because "[w]hether the CPGR applies depends on the 'frequency, timing, or amount' of premium payments, and a planned premium can be set up to ensure that timely payment thereof keeps the CPGR in effect[,] . . . even under [Lincoln NY's] interpretation, the prorated portion of that annual planned premium must be refunded." Opposition at 11-12; *see* CPGR at 1.

Some of Plaintiff's arguments certainly appear compelling at first blush. But a close reading of the statutory text and the Policy reveal that, for a universal life insurance policy crafted like the one at issue here, a Planned Premium simply is not paid for any specific "period." For instance, a Planned Premium can be less than or greater than the monthly cost of insurance. *See* Policy at 3 ("The Planned Premium may need to be increased to keep this policy and the coverage in force; payment of the Planned Premium may not prevent th[e] Policy from terminating."). A paid Planned Premium may not necessarily "prevent th[e] policy from terminating," and "[f]ailure to pay a Planned Premium will not, in itself, cause th[e] policy to terminate." *Id.* at 8. The Policy will only terminate if it enters the grace period, *i.e.*, if "the Cash Surrender Value is less than the monthly deduction due" —unless, as discussed above, the CPGR applies—and the Owner fails to cure in the manner required by the Policy. *Id.* at 8-9.

None of Plaintiff's arguments otherwise are able to overcome this practical reality. First, the so-called load charge is a one-time charge that applies around when the Planned Premium is deposited into the Policy Account. *See id.* at 2 (discussing how the "net premium factor [is] assessed against the premium before it is applied to the Policy Value"). The Policy states that the "Monthly Cost of Insurance and Administrative Charges," of which the net premium factor is a part, are "applied to cover the company's cost of insurance and other expenses." *Id.* A more natural reading of this provision is that the "Monthly Cost of Insurance" covers the "company's cost of insurance," whereas the "Administrative Charges," like the load charge, cover "other expenses." But even assuming the load charge covers the company's cost of insurance in some part, there is nothing to indicate that the load charge covers any specific period of coverage. For example, the Policy does not suggest that this charge could stop the Policy from entering the grace period. *See id.* at 9 ("If on a Monthly Anniversary Day the Cash Surrender Value is less than the monthly deduction due, Your policy will enter the grace period."). Nor does the termination provision help Plaintiff's case; the fact that an amount may be *sufficient* to keep a policy in force does not mean that the amount *necessarily* pays for two months of coverage. Finally, the CPGR is merely used to prevent a policy from entering the grace period by relying on an alternate reference value. CPGR at 1, 4. This alternate reference value "is not used in determining the actual Policy Value." *Id.* at 1. It is still the monthly deductions that actually pay for the insurance.[4]

Moreover, Lincoln NY compellingly demonstrates the myriad issues that would result from interpreting a Planned Premium as being "for" a specific period. For instance, if the Owner makes

[4] Plaintiff contends, in a footnote, that "[i]f necessary, Plaintiff can elaborate [on its CPGR argument] in an Amended Complaint." Opposition at 11 n.2. To the extent this can be construed as a request for leave to amend, it is denied, as no elaboration is necessary. The CPGR speaks for itself and is simply not a premium paid "for any period" of coverage.

an unplanned deposit into the Policy Account, it would be exceedingly difficult to identify which payment—the unplanned deposit or the "annual" Planned Premium—was for any specific period of coverage. Plaintiff responds that "[t]he answer . . . is to look at the four corners of the Statute which does not make any reference to, or permit exemptions for, unscheduled payments," and that "[i]n any event, how these hypotheticals might be resolved on the merits has no impact on whether Plaintiff has stated a plausible claim for relief." Opposition at 12. Plaintiff thus seemingly suggests that any unscheduled payments must also be interpreted to cover some period of time. But Plaintiff provides no logical clues as to how that may be done, or why it would be reasonable to interpret the statute to apply to these premiums given the flexible structure of the Policy. And while Plaintiff wants the Court to overlook this issue, this scenario demonstrates exactly why Planned Premiums are not premiums "for any period."

In addition, interpreting a Planned Premium as being "for any period" would create irreconcilable tension with the complementary portion of section 3203(a)(2), which outlines what the insurance company may do if "the death of the insured occurs within the grace period." N.Y. Ins. Law § 3203(a)(2). "It is well settled that 'a statute or legislative act is to be construed as a whole, and all parts of an act are to be read and construed together.'" *MacNeil v. Berryhill*, 869 F.3d 109, 113 (2d Cir. 2017) (quoting *N.Y. State Psychiatric Ass'n, Inc. v. N.Y. State Dep't of Health*, 19 N.Y.3d 17, 23-24 (2012)). Under that provision of section 3203(a)(2), if the insured's death occurs within the grace period, "the insurer may deduct from the policy proceeds the portion of any unpaid premium applicable to the period ending with the last day of the policy month in which such death occurred," so long as that was not otherwise waived. N.Y. Ins. Law § 3203(a)(2).

If the Court were to interpret this provision consistent with Plaintiff's proposed meaning of "premium actually paid for any period," an insurance company would seemingly be permitted

to deduct from the Policy Account an unpaid Planned Premium, even if a prorated portion of that unpaid Planned Premium was substantially greater than the relative cost of insurance for that month. But Planned Premiums are, by definition, optional statements of intent. *See* Policy at 8 ("Payment of the Planned Premium is [the Owner's] option."). Plaintiff's reading of the statute would thus transform a statement of intent into a binding promise upon the death of the insured. Plaintiff has no real response to this, stating solely, "that provision only applies when the death occurs 'within the grace period provided in the policy,' which is not at issue here." Opposition at 13. Although that may be true, the Court must still interpret the statute, and "[i]nterpretation of one provision of a statute . . . 'cannot be divorced from its statutory context.'" *MacNeil*, 869 F.3d at 113 (quoting *In re Avella v. City of New York*, 29 N.Y.3d 425, 436 (2017)). The Court cannot ignore the implications of Plaintiff's proposed reading on other parts of the statute—particularly those within the same subsection.

Plaintiff makes an additional argument separate and apart from the statutory text: The Policy referred to this as an "ANNUAL" Planned Premium, Policy at 4, and, Plaintiff contends, a reasonable person would interpret this to mean that the Planned Premium was for an "annual" period, *see* Opposition at 10; *see Dean v. Tower Ins. Co.*, 19 N.Y.3d 704, 708 (2012) ("Insurance contracts must be interpreted according to common speech and consistent with the reasonable expectation of the average insured." (quoting *Cragg v. Allstate Indem. Corp.*, 17 N.Y.3d 118, 122 (2011)). In support, Plaintiff draws upon New York's *contra proferentem* doctrine, which requires courts, as a last resort, to resolve ambiguities in an insurance contract in favor of the insured. Dkt. 19 at 3 ("At best, [Lincoln NY's] argument is that the meaning of 'premium' under the Policy is ambiguous, but 'New York law recognizes a well-established *contra proferentem* rule, under which any ambiguity in an insurance policy must be construed against the insurer.'" (quoting *U.S.*

Bank Nat'l Ass'n v. PHL Variable Ins. Co., No. 12 Civ. 6811 (CM), 2014 WL 2199428, at *7 (S.D.N.Y. May 23, 2014))); Opposition at 10 ("Plaintiff does not invoke *contra preferentem* [sic] to construe the meaning of the Statute but rather to resolve any ambiguity relating to what the Policy meant by 'annual' 'planned premium.'"); *see Schering Corp. v. Home Ins. Co.*, 712 F.2d 4, 10 n.2 (2d Cir. 1983) ("[C]*ontra preferentem* [sic] is used only as a matter of last resort, after all aids to construction have been employed but have failed to resolve the ambiguities in the written instrument.").

But the Court need not go so far, because the plain language of the Policy does not support Plaintiff's reading. *See Olin Corp. v. Am. Home Assurance Co.*, 704 F.3d 89, 103 n.19 (2d Cir. 2012) ("Because [the provision] is unambiguous, we do not consider extrinsic evidence in interpreting the provision, nor do we apply the rule of *contra proferentem*." (citation omitted)). "It is an elementary rule of contract construction that clauses of a contract should be read together contextually in order to give them meaning." *HSBC Bank USA v. Nat'l Equity Corp.*, 719 N.Y.S.2d 20, 22 (App. Div. 2001). The Policy explicitly defines the Premium Frequency as "*how often* [the Owner] intend[s] to pay the Planned Premium." Policy at 8 (emphasis added). The Policy also makes clear that the "Planned Premium and Premium Frequency, as shown on the policy specifications page, are selected by [the Owner]." *Id.* Thus, the Premium Frequency—which in this case was annual—defines the anticipated recurrence of payment of the Planned Premium; it does not state the Planned Premium is *for* a specific period of coverage. Plaintiff cannot interpret the word "annual" in isolation to create ambiguity where there is none.

Finally, Plaintiff argues that Lincoln NY's reading of the statute would effectively remove all universal life insurance policies from its coverage. Section 3203(a)(2) applies to "all life insurance policies," save two types not relevant here. *See* N.Y. Ins. Law § 3203(a)(1)-(2). For

instance, a term life insurance policy would more clearly fall under the statute. With a term life insurance policy, the insured pays for life insurance for a specified term and does not pay any funds into a cash-value account. *See* 31 N.Y. Prac., New York Insurance Law § 24:4 ("'Term life' insurance is defined as life insurance for a specified term only, the premium being calculated on a basis which provides coverage only for a death which occurs during the term"); 11 N.Y.C.C.R. § 53-2.7; *see also* Motion to Dismiss at 6-7. As Plaintiff explains, the legislature was surely aware of how to distinguish between universal life insurance policies from term life insurance policies. Opposition at 8, 15; *see, e.g.*, N.Y. Ins. Law § 3203(a)(1) (imposing a longer grace period for "policies in which the amount and frequency of premiums may vary").

But *all* universal life insurance policies are not before this Court, and the Court has no occasion to pass on all forms of universal life insurance policies available in New York state. *See* Dkt. 28 at 4 (Lincoln NY arguing, "Plaintiff assumes that all universal life contracts are structured like the Policy . . . . This case presents the provisions of a specific Policy, as well as Plaintiff's choices and voluntary payment under that Policy."). The Court looks only to this Policy, and concludes that Lincoln NY was not statutorily required to refund some portion of the Planned Premium.

While Plaintiff here could have elected the Option II death benefit, pursuant to which Lincoln NY would have paid out both the Policy Account and the Specified Amount upon Ms. Lupe's death, Policy at 10, Plaintiff chose not to do so. Instead, Plaintiff elected the Option I benefit, pursuant to which the Policy Account—and any Planned Premiums deposited into that account—would not be refunded if that Policy Account (times the applicable tax multiplier) were lower than the Specified Amount. The Court will not now invalidate Plaintiff's election. New

York law does not prohibit this type of plan, and the law does not mandate that Lincoln NY refund any portion of the Planned Premiums.

B. "Actually Paid"

The Court next turns to the meaning of the phrase "actually paid." *See* N.Y. Ins. Law § 3203(a)(2) ("[I]f the death of the insured occurs during a period for which the premium has been paid, the insurer shall add to the policy proceeds a refund of any premium *actually paid* for any period beyond the end of the policy month in which such death occurred." (emphasis added)). Whereas Lincoln NY contends that the "statute's emphatic use of 'actually' . . . distinguishes statements of intent and funds to which the Owner retains some rights from premium payments that become revenue to the insurer," Motion to Dismiss at 13, Plaintiff argues that "[t]he use of the word 'actually' presumably distinguishes a premium that was due but not paid," Opposition at 15.

Admittedly, the phrase "actually paid," in the abstract, might not be enough to make clear that Planned Premiums are not covered by this provision. However, the Court must read the phrase "actually paid" in context. *See United States v. Kozeny*, 541 F.3d 166, 171 (2d Cir. 2008) ("Statutory enactments should, moreover, be read so as 'to give effect, if possible, to every clause and word of a statute.'" (quoting *Duncan v. Walker*, 533 U.S. 167, 174 (2001)). When read in conjunction with the term "for any period," the phrase "actually paid" serves to further distinguish between payments promised and payments that have actually paid for a period of coverage. As Lincoln NY points out, Planned Premiums are simply "a statement of intent and increase the account value," and in doing so "earn[] interest, and . . . are accessible to the owner." Motion to Dismiss at 13. In other words, although these funds are largely transferred to the Policy Account, the funds do not actually pay for any insurance until they are taken from the Policy Account via

the monthly deduction. *See Banker's Tr. Co. v. Equitable Life Assurance Soc'y*, 257 N.Y.S.2d 502, 506 (App. Div. 1965) ("[T]he cash surrender value of a policy is a 'fund' held by the insurer for the benefit of the insured."), *rev'd on other grounds sub nom. Bankers Tr. Co. v. Equitable Life Assurance Soc'y*, 19 N.Y.2d 552 (1967). Although Plaintiff contends that the Planned Premiums are revenue to Lincoln NY "insofar as [Lincoln NY] claims to use these premium payments to offset the death benefits paid to policyholders" and because Lincoln NY deducts the so-called load charge, Opposition at 15, the fact that Lincoln NY may be able to benefit from the Planned Premium does not mean these funds "actually pay" for any period of insurance.

* * *

In light of the above, the Court need not consider Lincoln NY's policy arguments—or, for that matter, Plaintiff's policy arguments. For instance, Lincoln NY argues that section 3203(a)(2) has the "straightforward purpose" of "prevent[ing] insurers from taking and keeping money for which the insured gets no benefit." Motion to Dismiss at 10. According to Lincoln NY, "the customer immediately benefits from a Planned Premium deposit and the insurer upholds its end of the bargain by paying interest, adjusting the COI charge, providing the opportunity for a loan or (partial) surrender, and so forth." *Id.* But when engaging in statutory interpretation, "[t]he relevant question is not whether, as an abstract matter, the rule advocated by [a party] accords with good policy." *Badaracco v. Comm'r*, 464 U.S. 386, 398 (1984). It is not a court's job to "rewrite a statute because [it] might deem its effects susceptible of improvement." *Id.* Instead, the Court's job is to interpret the statutory language. Having reviewed the plain text and the surrounding statutory provisions, the Court determines that the Planned Premium here was not a "premium actually paid for any period beyond the end of the policy month" in which the insured died, such that it would be covered under the statute.

The Court therefore also does not address (1) Lincoln NY's alternative argument that Plaintiff has "already received the Policy Account value, including any value attributable to [Plaintiff's] last Planned Premium deposit," meaning there is "no premium to be refunded," Motion to Dismiss at 17-19, or (2) Lincoln NY's argument that Plaintiff's class allegations suffer fundamental standing defects, *id.* at 19-24. In addition, because the Court finds that the statute does not require Lincoln NY to refund the Planned Premiums, the Court denies Lincoln NY's request for judicial notice of the NYDFS Product Outlines as moot. *See United States v. Bleznak*, 153 F.3d 16, 21 n.2 (2d Cir. 1998) ("In connection with this issue, appellants have filed a motion asking us to take judicial notice of several court filings cited in their brief. Because these filings are not relevant to our disposition of this appeal, we deny the motion as moot."); *Grievance Comm. of S. Dist. of N.Y. v. Grimm*, 691 F. App'x 668, 671 (2d Cir. 2017) ("Because we reach these conclusions without consulting the documents that are the subject of the Committee's motion for judicial notice, that motion is denied as moot.").

IV. Conclusion

For the aforementioned reasons, the Court grants Lincoln NY's motion to dismiss with prejudice and denies as moot its request for judicial notice of the NYDFS Product Outlines. The Clerk of the Court is respectfully directed to terminate all motions and close this case.

SO ORDERED.

Dated: July 2, 2021
New York, New York

JOHN P. CRONAN
United States District Judge

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

McKinney's Consolidated Laws of New York Annotated
Insurance Law (Refs & Annos)
Chapter 28. Of the Consolidated Laws (Refs & Annos)
Article 32. Insurance Contracts--Life, Accident and Health, Annuities (Refs & Annos)

McKinney's Insurance Law § 3203

§ 3203. Individual life insurance policies; standard provisions as to contractual rights and responsibilities of policyholders and insurers

Effective: December 18, 2013
Currentness

(a) All life insurance policies, except as otherwise stated herein, delivered or issued for delivery in this state, shall contain in substance the following provisions, or provisions which the superintendent deems to be more favorable to policyholders:

(1) that, for policies in which the amount and frequency of premiums may vary, after payment of the first premium, the policyholder is entitled to a sixty-one day grace period, beginning on the day when the insurer determines that the policy's net cash surrender value is insufficient to pay the total charges necessary to keep the policy in force for one month from that day, within which to pay sufficient premium to keep the policy in force for three months from the date the insufficiency was determined. For all other policies, after payment of the first premium, the policyholder is entitled to a thirty-one day grace period or of one month following any subsequent premium due date within which to make payment of the premium then due. During such grace period, the policy shall continue in full force;

(2) that if the death of the insured occurs within the grace period provided in the policy, the insurer may deduct from the policy proceeds the portion of any unpaid premium applicable to the period ending with the last day of the policy month in which such death occurred, and if the death of the insured occurs during a period for which the premium has been paid, the insurer shall add to the policy proceeds a refund of any premium actually paid for any period beyond the end of the policy month in which such death occurred, provided such premium was not waived under any policy provision for waiver of premiums benefit. This paragraph shall not apply to single premium or paid-up policies;

(3) that the policy shall be incontestable after being in force during the life of the insured for a period of two years from its date of issue, and that, if a policy provides that the death benefit provided by the policy may be increased, or other policy provisions changed, upon the application of the policyholder and the production of evidence of insurability, the policy with respect to each such increase or change shall be incontestable after two years from the effective date of such increase or change, except in each case for nonpayment of premiums or violation of policy conditions relating to service in the armed forces. At the option of the insurer, provisions relating to benefits for total and permanent disability and additional benefits for accidental death may also be excepted;

(4) that the policy, together with the application therefor if a copy of such application is attached to the policy when issued, shall constitute the entire contract between the parties; but in the case of policies that provide that the death benefit or other policy

provisions may be changed by written application or by the written notice of exercise of one or more options provided in the policy, or automatically by the terms of the policy, the policy may also contain a provision that when such written application or notice of exercise of an option is accepted by the insurer or a notice of any change is issued by the insurer and, in each case, a copy of such application or notice is returned by mail or delivered to the policyholder at the policyholder's last post office address known to the insurer, such application or notice shall become part of the entire contract between the parties;

(5) that if the age of the insured has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age;

(6) that the insurer shall annually ascertain and apportion any divisible surplus accruing on the policy;

(7)(A) that, in the case of policies which provide for the crediting of additional amounts pursuant to subsection (b) of section four thousand two hundred thirty-two of this chapter or under which cash surrender values are adjusted in accordance with a market-value adjustment formula or which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums or which provide an option for changes in benefits or premiums other than a change to a new policy, specifies the mortality table, interest rate and method used in calculating cash surrender values and any paid-up nonforfeiture benefits available under the policy;

(B) that, in the case of all other policies, specifies the cash surrender values and other options available in the event of default in a premium payment after premiums have been paid for a specified period, together with a table showing, in figures, all options available during each of the policy's first twenty years. Such options shall comply with the requirements of subsection (a) of section four thousand two hundred twenty or section four thousand two hundred twenty-one of this chapter;

(8)(A) that, for a policy not in default and where three full years' premiums have been paid or, in the case of a policy where the policyholder may vary the amount and frequency of premiums to be paid to the insurer, after three years from the date of issue of the policy, the policyholder shall be entitled to a loan in an amount not exceeding the loan value, under the conditions specified in section four thousand two hundred twenty-two of this chapter. However, a policyholder shall be entitled to a loan from an equity index account that credits additional amounts less frequently than annually at any time the equity index policy has a loan value;

(B) that the sole security for the loan shall be assignment or pledge of the policy;

(C) that, unless the policy provides for the crediting of additional amounts pursuant to subsection (b) of section four thousand two hundred thirty-two of this chapter or provides for the adjustment of the policy loan value in accordance with a market-value adjustment formula or causes on a basis guaranteed in the policy unscheduled changes in benefits or premiums or provides an option for changes in benefits or premiums other than a change to a new policy, the policy shall contain a table showing the loan values, if any, available during each of the policy's first twenty years;

(D) that, in making a loan, the insurer may reduce the loan value (in addition to the indebtedness deducted in determining such value) by any unpaid premium balance for the current policy year;

(E) that, if the loan is made or repaid on a date other than the anniversary of the policy, the insurer may collect interest for the portion of the current policy year on a pro rata basis;

(F) that, at the option of the insurer, the loan shall bear interest (i) at a maximum rate of not more than seven and four-tenths per centum per annum if payable in advance or the equivalent effective rate of interest if otherwise payable, or (ii) at a rate not in excess of an adjustable maximum rate established from time to time by the insurer as permitted by law. If the policy provides for an adjustable rate, the policy shall specify the regular intervals at which the interest rate is to be determined which shall be at least once every twelve months but not more frequently than once in any three month period;

(G) the policy may further provide: (i) that if the interest on the loan is not paid when due, it shall be added to the existing loan, and shall bear interest at the applicable rate or rates payable on the loan determined in accordance with the provisions of the policy, and (ii) subject to subsection (e) of section three thousand two hundred six of this article that when the total indebtedness on the policy, including interest due or accrued, equals or exceeds the amount of the policy's loan value and if at least thirty days' prior notice shall have been given in the manner provided in section three thousand two hundred eleven of this article, then the policy shall terminate and become void;

(H) any policy which provides for the crediting of additional amounts pursuant to subsection (b) of section four thousand two hundred thirty-two of this chapter may also provide that if any indebtedness is owed to the insurer on any part of the loan value which would otherwise be credited with additional amounts, such additional amounts may be reduced so that the total amounts credited on such part are so credited at a rate that is up to two percent per annum less than the applicable loan interest rate charged or at such other rate as the superintendent, upon the insurer's demonstrating justification therefor, may allow;

(I) this paragraph eight shall not apply to term insurance;

(J) this paragraph eight shall not apply to any policy qualified for special tax treatment under subsection (b) of section four hundred three of the Internal Revenue Code of 1986, [1] as amended, to the extent such application would prevent such qualification;

(9) a table showing the amounts of the applicable installment or annuity payments, if the policy proceeds are payable in installments or as an annuity;

(10) that the policy shall be reinstated at any time within three years from the date of default, unless the cash surrender value has been exhausted or the period of extended insurance has expired, if the policyholder makes application, provides evidence of insurability, including good health, satisfactory to the insurer, pays all overdue premiums with interest at a rate not exceeding six per centum per annum compounded annually, and pays or reinstates any other policy indebtedness with interest at a rate not exceeding the applicable policy loan rate or rates determined in accordance with the policy's provisions. This provision shall be required only if the policy provides for termination or lapse in the event of a default in making a regularly scheduled premium payment;

(11) that upon surrender of the policy, together with a written request for cancellation, to the insurer during a period of not less than ten days nor more than thirty days from the date the policy was delivered to the policy owner, the insurer shall refund either (i) any premium paid for the policy, including any policy fees or other charges or (ii) if the policy provides for the adjustment of the cash surrender benefit in accordance with a market-value adjustment formula and if the policy or a notice attached to it so provides, the amount of the cash surrender benefit provided under the policy as so adjusted assuming no surrender charge plus the amount of all fees and other charges deducted from any premium paid or from the policy value; provided, however,

that a policy sold by mail order must contain a provision permitting the policy owner a thirty day period for such surrender. A provision to this effect shall appear in the policy or in a notice attached to it;

(12) in any policy under which additional amounts may be credited pursuant to subsection (b) of section four thousand two hundred thirty-two of this chapter, that states the guaranteed factors of mortality, expense and interest, and a statement of the method used by the insurer in calculating actual policy values;

(13) in any policy under which additional amounts may be credited pursuant to subsection (b) of section four thousand two hundred thirty-two of this chapter, that such additional amounts shall be nonforfeitable after the effective date of their crediting except for any charges imposed under the policy which are not greater than those allowed under subsection (n-1) or any market value adjustment made pursuant to subsection (n-2) of section four thousand two hundred twenty-one of this chapter; and

(14) in any policy under which additional amounts may be credited for any period pursuant to subsection (b) of section four thousand two hundred thirty-two of this chapter, that the policy shall state the frequency at which additional amounts are credited, which shall be no less frequently than annually, except that policies that credit additional amounts in an equity index account may do so in such account no less frequently than every three years;

(15) that states on the policy data or policy specifications page of a participating cash value policy that dividends are not guaranteed and the insurer has the right to change the amount of dividend to be credited to the policy which may result in lower dividend cash values than were illustrated, or, if applicable, require more premiums to be paid than were illustrated.

(16) that states on the policy data or policy specifications page of a life insurance policy subject to subsection (b) of section four thousand two hundred thirty-two of this chapter, to the extent applicable, that additional amounts are not guaranteed and the insurer has the right to change the amount of interest credited to the policy and the amount of cost of insurance or other expense charges deducted under the policy which may require more premium to be paid than was illustrated or the cash values may be less than those illustrated.

(17) that states on the policy data or policy specification [2] page the minimum guarantee interest rate used to determine the guaranteed policy values.

(b)(1) A life insurance policy delivered or issued for delivery in this state may exclude or restrict liability in the event of death occurring while the insured is resident in a specified foreign country or countries, but shall not contain any provision excluding or restricting liability in the event of death caused in a certain specified manner, except as a result of:

(A) conditions specified in subsection (c) hereof, subject to the terms of such subsection;

(B) suicide within two years from the date of issue of the policy;

(C) aviation under conditions specified in the policy;

(D) hazardous occupations specified in the policy, provided death occurs within two years from the date of issue of the policy.

(2) The superintendent may approve provisions that vary from subparagraphs (A) through (D) of paragraph one hereof and subsection (c) hereof, whenever he deems such substitute provisions to be substantially the same or more favorable to policyholders.

(3) If a death occurs that is subject to an exclusion or restriction pursuant to this subsection or subsection (c) hereof, the insurer shall pay the reserve on the face amount of the policy, computed according to the mortality table and interest rate specified in the policy, together with the reserve for any paid-up additions thereto, and any dividends standing to the credit of the policy, less any indebtedness to the insurer on the policy, including interest due or accrued; provided that if the policy shall have been in force for not more than two years, the insurer shall pay the amount of the gross premiums charged on the policy less dividends paid in cash or used in the payment of premiums thereon and less any indebtedness to the insurer on the policy, including interest due or accrued.

(c)(1) A life insurance policy delivered or issued for delivery in this state may contain provisions excluding or restricting liability in the event of death as a result of:

(A) war or an act of war, if the cause of death occurs while the insured is serving in any armed forces or attached civilian unit and death occurs no later than six months after the termination of such service;

(B) the special hazards incident to service in any armed forces or attached civilian unit, if the cause of death occurs during the period of such service while the insured is outside the home area, and if death occurs outside the home area or within six months after the insured's return to the home area while in such service or within six months after the termination of such service, whichever is earlier;

(C) war or an act of war, within two years from the date of issue of the policy, if the cause of death occurs while the insured is outside the home area but is not serving in any armed forces or attached civilian unit, and death occurs outside the home area or within six months after the insured's return to the home area.

(2) The superintendent may, by regulation, prescribe reasonable conditions relating to the use of provisions permitted by paragraph one hereof. The provisions of subsection (b) hereof shall apply to any policy containing any provision permitted by this subsection.

(3) As used in this subsection, the term:

(A) “armed forces” means the military, naval, or air forces of any country, international organization, or combination of countries;

(B) “attached civilian unit” means a civilian non-combatant unit serving with any armed forces;

(C) “home area” means the fifty states of the United States, the District of Columbia, and Canada;

(D) “war” includes any war declared or undeclared, and armed aggression resisted by any armed forces;

(E) “act of war” means any act peculiar to military, naval, or air operations in time of war; and

(F) “special hazards incident to service”, includes those hazards resulting in the insured's death being presumed by reason of being missing, in action, or otherwise, or the insured's death from disease or injury, accidental or otherwise, to which a person serving in, or with, any armed forces or attached civilian units is exposed in the line of duty.

(4) In permitting war exclusions, it is the legislative intent that such exclusions are not to be construed or interpreted as exclusions because of the status of the insured as a member of any armed forces or attached civilian units, or because of the presence of the insured as a civilian in a combat area or area adjacent thereto. Such permissible exclusions shall be construed and interpreted according to the fair import of their terms so as not to exclude deaths due to diseases or accidents which are common to the civilian population and are not attributable to special hazards to which a person serving in such forces or units is exposed in the line of duty.

(5) Any such war exclusion shall terminate six months after the end of the war in which the insured was engaged or the war which the insured was likely to engage in at the time of application for this policy, after the discharge, release or separation of the insured from active military service, after the demobilization of the insured, or after the insured permanently leaves the war area, whichever occurs first. The end of war shall be determined by an order of the president of the United States or by federal law or shall be deemed to occur on the effective date of an agreement or declaration to end all hostilities which has been adopted or accepted by all armed forces involved therein, or in the absence of such an agreement or declaration at the end of ninety continuous days from the end of all hostilities.

(d)(1) Subsections (b) and (c) hereof shall not apply to any provision in a life insurance policy for additional benefits in the event of accidental death.

(2) If a policy provides that the death benefit may be increased or other policy provisions changed upon the application of the policyholder and the production of evidence of insurability, the policy may also provide that the two-year exclusions permitted under subparagraph (B) or (D) of paragraph one of subsection (b) hereof or subparagraph (C) of paragraph one of subsection (c) hereof shall run from the date of issue of the policy except that it shall run from the effective date of each subsequent increase or change with respect to each such increase or change.

(e) For policies that credit additional amounts in an equity index account less frequently than annually: (1) if the policy holder requests a full surrender of a policy prior to the expiration of the equity index crediting period, the insurer shall provide a statement to the policyholder, prior to processing the surrender, to the effect that: (A) no additional interest based on the equity index will be credited, since the equity index crediting period has not yet expired, and that only the guaranteed interest will be credited to the account; and (B) the policyholder is advised to consider alternatives to a full surrender of the policy prior to the crediting of additional interest based on the equity index, such as a policy loan or, if available, a partial withdrawal of the policy; (2) in determining the additional amount to be credited to the policy in accordance with an equity index, the insurer shall include, in the calculation of the credit, any amounts withdrawn, including for policy loans, from the equity index account for the period of time prior to their withdrawal; (3) the policy shall include an option that credits additional amounts at least annually; and (4) the policy may provide that the amounts to be paid upon the exercise of a policy loan may be secured by the value of the policy's equity index account or by the general account of the insurer.

(f) Any of the provisions of this section, or portions thereof, exclusive of paragraph eleven of subsection (a) of this section, that do not apply to a single premium, nonparticipating, or term policy, shall to that extent not be incorporated in such policy. This section shall not apply to group life insurance.

Credits

(L.1984, c. 367, § 1. Amended L.1985, c. 160, § 1; L.1986, c. 365, §§ 2 to 5; L.1991, c. 467, § 28; L.1994, c. 251, § 1; L.1994, c. 714, § 1; L.2008, c. 264, § 1, eff. Oct. 5, 2008; L.2013, c. 535, §§ 1-3, eff. Dec. 18, 2013.)

Notes of Decisions (296)

Footnotes

1 26 USCA § 403.

2 So in original. Probably should be “specifications”.

McKinney's Insurance Law § 3203, NY INS § 3203

Current through L.2021, chapters 1 to 548. Some statute sections may be more current, see credits for details.