CJ-2022-243
Stinson



**IN THE DISTRICT COURT OF OKLAHOMA COUNTY**
**STATE OF OKLAHOMA**

| | | |
|---|---|---|
| **MICHAEL ADAMS,** | ) | |
| | ) | |
| **Plaintiff,** | ) | |
| | ) | |
| **v.** | ) | **Case No.** CJ-2022-243 |
| | ) | |
| **NATIONAL HEALTH INSURANCE COMPANY,** | ) | |
| | ) | |
| | ) | |
| **Defendant.** | ) | |

**PETITION**

**COMES NOW** Plaintiff, Michael Adams, and for his cause of action against Defendant National Health Insurance Company, alleges and states:

1. Plaintiff Michael Adams is a citizen of the State of Oklahoma and a resident of Oklahoma City, Oklahoma County, State of Oklahoma.

2. Defendant National Health Insurance Company ("NHIC") is a foreign insurance company incorporated in the State of Texas and licensed to and engage in the business of selling insurance policies to the citizens of the State of Oklahoma.

3. The events which give rise to this lawsuit occurred in Oklahoma County, Oklahoma.

4. The District Court in and for Oklahoma County has jurisdiction over the parties pursuant to 12 O.S. §§ 137 - 138.

5. NHIC issued a Short-Term Medical insurance policy to Plaintiff, Policy No. 2010159159 which became effective on September 1, 2020 ("Policy"), which provided certain health insurance benefits to Plaintiff.

6. While the Policy was in full force and effect, Plaintiff was diagnosed with colon cancer.

7. Plaintiff notified NHIC of his diagnosis and received pre-authorization to receive the necessary treatment.

8. Thereafter, Plaintiff underwent the necessary and pre-approved medical treatment, including laparoscopic surgery, incurring medical expenses of approximately $180,000.00.

9. Plaintiff initiated a claim for benefits available under the Policy.

10. In response to Plaintiff's claim, NHIC commenced an investigation specifically designed to deny, delay, and / or underpay Policy benefits available to Plaintiff under the Policy.

11. NHIC's investigation focused not on issuing payment for the medically necessary medical treatment it pre-approved Plaintiff to receive, rather into determining whether it could isolate any errors made by Plaintiff in his application for insurance.

12. NHIC gathered extensive medical records of Plaintiff pre-dating his application of insurance for the purposes of isolating errors made in the application process.

13. Among the records gathered by NHIC were records from McBride Orthopedic Hospital ("McBride") evidencing Plaintiff underwent an L4-5 / L5-S1 hemilaminotomy surgery on or about July 25, 2019 to treat an injury he suffered when he tripped over a hose while working.

14. Upon receipt of Plaintiff's McBride medical records, NHIC rescinded Plaintiff's Policy claiming "[t]he health information we received would have made you ineligible for this policy at the time you applied."

15. The basis of NHIC's recession decision was based upon the following question on the insurance application for the Policy to which Plaintiff answered in the negative:

> Within the last 5 years, has any applicant received medical or surgical treatment, consulted a health care professional, or has medication been prescribed or recommended for the following:
> …
> c. Neck or Back Disorder, Joint Replacement

16. The Policy contains a section title "Rescission" that reads as follows:

> "We may rescind coverage for a Covered Person or all Covered Persons if We determine that there was Fraud or intentional misrepresentation of a material fact that caused Us to issue this coverage when coverage would not have been issued. Rescission causes coverage to be terminated back to the Effective Date as if the coverage were never issued.
>
> Rescission will result in denial of all applicable claims. If rescission occurs We will refund premiums received less any claims We have paid for the person(s) whose coverage is rescinded. If We have paid claims in excess of the amount of premium We received, We have the right to obtain a refund."

17. Pursuant to 36 O.S. § 3609, statements made by a prospective insured in an insurance application are "deemed to be representations and not warranties" and shall not prevent recovery of benefits unless: "(1) Fraudulent; or (2) Material to the acceptance of the risk, or to the hazard by the insurer; or (3) The insurer in good faith would either not have issued the policy, or would have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required by the application for the policy or otherwise."

18. Further, long-standing precedent established by the Oklahoma Supreme Court requires an insurance company to find an insured had an "intent to deceive" in order to lawfully rescind an insurance policy due to allegedly false statements within an application for insurance. *See generally Benson v. Leaders Life Ins. Co.*, 2012 OK 111, 339 P.3d 843.

19. NHIC conducted no investigation into whether the claimed errors within Plaintiff's application for insurance were made with the requisite "intent to deceive."

20. NHIC refused to conduct an interview of either Plaintiff, the agent responsible for completing Plaintiff's application for insurance, or any other individual with factual knowledge of the circumstances surrounding the completion of the application for insurance prior to rescinding the Policy.

21. Plaintiff did not have an "intent to deceive" NHIC when he completed the application for insurance.

22. NHIC had an insufficient factual predicate for the recession of the Policy.

23. NHIC conducted no investigation into whether the disclosure of Plaintiff's 2019 medical treatment at McBride would have resulted in the non-issuance of the Policy prior to rescinding the policy.

24. The Policy does not define the term "disorder," which in its plain and ordinary usage is generally defined as "an abnormal physical or mental condition."[1]

25. However, the Policy does define the term "Injury:"

> "Accidental bodily damage, independent of all other causes (including, without limitation, Sickness[2]), occurring unexpectedly and unintentionally. The Injury must be definite to a single time and place. Benefits are available for an Injury that is first sustained on or after the Covered Person's Effective at. An Injury that is sustained before the Covered Person's Effective Date will be considered a Pre-Existing Condition."

26. The Policy also defines the term "Sickness:"

> "Disease or illness of a Covered Person. Sickness does not include a family history of a disease or illness, or a genetic predisposition for the development of a future disease or illness. Sickness includes Complications of Pregnancy but not the pregnancy itself."

The term "illness," as used in the definition of "Sickness" is not defined within the Policy either, but is defined in its plain and ordinary usage as "an unhealthy condition of body or mind."[3]

27. In their plain and ordinary use, the definitions of "disorder" and "illness" are indistinguishable from one another.

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[1] https://www.merriam-webster.com/dictionary/disorder.
[2] As is common in insurance policies, capitalized words are considered terms of art that are defined by the policy itself and, when used in the policy, are used as defined. "Sickness" is a defined term in the Policy at issue here.
[3] https://www.merriam-webster.com/dictionary/illness.

28. Pursuant to the definitions set forth in the Policy, an "illness" and thus a "disorder" falls within the definition of "Sickness."

29. Pursuant to the definitions set forth in the Policy, an "Injury" is distinguishable from a "Sickness."

30. Plaintiff's 2019 medical treatment at McBride was treatment for an "Injury", not treatment for a disorder.

31. Alternatively, the terms "Neck or Back Disorder, Joint Replacement" as used in the application for insurance are ambiguous.

32. An ambiguity within an insurance contract exists if and when a term or provision is "susceptible to more than one meaning." When determining whether a term or provision in an insurance contract is ambiguous, "the language is given the meaning understood by a person of ordinary intelligence." *Max True Plastering, Co. v. U.S. Fidelity and Guar. Co.*, 912 P.2d 861, 869, 1996 OK 28, ¶ 19.

33. Oklahoma adheres to the "Reasonable Expectations Doctrine" which holds that in the event a term or provision within an insurance contract is deemed to be ambiguous, "the objectively reasonable expectations of applicants, insureds and intended beneficiaries concerning the terms of insurance contracts are honored even though painstaking study of the policy provisions might have negated those expectations." *Max True Plastering, Co. v. U.S. Fidelity and Guar. Co.*, 912 P.2d 861, 862, 1996 OK 28, par. 1.

**BREACH OF CONTRACT AGAINST NATIONAL HEALTH INSURANCE COMPANY**

34. Plaintiff hereby adopts and realleged each of the facts and allegations set for in Paragraphs 1 – 33 above.

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