INSURANCE

A municipal license fee ordinance which separately defines banking and insurance businesses and specifically imposes a different rate upon those businesses than would be imposed upon other kinds of businesses on its face appears to be an effort to regulate banking and insurance and is unconstitutional and void. Actouka v. Kolonia Town, 5 FSM R. 121, 122 (Pon. 1991).

An insurance company that has no contractual obligation to persons other than its insured until a court determines the liability of its insured, cannot be joined as a party to a lawsuit to determine that liability. Wilson v. Pohnpei Family Headstart Program, Inc., 7 FSM R. 411, 413 (Pon. 1996).

In the absence of a contractual or statutory provision authorizing a direct action against or the joinder of a liability insurer, an injured person, for lack of privity between himself and the insurer, has no right of action at law against the insurer and cannot join the insured and the liability insurer as parties defendant. Moses v. M.V. Sea Chase, 10 FSM R. 45, 52 (Chk. 2001).

An insurance company that has no contractual obligation to persons other than its insured until a court determines its insured's liability, cannot be joined as a party to a lawsuit to determine that liability. Moses v. M.V. Sea Chase, 10 FSM R. 45, 52 (Chk. 2001).

When no national or state statute or contractual provision authorizes a third party's suit against or joinder of an insurer, an injured party's causes of action against and joinder of an insurer will be dismissed. Moses v. M.V. Sea Chase, 10 FSM R. 45, 52-53 (Chk. 2001).

When there was no legal requirement for the lessor to offer insurance to the lessee in a car rental agreement, the lessor's failure to offer insurance to the lessee in a rental agreement does not serve as a defense to the damages assessed against the lessee for an accident. Jackson v. George, 10 FSM R. 523, 527 (Kos. S. Ct. Tr. 2002).

The FSM Supreme Court does not look kindly upon contractual provisions that can only be understood by individuals who possess an advanced degree in insurance law. Clear, understandable, precise language is a condition to a finding that an insured must bear the cost of litigating in a remote forum. Phillip v. Marianas Ins. Co., 11 FSM R. 559, 562 n.3 (Pon. 2003).

To the extent that a purported forum selection clause could be interpreted to require suit in a foreign country, it must be struck down as void as against public policy unless it is a freely negotiated, arms-length agreement between parties with relatively equal bargaining power. An insurance contract that seeks to oust the FSM Supreme Court's jurisdiction will not be upheld when the insured is an FSM citizen and resident, the insurance policy is obtained in the FSM from an FSM-based agent, the premiums are paid in the FSM to cover vehicles operating in the FSM, and the incident giving rise to a claim occurred in the FSM. The clause is against public policy because it impedes the administration of justice relating to insurance claims, and would undermine the public's confidence in business dealings if upheld. To require such lawsuits to be filed in a foreign country would not only be onerous, but would essentially render insurance companies immune from suit. Phillip v. Marianas Ins. Co., 11 FSM R. 559, 562-63 (Pon. 2003).

Contracts impose on the parties thereto a duty to do everything necessary to carry them out, and there is an implied undertaking in every contract on each party's part that he will not

intentionally and purposely do anything to prevent the other party from carrying out his part of the agreement, or do anything which will have the effect of destroying or injuring the right of the other party to receive the fruits of the contract, and the FSM Supreme Court will entertain such claims in the context of insurance contracts, where the insurer possesses greater sophistication, can be expected to assist local insureds in understanding the relevant legal terminology, and has a specialized role in processing claims. Phillip v. Marianas Ins. Co., 12 FSM R. 301, 307 (Pon. 2004).

A measure of damages for the tort of negligent misrepresentation (also called deceit) employs the benefit of the bargain rule when damages can be proved with reasonable certainty. Under this principle, the insurer would be entitled to its premium, which would be set off against what it owed its insured. Phillip v. Marianas Ins. Co., 12 FSM R. 464, 469 (Pon. 2004).

Rescission of an insurance contract would, if granted, absolve an insured from liability for the premium and could even entitle him to return of the premium paid. Phillip v. Marianas Ins. Co., 12 FSM R. 464, 470 (Pon. 2004).

Reformation of an insurance contract may be sought under a theory of mutual mistake or mistake or fraud of the insurance agent. Phillip v. Marianas Ins. Co., 12 FSM R. 464, 470 (Pon. 2004).

Reformation is an equitable doctrine that allows a court to conform a contract (even an insurance contract) to the true agreement between the parties rather than the agreement as written. Phillip v. Marianas Ins. Co., 12 FSM R. 464, 470 (Pon. 2004).

Courts have permitted attorney's fee awards under the vexatious conduct exception when the plaintiff has proven the defendant's breach of the implied covenant or implied duty of good faith and fair dealing (also called the bad faith tort). If a plaintiff were to prevail on a bad faith tort claim against an insurer, the insurer would be liable to him for reasonable attorney's fees that are proximately caused by the bad faith conduct. Phillip v. Marianas Ins. Co., 12 FSM R. 464, 471 (Pon. 2004).

The Foreign Investment Act of 1997 establishes a system of Categories of economic sectors for the purposes of implementing the FSM policy to welcome foreign investment in all sectors of the FSM economy. Three of these categories are made up of economic sectors that are of special national significance and therefore fall within the national government's jurisdiction in respect of foreign investment regulation. The first is the National Red List. No foreign investment is permitted in the activities specified on this list, which includes the minting of money and arms manufacture. The second is the National Amber List. Banking (other than as defined in Title 29 of the FSM Code) and insurance are included on this list. Certain criteria specified in the FSM Foreign Investment Regulations must be met before investment is permitted in these areas. A third category of activities that fall within the jurisdiction of the national government appear on the National Green List. Helicopter Aerial Survey Pty., Ltd. v. Pohnpei, 15 FSM R. 329, 333-34 (Pon. 2007).

When there is no evidence before the court that, if it were not for the employer's maintaining life insurance for the employees, the employee would have either quit his job and taken a job with a different employer that provided life insurance benefits or that he would have purchased his own life insurance policy from another source, the employee's widow cannot recover on a promissory estoppel or detrimental reliance theory since she cannot show that the employee

relied on the employer's alleged promise to provide life insurance and her mere assertion, first made in her closing argument, that had they known they might have found another policy is insufficient to prove reliance. John v. Chuuk Public Utility Corp., 16 FSM R. 226, 228 (Chk. 2008).

In the absence of special circumstances, such as the existence of an incontestable clause in the policy, fraud is fully available to the insurer as a defense in an action at law on the policy. Sigrah v. Micro Life Plus, 16 FSM R. 253, 258 (Kos. 2009).

An insurer may void an insurance contract on the grounds that the insured willfully misrepresented a material fact since the misrepresentation prevents a meeting of the minds, or mutual assent, as to the risk to be insured. A material representation or omission of fact in an insurance application, relied on by the insurer in issuing the policy, renders the coverage voidable at the insurance company's option. This protects the insurer's right to know the full extent of the risk it undertakes when an insurance policy is issued. The mutual good faith which is required in a life insurance contract will not permit a recovery where the insured intentionally withholds or conceals material changes in the condition of his health. Sigrah v. Micro Life Plus, 16 FSM R. 253, 259 (Kos. 2009).

An insurer seeking rescission of an insurance contract based on a misrepresentation in an insurance application must tender the premiums back to the insured. Sigrah v. Micro Life Plus, 16 FSM R. 253, 260 (Kos. 2009).

An insurer seeking to rescind a life insurance policy upon a ground which rendered it voidable from the beginning must return or tender the premium paid thereunder because rescission of an insurance contract would, if granted, absolve an insured from liability for the premium and entitle him to return of the premium paid since the general rule is that a contract must be rescinded in whole and cannot be rescinded in part. Sigrah v. Micro Life Plus, 16 FSM R. 253, 260 (Kos. 2009).

Reinstatement of an insurance policy cannot take place until after the insurer learned of the insured's misrepresentation and then waived it. Sigrah v. Micro Life Plus, 16 FSM R. 253, 260 n.3 (Kos. 2009).

The court will not hesitate to deny rescission and order enforcement of the contract when the party seeking rescission has not made a timely tender of the premiums (or benefit) it received under the contract. Sigrah v. Micro Life Plus, 16 FSM R. 253, 261 (Kos. 2009).

Under the FSM Constitution, the power to establish systems of social security and public welfare may be exercised concurrently by Congress and the states. The State of Chuuk therefore has the constitutional authority to establish a system of health insurance since it is a system created to promote and advance the public welfare of Chuuk. Chuuk Health Care Plan v. Department of Educ., 18 FSM R. 491, 496 (Chk. 2013).

The FSM does not need each state employee to individually notify it that the employee is enrolled in the Chuuk Health Care Plan since the Act provides for universal coverage for Chuuk residents. Chuuk Health Care Plan v. Department of Educ., 18 FSM R. 491, 496 (Chk. 2013).

When the insurance carrier approved the patient's off-island referral within two days and was ready to put her on the earliest possible flight but the patient did not leave until 20 days

later and when this long delay was the proximate cause of the patient's death, the insurance carrier's actions were not the proximate cause of her death because the insurance carrier did not cause the delay. William v. Kosrae State Hosp., 18 FSM R. 575, 581 (Kos. 2013).

A 1991 memorandum of understanding between the insurer and the Kosrae State Hospital that required that the hospital provide all necessary health care services within Kosrae to all covered persons and that these services would include the cost of a medical or other attendant to accompany a covered person to a health care facility is an agreement that allocates the cost of attendants between the parties to the memorandum and it does not, by itself, allocate costs or create duties between the state and the insureds ("covered persons") and their families. William v. Kosrae State Hosp., 18 FSM R. 575, 582 (Kos. 2013).

When the statute is silent about what result should follow if the Health Care Board does not submit draft legislation for the selection of its members by citizen enrolles and when that statute only directs the submission of draft legislation but does not require (nor could it) its enactment, the Board's failure to comply does not render the Board's composition illegal or its acts ultra vires. Mailo v. Chuuk Health Care Plan, 19 FSM R. 185, 188 (Chk. 2013).

A plaintiff's claim under a promissory estoppel and detrimental reliance cause of action is supported when the plaintiff has timely paid the insurance premiums since 1996; when her reasonable expectation was that she and her dependents would receive life and cancer insurance coverage; when she expected that, as an insured, that the insurer's agents would provide her with accurate and reliable information about the policies, which would include when a dependent is no longer covered and what steps to take when coverage has ceased; when the insurer did not fulfill these expectations, to the detriment of her and her dependents; and when, if the insurer had properly advised her, she would have had the opportunity to take out a separate cancer policy for her daughter and her daughter would have been eligible for cancer policy benefits once she was diagnosed with cancer in 2009. Johnny v. Occidental Life Ins., 19 FSM R. 350, 359-60 (Pon. 2014).

The doctrine of unjust enrichment does not apply when there is a legally binding agreement in the form of life and cancer insurance policies that the parties agreed to and executed. Johnny v. Occidental Life Ins., 19 FSM R. 350, 360 (Pon. 2014).

The statutory requirement that an insurance policy must be signed by two major officers of the insurance company is fulfilled when the cover page of the policy shows the signatures of the company's Secretary and President. Johnny v. Occidental Life Ins., 19 FSM R. 350, 361 (Pon. 2014).

Contracts impose on the parties a duty to do everything necessary to carry them out, and there is an implied undertaking in every contract on each party's part that he will not intentionally and purposely do anything to prevent the other party from carrying out his part of the agreement, or do anything which will have the effect of destroying or injuring the right of the other party to receive the fruits of the contract. The FSM Supreme Court will entertain such claims in the context of insurance contracts, when the insurer possesses greater sophistication, provides the policy, can be expected to assist insureds in understanding the relevant terminology in the policy, and has a specialized role in processing claims. Johnny v. Occidental Life Ins., 19 FSM R. 350, 361-62 (Pon. 2014).

Under the circumstances of an insurance case, there may be a duty to disclose information,

based on a relationship of confidence or trust between the parties, or based on one party's superior knowledge or means of knowledge. Johnny v. Occidental Life Ins., 19 FSM R. 350, 362 (Pon. 2014).

As used in the insurance context, bad faith does not refer to misconduct of a malicious or immoral nature. Rather, the bad faith concept emphasizes unfaithfulness to an agreed common purpose or to the justifiable expectations of the other party to the contract. In short, a showing of bad faith requires that insurers not act unreasonably or arbitrarily when dealing with their insureds. Johnny v. Occidental Life Ins., 19 FSM R. 350, 362 (Pon. 2014).

Insuring vessels that later navigate through FSM waters is not, by itself, sufficient to give the court personal jurisdiction over the insurer. People of Eauripik ex rel. Sarongelfeg v. Osprey Underwriting Agency, Ltd., 20 FSM R. 205, 210 (Yap 2015).

Since the FSM long-arm statute only requires for personal jurisdiction that the defendant be a party to a contracting to insure a risk located in the FSM, it may cover an agency providing underwriting and claims services for the actual insurers at Lloyd's of London. People of Eauripik ex rel. Sarongelfeg v. Osprey Underwriting Agency, Ltd., 20 FSM R. 205, 210-11 n.2 (Yap 2015).

Since the FSM long-arm statute specifically provides for personal jurisdiction over non-residents contracting to insure any person, property, or risk located within the FSM at the time of contracting, it does not allow the court to exercise personal jurisdiction over an insurer that insured a vessel that was not located in the FSM, but was in Singapore at the time of contracting for marine insurance. People of Eauripik ex rel. Sarongelfeg v. Osprey Underwriting Agency, Ltd., 20 FSM R. 205, 211 (Yap 2015).

Without a direct action statute, an injured third-party cannot sue an insurer directly because an insurer has no contractual obligation to persons other than its insured, at least until a court determines the liability of its insured and the insurer cannot be joined as a party to a lawsuit to determine that liability. People of Eauripik ex rel. Sarongelfeg v. Osprey Underwriting Agency, Ltd., 20 FSM R. 205, 211 (Yap 2015).

Even without a direct action statute, an insurer with world-wide coverage could expect to be called upon to help defend its insured in FSM courts. People of Eauripik ex rel. Sarongelfeg v. Osprey Underwriting Agency, Ltd., 20 FSM R. 205, 211 (Yap 2015).

Generally, an insurer has the duty to defend, the duty to indemnify, the duty to settle, and the duty (or implied covenant) of good faith and fair dealing. These duties are all owed to its insured with whom the insurer has a contractual relationship, not to injured third-party claimants. People of Eauripik ex rel. Sarongelfeg v. Osprey Underwriting Agency, Ltd., 20 FSM R. 205, 213 (Yap 2015).

An injured claimant may not sue an insurer for breach of the duty of good faith and fair dealing. The duty is a product of the fiduciary relationship created by the contract between the insurer and its insured. People of Eauripik ex rel. Sarongelfeg v. Osprey Underwriting Agency, Ltd., 20 FSM R. 205, 213 (Yap 2015).

An insured's cause of action for the insurer's breach of the covenant of good faith and fair dealing is assignable to the injured third-party claimant, and the assignee may sue on it. People

of Eauripik ex rel. Sarongelfeg v. Osprey Underwriting Agency, Ltd., 20 FSM R. 205, 213 (Yap 2015).

When an insurance carrier's endorsement contained within an employer's policy limited the applicability of the CNMI Workers' Compensation Program to "the benefits provided under the Workers' Compensation Law of the CNMI," (which would entail that statute's "determination of pay," that statute's exclusive remedy provision setting forth tort immunity does not apply, and an employee would not be forestalled from also bringing a civil action sounding in negligence. Hairens v. Federated Shipping Co., 20 FSM R. 404, 409 (Pon. 2016).

When the insurance agents' failure to differentiate between the insured's life and cancer policies was careless, but not arbitrary and unreasonable, and did not deprive the insured of her bargained-for benefit, the trial court's conclusion that the insurers breached the implied covenant of good faith and fair dealing or that they engaged in bad faith conduct was reversible error. Occidental Life Ins. Co. v. Johnny, 20 FSM R. 420, 428-29 (App. 2016).

A plaintiff's averment that the defendant engaged in practices designed to discourage employee enrollment in health insurance is merely a conclusory allegation insufficient to state a claim because there are no facts alleged in support of the conclusion. Chuuk Health Care Plan v. FSM Dev. Bank, 21 FSM R. 300, 309 (Chk. 2017).

Breach of an implied covenant of good faith and fair dealing is a common law cause of action. It is a tort claim that arises out of a contractual relationship between the parties, and it rests on the premise that whenever a party's cooperation is necessary for the performance of a contractual promise, there is a condition implied that the cooperation will be given. Donre v. FSM Nat'l Gov't Employees' Health Ins. Plan, 21 FSM R. 592, 598 (Pon. 2018).

A supplemental term life insurance rider does not constitute an individual insurance plan. It is in name and in function an attachment to an existing insurance plan. Barnabas v. Individual Assurance Co., 22 FSM R. 252, 256 (Pon. 2019).

A "policy endorsement" is an insurance-specific document that may add, remove or modify existing coverage. It is not a stand-alone document. Barnabas v. Individual Assurance Co., 22 FSM R. 252, 256 (Pon. 2019).

A "conversion privilege" allows term life insurance to convert to a permanent or individual policy. Term life insurance cannot be or become an individual policy without a conversion option. Barnabas v. Individual Assurance Co., 22 FSM R. 252, 256 (Pon. 2019).

– Agents and Brokers

An insurance broker is an independent middleman between the insured and the insurance company who does not represent any particular insurance company. Actouka Executive Ins. Underwriters v. Simina, 15 FSM R. 642, 651 (Pon. 2008).

An agreement to perform the service of obtaining insurance is different from the contract of insurance itself. Actouka Executive Ins. Underwriters v. Simina, 15 FSM R. 642, 651 (Pon. 2008).

When an insurance agent's contract with the insurer contains language regarding the agent's duty to make certain that the premium checks were sent to the insurer, the agent is liable to the insurer for breach of contract when the agent failed to fulfill the contractual obligation to send the premium checks to the insurer's office in Kansas City. Individual Assurance Co. v. Iriarte, 16 FSM R. 423, 437-38 (Pon. 2009).

Since insurance agents are required to exercise the utmost good faith, loyalty, and honesty toward the insurer during the times that they acted as the insurer's agents, by cashing the premium checks, and thereby failing to send the checks on to the insurer, they breached this duty. Individual Assurance Co. v. Iriarte, 16 FSM R. 423, 441 (Pon. 2009).

An insurer has no duty to its agents to undertake an investigation for the agents' benefit in order to stop the agents from converting the insurer's property. When the insurer's property was converted by the agents' intentional actions, the agents cannot argue that the insurer should have known that they were converting – stealing – the insurer's property, and that since the insurer should have stopped them but did not stop them from doing what they had no right to do, the agents should not have to pay back what they took. Individual Assurance Co. v. Iriarte, 16 FSM R. 423, 443 (Pon. 2009).

The insurer ratified, or approved, the check cashing activities of its agents to the extent that they distributed the money obtained from the checks to policy holders for legitimate insurance purposes, and that the insurer gave credit to its agents for these distributions shows this conclusively. But the insurer never ratified the agents' conversion of the funds that were not accounted for, or were not used for insurance purposes since the insurer's efforts to figure out what had happened, to stop it from happening, to arrive at an accounting for the missing money, and to restore order to its Pohnpei operation, manifest its disapproval of the practice of cashing premium checks initiated and continued by its agents. Individual Assurance Co. v. Iriarte, 16 FSM R. 423, 444 (Pon. 2009).

While there may be no general duty to explain the type of insurance involved, insurance agents may be found to have additional duties when specifically questioned by the insured as to the appropriate level of insurance. Johnny v. Occidental Life Ins., 19 FSM R. 350, 358 (Pon. 2014).

A principal is bound by, and liable for, the acts which his agent does with or within the actual or apparent authority from the principal, and within the scope of the agent's employment, and an insurance company's general agent is one who has authority to transact all the business of an insurance company of a particular kind, or in a particular place, and whose powers are coextensive with the business entrusted in the agent's care. Agents have been regarded as general agents when they fully represent the insurance company in a particular district and are authorized to solicit insurance, receive money and premiums, issue and renew polices, appoint subagents, and adjust loses. Johnny v. Occidental Life Ins., 19 FSM R. 350, 362-63 (Pon. 2014).

Not every mistake by an insurer or its agent rises to the level of bad faith – is automatically unreasonable or arbitrary. An insurance agent's misrepresentation, particularly an unintentional misrepresentation, may breach the agent's duty of care toward the insured rather than constitute bad faith and unreasonable and arbitrary conduct towards an insured. Occidental Life Ins. Co. v. Johnny, 20 FSM R. 420, 428 (App. 2016).

– Application for and Acceptance

An insurance contract, like all contracts, requires an offer and acceptance to be effective, and, like any contract, an insurance contract is formed when an unrevoked offer by one person is accepted by another, thus satisfying the two prerequisites of mutual assent. Sigrah v. Micro Life Plus, 16 FSM R. 253, 257 (Kos. 2009).

An application for insurance standing alone does not constitute a contract upon which judgment can be recovered. It is merely an offer or request for insurance which may either be accepted or rejected by the insurer. An insurer is at liberty to choose its own risks and is not bound to accept an insurance application for insurance. Sigrah v. Micro Life Plus, 16 FSM R. 253, 258 (Kos. 2009).

An insurance contract may be established when one of the parties to the contract proposes to be insured and the other party agrees to insure, and the subject, the amount, and the rate of insurance are ascertained or understood and the premium is paid if demanded. Sigrah v. Micro Life Plus, 16 FSM R. 253, 258 (Kos. 2009).

An insurer may rely on an applicant's representations as truthful, and, in the absence of information that gives an insurer notice that an insurance applicant has misrepresented facts, an insurer has no duty to investigate an applicant's representations. Sigrah v. Micro Life Plus, 16 FSM R. 253, 258 (Kos. 2009).

An insurance applicant has a duty to be truthful and accurate in making representations when applying for insurance. In insurance law, a representation is a statement made prior to the issuance of a policy which tends to cause the insurer to assume the risk. Sigrah v. Micro Life Plus, 16 FSM R. 253, 259 (Kos. 2009).

A misrepresentation in a negotiation for a life insurance policy is a statement as a fact of something that the insured knows or should know is untrue. Sigrah v. Micro Life Plus, 16 FSM R. 253, 259 (Kos. 2009).

It is a long-established common law rule that an insurance applicant has a duty to inform the insurer of answers that would need to be changed between the date of the application and the insurance policy's effective date. The rule is that the insured must inform the company of any change in his physical condition of which he becomes cognizant after making the application for the policy and prior to the delivery thereof. This duty to disclose any change in health exists regardless of whether there is a policy provision requiring such disclosure. Sigrah v. Micro Life Plus, 16 FSM R. 253, 259 (Kos. 2009).

An insurer may void an insurance contract on the grounds that the insured willfully misrepresented a material fact since the misrepresentation prevents a meeting of the minds, or mutual assent, as to the risk to be insured. A material representation or omission of fact in an insurance application, relied on by the insurer in issuing the policy, renders the coverage voidable at the insurance company's option. This protects the insurer's right to know the full extent of the risk it undertakes when an insurance policy is issued. The mutual good faith which is required in a life insurance contract will not permit a recovery where the insured intentionally withholds or conceals material changes in the condition of his health. Sigrah v. Micro Life Plus,

16 FSM R. 253, 259 (Kos. 2009).

An insurer seeking rescission of an insurance contract based on a misrepresentation in an insurance application must tender the premiums back to the insured. Sigrah v. Micro Life Plus, 16 FSM R. 253, 260 (Kos. 2009).

If an insurer seeks to avoid liability for the policy death benefit because of the insured's misrepresentation in the application process, it must tender the premiums to the beneficiaries. If it does not, it cannot prevail on the defense that the insured's misrepresentation made the policy voidable. This is because, after an insured's death, if a tender of the premium in avoidance of the life insurance policy for misrepresentation is not made to the beneficiaries in a timely manner or within a reasonable time, the defense of fraud or misrepresentation is deemed waived, and if the beneficiaries refuse the tender, it should then be paid into court before the insurer seeks a decision on the merits of its defense of fraud or misrepresentation. Sigrah v. Micro Life Plus, 16 FSM R. 253, 260 (Kos. 2009).

An insurance contract was formed when there was an invitation made by the insurer to provide life and cancer insurance coverage to the plaintiff and the plaintiff offered to enroll under the policy and the insurer accepted the offer by issuing life and cancer insurance policies and accepting premiums that the plaintiff paid through bi-weekly allotments. The parties' reasonable expectations were that the plaintiff would make timely payments on the policy, and that the insurer would provide coverage subject to the policy's terms. Johnny v. Occidental Life Ins., 19 FSM R. 350, 357 (Pon. 2014).

When the insurer's denial of insurance benefits was lawful, the insured does not have a breach of contract claim. Donre v. FSM Nat'l Gov't Employees' Health Ins. Plan, 21 FSM R. 592, 598 (Pon. 2018).

– Claims and Benefits

The court cannot say that an insurance claims process which consumed between 3 and 4 months from the filing of the claim to the issuance of a denial is so lengthy, so egregious, as to constitute bad faith as a matter of law. Phillip v. Marianas Ins. Co., 12 FSM R. 301, 308 (Pon. 2004).

An insurance policy beneficiary has standing to sue for unpaid insurance policy benefits. John v. Chuuk Public Utility Corp., 15 FSM R. 169, 171 (Chk. 2007).

Only if a life insurance policy had no designated or named beneficiary, would the policy benefits be payable to his estate to be distributed through probate to his heirs or devisees. John v. Chuuk Public Utility Corp., 15 FSM R. 169, 171 (Chk. 2007).

When the plaintiff alleges that she is the third-party beneficiary of an insurance contract, the six-year statute of limitations for breach of contract generally applies. John v. Chuuk Public Utility Corp., 15 FSM R. 169, 171 (Chk. 2007).

Only if a life insurance policy has no designated or named beneficiary, would the policy benefits be payable to a decedent's estate to be distributed through probate to his heirs or devisees. In re Estate of Manas, 15 FSM R. 609, 611 (Chk. S. Ct. Tr. 2008).

When the decedent's life insurance policy named his mother, who predeceased the decedent, as beneficiary, the rights in the policy became part of her estate when she died and descended to the devisees according to her will, if she had one, or her heirs according to the law of intestate succession, if she had no will. In re Estate of Manas, 15 FSM R. 609, 611 (Chk. S. Ct. Tr. 2008).

Generally rights of a beneficiary pass to the beneficiary's estate in the event of the beneficiary's death during the lifetime of the insured, but if a policy reserves to the insured the right to change the beneficiary, the beneficiary's rights may cease in the event of the beneficiary's death during the insured's lifetime. In re Estate of Manas, 16 FSM R. 82, 83 (Chk. S. Ct. Tr. 2008).

An insurance policy's benefits are payable only to those who are beneficiaries. Sigrah v. Micro Life Plus, 16 FSM R. 253, 256 n.1 (Kos. 2009).

If an insurer seeks to avoid liability for the policy death benefit because of the insured's misrepresentation in the application process, it must tender the premiums to the beneficiaries. If it does not, it cannot prevail on the defense that the insured's misrepresentation made the policy voidable. This is because, after an insured's death, if a tender of the premium in avoidance of the life insurance policy for misrepresentation is not made to the beneficiaries in a timely manner or within a reasonable time, the defense of fraud or misrepresentation is deemed waived, and if the beneficiaries refuse the tender, it should then be paid into court before the insurer seeks a decision on the merits of its defense of fraud or misrepresentation. Sigrah v. Micro Life Plus, 16 FSM R. 253, 260 (Kos. 2009).

Cash advances are deducted from the policy's cash value and if the insured dies before repaying it that amount (plus interest) is deducted from the death benefit. Iriarte v. Individual Assurance Co., 18 FSM R. 340, 360 n.10 (App. 2012).

When the insurance benefit is a amount of $10,000 lump sum payment; when the agreement does not specify if expenses incurred for an attendant accompanying a patient for off-island treatment is covered under the policy; and when there was no evidence presented at trial as to the nature and amount of expenses incurred, the expenses claim will be denied. Johnny v. Occidental Life Ins., 19 FSM R. 350, 360-61 (Pon. 2014).

When certain expenses had been covered by a different insurance plan, the court will not grant relief that would provide the plaintiff with a double recovery. Johnny v. Occidental Life Ins., 19 FSM R. 350, 361 (Pon. 2014).

When the damages amount was a liquidated sum and the insurance contract involved a promise to pay money if certain events occurred, the plaintiff will be awarded the 9% statutory rate of interest from a reasonable time of 60 days after the diagnosis of her daughter's cancer was submitted to the insurer in a claim form for accident and health policies. Johnny v. Occidental Life Ins., 19 FSM R. 350, 363 (Pon. 2014).

An insurance contract in the FSM that made reference to "the benefits provided under the Workers' Compensation of the CNMI," only intended to merely utilize 4 N. Mar. I. Code § 9310 to ascribe a dollar amount to the benefits to which an injured employee would be entitled, as opposed to adopting the entire CMNI Workers' Compensation Program. Hairens v. Federated

Shipping Co., 20 FSM R. 404, 408 (Pon. 2016).

When the insurer's denial of insurance benefits was lawful, the insured does not have a breach of contract claim. Donre v. FSM Nat'l Gov't Employees' Health Ins. Plan, 21 FSM R. 592, 598 (Pon. 2018).

When the insured's remaining claims are all based on the insurer's denial of insurance coverage and when that denial was lawful, the insured's remaining claims will be dismissed. Donre v. FSM Nat'l Gov't Employees' Health Ins. Plan, 21 FSM R. 592, 598 (Pon. 2018).

– Coverage

When the insurance contract language excludes bailment leases, a plaintiff vehicle rental business is not entitled to judgment as a matter of law on a claim that the defendants breached the insurance contract when they did not pay for a damaged rental vehicle. Phillip v. Marianas Ins. Co., 12 FSM R. 301, 305 (Pon. 2004).

In an insurance contract that provides that when the word "insured" is utilized in an "unqualified" manner within the contract, the word will be understood to include all individuals who operate an insured vehicle with the permission of the named insured, but where an exclusion provision does not utilize the word "insured" in an unqualified manner and instead specifies that the provision applies to the "Named Insured," the effect of that qualification is to narrow the definition of "insured" to only those individuals who are actually named on the policy. The term "Named Insured" does not include permissive users. Phillip v. Marianas Ins. Co., 12 FSM R. 301, 306 (Pon. 2004).

When there is a contradiction between the first and second sentences of an insurance policy exclusion, it must be construed against the insurance company that drafted the language and was in a superior bargaining position when the contract was entered into. Phillip v. Marianas Ins. Co., 12 FSM R. 301, 306 n.3 (Pon. 2004).

As the vessels' owner, and as a named insured under the policies along with the four states, the FSM received a benefit as a result of the fleet insurance coverage, but in order to establish a claim for quantum meruit, the insurance broker must demonstrate that the FSM was unjustly enriched by the benefit of the broker paying the premium for Chuuk. But the agreement between Chuuk and the FSM was that FSM would permit Chuuk to use vessels that the FSM owned and Chuuk, in return, would pay for insurance coverage for those vessels; so by advancing the insurance premium, the broker met Chuuk's obligation to the FSM in this regard. The primary benefit conferred by the insurance premium payments went to Chuuk, and not to the FSM, since Chuuk was also an insured along with the FSM under the policies and it was Chuuk's, not the FSM's, obligation to provide coverage for the vessels. To suggest that when Chuuk failed to meet its obligation to the FSM to insure the vessels, the FSM became liable for the premiums on the vessels is to lose sight of the fact that the vessels were being operated by Chuuk and for Chuuk's benefit on the condition that Chuuk provide the insurance. The broker's remedy for the premium nonpayment is against Chuuk, who breached its agreement with the FSM by failing to pay for the premiums. The broker's remedy does not extend to the FSM. Actouka Executive Ins. Underwriters v. Simina, 15 FSM R. 642, 655 (Pon. 2008).

Every Chuuk resident is enrolled in the Chuuk Health Care Act and is eligible to receive

benefits under it, except for unemployed noncitizens residing in the State who are not dependents of enrollees. Chuuk Health Care Plan v. Pacific Int'l, Inc., 17 FSM R. 617, 620 (Chk. 2011).

Under the Chuuk Health Care Act, a "resident" is any Chuuk citizen for whom Chuuk is his principal residence, or any noncitizen who has established an ongoing physical presence in Chuuk and whose presence is sanctioned by law and is not merely transitory in nature. The non-citizen workers' ongoing physical presence in Chuuk is clearly sanctioned by law when the non-citizen employees apply annually for labor certification and for entry permits in order to maintain their employment in Chuuk. Chuuk Health Care Plan v. Pacific Int'l, Inc., 17 FSM R. 617, 620 (Chk. 2011).

Even though a contractor's non-citizen employees cannot be domiciled in Chuuk, they might have a legal residence here, but, even if they are not considered to have a legal residence here, they do have an actual residence in Chuuk that is legally sanctioned, and they are thus, by statute, enrolled in and eligible for Chuuk Health Care Plan benefits and their employer is therefore liable, as a matter of law, to the Plan for the employees' and the employer's contributions of the health insurance premiums for its non-citizen as well as citizen employees on Chuuk. Chuuk Health Care Plan v. Pacific Int'l, Inc., 17 FSM R. 617, 620 (Chk. 2011).

Under a fleet insurance policy, the premiums must be paid for all the ships in the fleet before any has coverage. Chuuk v. Actouka Executive Ins. Underwriters, 18 FSM R. 111, 118 (App. 2011).

Every Chuuk state employee is automatically an enrollee in the Chuuk Health Care Plan by operation of law since under the Chuuk Health Care Plan Act every Chuuk resident (except unemployed noncitizens who are not dependents of enrollees) is enrolled in and is eligible to receive benefits and "resident' means any citizen of Chuuk for whom Chuuk is his principal residence or any noncitizen who has established an ongoing physical presence in Chuuk and whose presence is sanctioned by law and is not merely transitory in nature. Chuuk is an employer as defined by the Act. Chuuk Health Care Plan v. Department of Educ., 18 FSM R. 491, 496 (Chk. 2013).

Non-citizen employees who reside in Chuuk are covered by the Chuuk Health Care Plan and required to make health insurance premium contributions. Chuuk Health Care Plan v. Chuuk Public Utility Corp., 18 FSM R. 409, 411 n.1 (Chk. 2012).

The insurer did not breach an insurance policy's terms when it denied coverage because the dependent was not a covered family member since, although she was under 25, she had not been enrolled as a full time student in a post-secondary institution of higher learning for five calendar months or more. Johnny v. Occidental Life Ins., 19 FSM R. 350, 358 (Pon. 2014).

The promises made by the insurer's agents bind the insurer and must be enforced in order to avoid manifest injustice because if the plaintiff had enrolled her daughter under a separate cancer policy, she would have been covered under her own policy, but instead, the agent's misrepresentation caused her to keep her daughter under her cancer policy, making the daughter ineligible at the time she was diagnosed with cancer because she did not qualify as a covered family member under that policy's provisions. Johnny v. Occidental Life Ins., 19 FSM R. 350, 359 (Pon. 2014).

When an agent has been employed by the insurer for approximately 25 years and, although he may not have had the power to unilaterally amend policies, he informed the plaintiff that cancer coverage was up to 25 years of age; and when, because he was the manager of the insurer's office in Pohnpei and aside from a subordinate he was the only insurer's representative whom the plaintiff was in contact with, the plaintiff had ample reason to rely and accept his statements as the truth. Johnny v. Occidental Life Ins., 19 FSM R. 350, 363 (Pon. 2014).

When the medical insurance coverage excludes treatment of injuries that are attributable to the member's own intemperate use of drugs or alcohol and when the insured was extremely intoxicated and admittedly under the heavy influence of sakau, the court will consider whether the plaintiff, despite his intoxication, would have fallen from the ridge since if the fall would have occurred even if the insured was not drunk, then the insured's injuries should have been covered because the denial of insurance benefits was attributed to his intoxication. Donre v. FSM Nat'l Gov't Employees' Health Ins. Plan, 21 FSM R. 592, 596-97 & n.3 (Pon. 2018).

When, because of the insured's misconduct, the insurer was not obligated to cooperate by extending medical coverage to the insured, the insured's cause of action for breach of implied covenant of good faith and fair dealing is void. Donre v. FSM Nat'l Gov't Employees' Health Ins. Plan, 21 FSM R. 592, 598 (Pon. 2018).

A "policy endorsement" is an insurance-specific document that may add, remove or modify existing coverage. It is not a stand-alone document. Barnabas v. Individual Assurance Co., 22 FSM R. 252, 256 (Pon. 2019).

A "universal life insurance policy" is a permanent, individual policy that accumulates cash value. Term insurance covers only a period of time and therefore does not accrue cash value. Accordingly, premium refunds do not normally apply to term insurance. Barnabas v. Individual Assurance Co., 22 FSM R. 252, 256 (Pon. 2019).

– Credit Life Insurance

Where a creditor accepts a premium payment for insurance that he has agreed to procure, where he makes a diligent effort to fulfill his agreement to do so, promptly notifies the debtor of his inability to procure insurance, he would not be held liable to the debtor, as he would have fulfilled his contract to attempt to procure insurance which is not a contract of insurance. FSM Dev. Bank v. Bruton, 7 FSM R. 246, 250 (Chk. 1995).

The general rule is that where a creditor has failed to both procure credit insurance paid for by the debtor and to notify the debtor of his failure to procure the insurance requested, prior to loss, the debtor may plead such failure as a defense or setoff. FSM Dev. Bank v. Bruton, 7 FSM R. 246, 250 (Chk. 1995).

Both contract and tort theories can be pursued by a debtor who alleges that a creditor has failed to procure credit insurance. FSM Dev. Bank v. Bruton, 7 FSM R. 246, 251 (Chk. 1995).

A creditor who undertakes to secure credit insurance for a debtor is liable to the debtor for negligent performance of that duty or of duty to notify debtor if insurance not obtained. FSM Dev. Bank v. Bruton, 7 FSM R. 246, 251 (Chk. 1995).

Failure of a creditor to notify the debtor of its failure to obtain insurance is negligence. As a consequence the creditor is liable to the debtor for the entire amount of the debtors' loss, otherwise the debtor is only entitled to return of full amount of insurance premiums paid. FSM Dev. Bank v. Bruton, 7 FSM R. 246, 251 (Chk. 1995).

A creditor who undertakes to secure credit insurance for a debtor is liable to the debtor for negligent performance of that duty or of duty to notify debtor if insurance not obtained. FSM Dev. Bank v. Carl, 20 FSM R. 592, 593 (Pon. 2016).

When the debtor has not produced evidence to show that credit insurance was obtained when the loan was entered into, the court will not rule that the debt has been discharged although, if credit insurance had been obtained, the debtor would have had a valid claim of discharge of the debt. FSM Dev. Bank v. Carl, 20 FSM R. 592, 594 (Pon. 2016).

When a borrower's credit life insurance policy was for a four-year term and expired about eighteen years before the borrower's death, the claim for insurance coverage to cover the borrower's debt is invalid. FSM Dev. Bank v. Carl, 21 FSM R. 640, 642-43 (Pon. 2018).

– Lapse and Cancellation

When a group insurance policy is non-participatory in that the employee contributes nothing to the payment of the premiums, no contractual relationship arises between the employee and the insurer. Therefore the insurer was under no contractual obligation to provide the decedent employee with notice that the group policy lapsed. John v. Chuuk Public Utility Corp., 16 FSM R. 66, 68 (Chk. 2008).

The effect of an employer's cancellation of the master policy in regard to an employee's coverage depends primarily on the time at which the employer does so. If it occurs before liability under the policy has attached, the insurer is released from any liability that might subsequently accrue so that when the insurer's coverage of CPUC employees lapsed before its employee died, and therefore before liability under the policy attached, the insurer, as a matter of law, was not liable. John v. Chuuk Public Utility Corp., 16 FSM R. 66, 68 (Chk. 2008).

When the court has not been supplied with the information necessary for the court to take judicial notice that life insurance was a state employee benefit when CPUC was created and what the insurance coverage's terms were or to conclude that CPUC has not adopted its own merit system with changed benefits, there are genuine issues of material fact that preclude either party being entitled to summary judgment: 1) whether state employees in 1997 were afforded life insurance benefits and on what terms (contributory, non-contributory; on the job only, 24-hour; etc.); 2) whether CPUC has since established its own merit system and then altered the benefits; and 3) whether, if notice of the lapse of insurance coverage was required, it was given for the July 2004 lapse. John v. Chuuk Public Utility Corp., 16 FSM R. 66, 69 (Chk. 2008).

When the group insurance plan is non-contributory – when the employee does not contribute anything towards payment of the insurance premiums – the employee is not entitled to notice that the employer has ceased paying the premiums. John v. Chuuk Public Utility Corp., 16 FSM R. 226, 227 (Chk. 2008).

37 F.S.M.C. 404, by its terms, does not apply to the cancellation of a life insurance policy when there are no issues of non-payment of a premium. Barnabas v. Individual Assurance Co., 22 FSM R. 252, 255 (Pon. 2019).

When 37 F.S.M.C. 404 does not apply to a life insurance policy's cancellation, the court will evaluate the matter according to the terms of the agreements among the parties. Barnabas v. Individual Assurance Co., 22 FSM R. 252, 256 (Pon. 2019).

When the continuation of a supplemental term life insurance policy was contingent upon sufficient enrollment in the group policy, and when, according to the plan's terms, if the plan enrollment fell below "35% of those eligible" to participate, the insurer could terminate the policy, the insurer was entitled to terminate the policy as set forth in the supplemental term life insurance policy. Barnabas v. Individual Assurance Co., 22 FSM R. 252, 257 (Pon. 2019).

When the supplemental term life insurance rider provided that 61 days' notice was required to terminate the supplemental life insurance plan, the insurer's notice to the employer, given 66 calendar days before termination, was sufficient notice as required by the policy. It was incumbent upon the employer, not the insurer, to provide notice to policyholders. Barnabas v. Individual Assurance Co., 22 FSM R. 252, 257 (Pon. 2019).

When the insureds received refunds through their employer, as what should occur only for group insurance policies, not individual insurance policies, and when the insurer instructed the employer to stop all employee payroll deductions for supplemental group life insurance, the insurer did not convert the insureds' money and was not unjustly enriched. Barnabas v. Individual Assurance Co., 22 FSM R. 252, 257 (Pon. 2019).

– Premiums

Insureds frequently pay premiums by executing a promissory note – a "premium note," and, depending on the circumstances of its execution, may pay the premium in full through the execution of a premium note. Phillip v. Marianas Ins. Co., 12 FSM R. 301, 309 (Pon. 2004).

Before an insurance company can obtain summary judgment on an action for enforcement of a premium note, the defenses available to the enforcement of a premium note must be addressed. Phillip v. Marianas Ins. Co., 12 FSM R. 301, 309 (Pon. 2004).

A measure of damages for the tort of negligent misrepresentation (also called deceit) employs the benefit of the bargain rule when damages can be proved with reasonable certainty. Under this principle, the insurer would be entitled to its premium, which would be set off against what it owed its insured. Phillip v. Marianas Ins. Co., 12 FSM R. 464, 469 (Pon. 2004).

Rescission of an insurance contract would, if granted, absolve an insured from liability for the premium and could even entitle him to return of the premium paid. Phillip v. Marianas Ins. Co., 12 FSM R. 464, 470 (Pon. 2004).

Various writings, admitted into evidence, which were signed on the behalf of Chuuk, the party to be charged, can establish by a preponderance of the evidence that the plaintiff and Chuuk entered into an agreement whereby the plaintiff would obtain insurance on Chuuk's

vessels for the two periods in question, and that Chuuk would pay for the premiums for the insurance obtained. Actouka Executive Ins. Underwriters v. Simina, 15 FSM R. 642, 651 (Pon. 2008).

A marine insurance broker who advances fleet insurance premiums may obtain reimbursement from the insured on whose behalf it advanced those premiums under an implied-in-law contractual right to reimbursement of the premiums it advanced on another's behalf when the implied-in-law contractual right is integrally related both to the contract whereby the broker was to procure insurance and to the insurance contracts that resulted from that agreement. Actouka Executive Ins. Underwriters v. Simina, 15 FSM R. 642, 652 (Pon. 2008).

When, although Chuuk did not pay the premiums, they were paid by the broker on Chuuk's behalf and the policies were in full force and effect for the vessels operated by Chuuk, Chuuk is responsible for these premiums because the broker established by a preponderance of the evidence at trial that the broker and Chuuk had entered into an agreement whereby the broker would procure insurance for the Chuuk-operated vessels and that Chuuk would pay for that insurance. This express contract serves as the basis for an implied-in-law contract that Chuuk is liable for reimbursement to the broker. Actouka Executive Ins. Underwriters v. Simina, 15 FSM R. 642, 653 (Pon. 2008).

The elements of a cause of action for quantum meruit are that 1) valuable goods or services are provided 2) to someone against whom recovery is sought 3) when the goods or services are enjoyed or used by the one against whom recovery is sought 4) under such circumstances that notified the person that the one performing the services or providing the goods expected payment. The fact that Chuuk did not know that its insurance broker had paid the premiums relates to the quantum meruit claim's fourth element, which is whether the benefit conferred by the in-force policies was enjoyed by Chuuk under circumstances such that Chuuk knew that the insurance broker expected payment. Since it is beyond question that Chuuk knew that the broker expected payment because Chuuk acknowledged in writing that the premiums were owed, the notice requirement to Chuuk is met by Chuuk's express acknowledgment that it owed the premiums pursuant to its enforceable contract with the broker. Accordingly, Chuuk's contention that it is not liable because it did not know that the broker had advanced the premiums on its behalf is without merit. Actouka Executive Ins. Underwriters v. Simina, 15 FSM R. 642, 654 (Pon. 2008).

An insurance broker did not violate the Chuuk Financial Management Act by advancing the premium on Chuuk's behalf when it was not a state officer, employee, or allottee within the meaning of the statute and it thus did not create an obligation within the statute's meaning because no evidence suggests that the broker was anything other than one of Chuuk's many vendors with whom Chuuk entered into a binding contract. Actouka Executive Ins. Underwriters v. Simina, 15 FSM R. 642, 654 (Pon. 2008).

When the evidence did not suggest that it was ever the understanding of those concerned that if one of the state operators failed to pay for insurance covering its vessels, the FSM would become liable for the insurance premiums because it owned the vessels, no contract to which the FSM was a party imposed such liability on the FSM. Actouka Executive Ins. Underwriters v. Simina, 15 FSM R. 642, 655 (Pon. 2008).

As the vessels' owner, and as a named insured under the policies along with the four states, the FSM received a benefit as a result of the fleet insurance coverage, but in order to

establish a claim for quantum meruit, the insurance broker must demonstrate that the FSM was unjustly enriched by the benefit of the broker paying the premium for Chuuk. But the agreement between Chuuk and the FSM was that FSM would permit Chuuk to use vessels that the FSM owned and Chuuk, in return, would pay for insurance coverage for those vessels; so by advancing the insurance premium, the broker met Chuuk's obligation to the FSM in this regard. The primary benefit conferred by the insurance premium payments went to Chuuk, and not to the FSM, since Chuuk was also an insured along with the FSM under the policies and it was Chuuk's, not the FSM's, obligation to provide coverage for the vessels. To suggest that when Chuuk failed to meet its obligation to the FSM to insure the vessels, the FSM became liable for the premiums on the vessels is to lose sight of the fact that the vessels were being operated by Chuuk and for Chuuk's benefit on the condition that Chuuk provide the insurance. The broker's remedy for the premium nonpayment is against Chuuk, who breached its agreement with the FSM by failing to pay for the premiums. The broker's remedy does not extend to the FSM. Actouka Executive Ins. Underwriters v. Simina, 15 FSM R. 642, 655 (Pon. 2008).

Life insurance premiums paid after the insured's death are unearned premiums and may be recovered from the date of the insured's death, provided that the date can be satisfactorily established. Sigrah v. Micro Life Plus, 16 FSM R. 253, 257 (Kos. 2009).

If an insurer seeks to avoid liability for the policy death benefit because of the insured's misrepresentation in the application process, it must tender the premiums to the beneficiaries. If it does not, it cannot prevail on the defense that the insured's misrepresentation made the policy voidable. This is because, after an insured's death, if a tender of the premium in avoidance of the life insurance policy for misrepresentation is not made to the beneficiaries in a timely manner or within a reasonable time, the defense of fraud or misrepresentation is deemed waived, and if the beneficiaries refuse the tender, it should then be paid into court before the insurer seeks a decision on the merits of its defense of fraud or misrepresentation. Sigrah v. Micro Life Plus, 16 FSM R. 253, 260 (Kos. 2009).

The court will not hesitate to deny rescission and order enforcement of the contract when the party seeking rescission has not made a timely tender of the premiums (or benefit) it received under the contract. Sigrah v. Micro Life Plus, 16 FSM R. 253, 261 (Kos. 2009).

Under a fleet insurance policy, the premiums must be paid for all the ships in the fleet before any has coverage. Chuuk v. Actouka Executive Ins. Underwriters, 18 FSM R. 111, 118 (App. 2011).

Under the Chuuk Health Care Act of 1994, it is the employer who is liable to the Health Care Plan for all health insurance premiums including the employee's contribution. Liability is not imposed on the employee. The Act also imposes sanctions on the employer for non-payment of the premiums. Chuuk Health Care Plan v. Chuuk Public Utility Corp., 18 FSM R. 409, 411 (Chk. 2012).

In order to collect overdue premiums or any amount imposed or authorized under the Chuuk Health Care Act of 1994, the Act authorizes civil actions against any person liable to pay any amount under the Act, that is, against the employer because under the Act that is who is liable. Chuuk Health Care Plan v. Chuuk Public Utility Corp., 18 FSM R. 409, 411 (Chk. 2012).

Non-citizen employees who reside in Chuuk are covered by the Chuuk Health Care Plan and required to make health insurance premium contributions. Chuuk Health Care Plan v.

Chuuk Public Utility Corp., 18 FSM R. 409, 411 n.1 (Chk. 2012).

Payment of Chuuk state employees' contributions and of the employer's contribution out of the Chuuk state funds held in the FSM Treasury is not be a tax or a levy on the national government or an illegal expenditure of FSM funds since the payment would be from Chuuk state funds and, because the obligation to withhold the Plan insurance premium contributions arises by operation of law, the Plan insurance premium contributions would be properly obligated and should be paid. Chuuk Health Care Plan v. Department of Educ., 18 FSM R. 491, 496-97 (Chk. 2013).

A plaintiff has a reasonable probability of success on the merits that insurance premiums will be ruled an income tax when the contributions are computed as a percentage of income earned as wages or salaries. Mailo v. Chuuk Health Care Plan, 18 FSM R. 501, 506 (Chk. 2013).

A statute that provides only that the Plan's Board "may prescribe" or "may establish" differing premium amounts based on the number of the enrollee's dependants, or on their risk factors, does not appear to require that differing premium amounts be set. Mailo v. Chuuk Health Care Plan, 18 FSM R. 501, 506 (Chk. 2013).

The balance-of-harms factor favors the defendant when the harm that it would suffer is that it would receive 16_% less revenue than it had expected or budgeted for on the basis of the 3% contribution it has been collecting instead of the 2½% that the plaintiff asks the court to enforce and when the harm to the plaintiff is the extra ½% contribution he is paying which could be credited to future health insurance premium contributions if found unlawful. Mailo v. Chuuk Health Care Plan, 18 FSM R. 501, 506 (Chk. 2013).

When the statute provides only that the Chuuk Health Care Plan's Board "may prescribe" or "may establish" differing premium amounts based on the number of the enrollee's dependants or on their "risk" factors, the statute does not require it, but leaves it to the Board's discretion, the Board may choose to assess premiums in a different manner. Mailo v. Chuuk Health Care Plan, 19 FSM R. 185, 189 (Chk. 2013).

When the health care assessments or premiums are not imposed by the Chuuk Legislature but are imposed by a public corporation, the Chuuk Health Care Plan through its Board and when the assessments or premiums are not deposited in the Chuuk General Fund but into a special trust fund, these attributes of the premium assessments are characteristic of a classic fee and the opposite of a classic tax. Even though the funds raised will be spent, at least indirectly, for the benefit of the entire Chuuk community since the funds will be spent for the benefit of people needing or using health care services, which is nearly everyone in Chuuk at one time or another, the premium assessments lie nearer the fee end of the spectrum than the tax end. Mailo v. Chuuk Health Care Plan, 19 FSM R. 185, 190 (Chk. 2013).

When the health insurance premiums and assessments are not raised for general revenue purposes and cannot be used for any Chuuk state government activity and can only be used for the purposes of the Health Care Plan Act and when the premiums or assessments help defray the cost of providing medical care, the benefits they provide are not of the sort often financed by a general tax. Mailo v. Chuuk Health Care Plan, 19 FSM R. 185, 190 (Chk. 2013).

When discretionary language "may" is used, which indicates that the insurance board has the power to consider these factors when assessing the insurance premiums and may exercise the power of applying these factors in the future, the discretion to do so is left with the board, and not with the court. Mailo v. Chuuk Health Care Plan, 20 FSM R. 18, 26 (App. 2015).

While it may be true that an agent and a principal may be sued in the same case for the same cause of action even when the principal's liability is predicated solely on the agency, when the principal's liability is not based on the agency but is based on a statute, the Chuuk Health Care Act of 1994, that imposes the liability only on the principal – the employer – and absolves the employee from any liability, the employee agent is not a proper party to the litigation. Chuuk Health Care Plan v. Waite, 20 FSM R. 282, 284 (Chk. 2016).

When the legal issue of whether the foreign citizen CPUC Chief Executive Officer could be a defendant in a lawsuit by the Chuuk Health Care Plan to collect unpaid health insurance premiums, thereby creating diversity jurisdiction, was previously litigated and a final decision rendered concluding that it could not be done; when the time to appeal that decision has expired; and when the same parties are present, res judicata bars the action in the FSM Supreme Court and the case will be dismissed without prejudice to any action in the Chuuk State Supreme Court. Chuuk Health Care Plan v. Waite, 20 FSM R. 282, 285 (Chk. 2016).

The Chuuk Health Care Plan enabling statute clearly imposes liability for the payments of premiums on all employers employing eligible residents of Chuuk. Chuuk Health Care Plan v. FSM Dev. Bank, 21 FSM R. 300, 305 (Chk. 2017).

Chuuk State Law No. 2-94-06 contemplates a comprehensive health insurance system whereby premium payments were required on behalf of eligible enrollees employed by the national government. The statute's language contemplates a system of "universal" coverage automatically extending to all eligible enrollees, which includes all employed Chuuk residents regardless of their employer. Chuuk Health Care Plan v. FSM Dev. Bank, 21 FSM R. 300, 306 (Chk. 2017).

When, although the regulations for the Chuuk Health Care Plan implement the actual premium amounts due, the statute itself provides for liability to make the premium payments, the Plan has shown facts that, if proven, entitle it to the relief sought for the defendant's non-payment of premiums. Chuuk Health Care Plan v. FSM Dev. Bank, 21 FSM R. 300, 308 (Chk. 2017).

A "universal life insurance policy" is a permanent, individual policy that accumulates cash value. Term insurance covers only a period of time and therefore does not accrue cash value. Accordingly, premium refunds do not normally apply to term insurance. Barnabas v. Individual Assurance Co., 22 FSM R. 252, 256 (Pon. 2019).

When the insureds received refunds through their employer, as what should occur only for group insurance policies, not individual insurance policies, and when the insurer instructed the employer to stop all employee payroll deductions for supplemental group life insurance, the insurer did not convert the insureds' money and was not unjustly enriched. Barnabas v. Individual Assurance Co., 22 FSM R. 252, 257 (Pon. 2019).