SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 35

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ALEXANDER ASHKENAZI, AS TRUSTEE OF THE ZABLIDOWSKY LIFE INSURANCE TRUST,

Plaintiff,

Index No.: 115034/07

-against-

Motion Seq. No. 013

AXA EQUITABLE LIFE INSURANCE COMPANY,

Defendant.

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HON. CAROL R. EDMEAD, J.S.C.

MEMORANDUM DECISION

In this breach of contract action to recover death benefit proceeds from certain life insurance policies, defendant AXA Equitable Life Insurance Company ("defendant") renews its motion for summary judgment to dismiss the remaining claims by plaintiff Alexander Ashkenazi as Trustee of the Zablidowsky Life Insurance Trust ("plaintiff"), and granting defendant's (second) counterclaim for rescission of the policies. According to defendant, the subject policies were fraudulently obtained and are two among at least eight policies totaling almost $44 million, which make up the stranger-owned life insurance ("STOLI") mill that the Trustee is using for his own purposes under the guise of a purported charitable entity.

Plaintiff opposes the motion, and cross moves to dismiss defendant's fraud counterclaim.

Factual Background

In December 2005, Estelle Zablidowsky (the "Insured"), her son Martin Zablidowski ("Martin"), and Alexander Ashkenazi ("Ashkenazi" or the "Trustee") applied for a $5 million life insurance policy naming the Trustee of the Zablidowsky Life Insurance Trust (the "Trust") as the owner and beneficiary (the "$5 million policy").

The application for this policy listed Ashkenazi and Martin as Trustees. The signatories on the application, *i.e.*, the Insured, Martin and Ashkenazi, represented that the Insured had (1) $825,000 of "Annual Earned Income (Income from occupation)" and "10.1 MIL" in "Net Worth," (2) $4 million in liquid assets and $6 million in real estate assets, (3) annual income for the current year of $825,000, consisting of $225,000 in dividends/interest, $550,000 in rental income, and $50,000 in pension/social security, and (4) $820,000 in annual income in the previous year, consisting of $220,000 in dividends/interest, $550,000 in rental income, and $50,000 in pension/social security. Defendants approved the application and issued the policy (the "$5 Million Policy")

The Insured also applied for a $7 million policy with another insurer, Lincoln Life & Annuity Company of New York ("Lincoln Life"),[1] which was issued effective October 8, 2005.

Then, in January 2006, the Insured, and Ashkenazi and Martin signed another application with defendant for an additional policy face-valued at $5 million, this time, representing that the only other policy in existence was the one previously issued by defendant for $5 million.[2] Defendant issued an additional policy, but for only $3 million (the "$3 million Policy").

Each signatory to both applications agreed that they understood "that the statements and answers in all parts of this application are true and complete to the best of" their knowledge and belief. They further understood that defendant "may rely on them in acting on this application."

The Insured died later that fall in 2006, within the two-year contestability period.

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[1] Defendant claims that the Lincoln Life application makes financial misrepresentations that the Insured had a net worth of $15.6 million and an annual income of $1.25 million.

[2] According to defendant, the amount additionally sought by the Insured's insurance broker was $5 million. However, defendant concluded that the Insured qualified for only an additional $3 million in insurance.

Thereafter, defendant conducted an investigation and determined that the applications contained misrepresentations about the Insured's financial status and other insurance coverage. Defendant gave notice of rescission and mailed two refund checks to the Trustee Ashkenazi for "all amounts paid as premiums."[3]

This action for breach of contract ensued. In response, defendant counterclaimed for declaratory relief, rescission and fraud.

By decision dated December 16, 2009, this Court granted defendant's initial motion for summary judgment, dismissed plaintiff's breach of contract claim, and granted defendant summary judgment on its second counterclaim for rescission.

On appeal, however, the First Department "den[ied] defendant's motion as premature without prejudice to renew at the completion of discovery." The First Department held:

> Summary judgment is premature at this juncture since there are issues of fact as to whether the decedent's net worth and the existence of another life insurance policy were material to AXA's decision to issue the policy . . . . Based on the submitted excerpts of the trial transcripts in Settlement Funding, LLC v. AXA Equitable Life Ins., 2010 WL 3825735, 2010 U.S. Dist LEXIS 104451 [S.D.N.Y.2010], and other submissions, plaintiff demonstrated that further discovery is warranted on the issues of whether AXA's submitted underwriting guidelines are complete, *whether AXA routinely ignored its own requirement to confirm an insured's financial net worth via an inspection report, and whether the financial information or any additional existing policies was material to AXA's underwriting decisions regarding similarly situated applicants*. Thus, proof of defendant's underwriting practices with respect to applicants with similar histories is required.
> (Internal citations omitted; emphasis added).

As discovery is now complete, defendant renews its motion for summary judgment (Plaintiff's memorandum of law, p. 4).

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[3] Plaintiff asserts that to date, defendant retained the premiums paid, totaling more than $480,000 (memorandum of law, p. 1).

Defendant argues that as this Court previously held, and which holding was left undisturbed on appeal, the statements made in the applications for the subject policies were entirely false, and the false statements were material to defendant's underwriting decisions. There was no further discovery on the falsity of the subject financial representations, and the Court may thus rely on its previous finding of falsity in this regard. Even if considered anew, the evidence remains that such statements were false. Furthermore, the same evidence (*i.e.*, underwriting guidelines, affidavit from defendant's underwriters, and notes) and recent deposition testimony since the Court's decision was issued, demonstrate the materiality of the financial misrepresentations. As such, defendant may rescind the policies in accordance with Insurance Law 3105.

In opposition, plaintiff argues that plaintiff cannot meet its burden on the motion, the underwriting guidelines gave defendant discretion to apply individual consideration when considering the financial status of a proposed insured older than 66 years of age, and the approving underwriter required to establish reliance is now deceased. His previously submitted affidavit is hearsay, and not subject to cross-examination so as to render it admissible to support a summary judgment motion. Further, the evidence demonstrates that defendant failed to conduct further inquiry of the information it knew to be false, ignored its financial underwriting guidelines and disregarded the information obtained under the underwriting process. Indeed, defendant, like many other insurers in the life settlement market, ignored underwriting guidelines, in order to issue higher premium payment generating policies with face values greater than the net worth of the insured, in hopes that the increasing in aged-insured would become unable to make premium payments, and cause the policy to lapse and permit defendant to retain

the previously collected, very substantial premium payments. Thus, the financial representations were not material to defendant's issuance of the policies, and defendant's reliance on the Insured's financial information was unreasonable, such that the defense of misrepresentation should be deemed waived. As shown by the verification procedures defendant undertook after the Insured passed away, the financial representations only became material to defendant when attempting to rescind the policies. Further, two jury trials in similar matters found the reliance of an insurer unreasonable under similar circumstances, and thus, defendant's motion should be denied. In the event the Court finds in favor of rescission, the Court should order the return of the premiums paid.

In support of its cross-motion to dismiss the fraud claim, plaintiff argues that defendant cannot meets its high burden as a sophisticated insurer to establish that reasonable reliance. Further, although Ashkenazi entered into an agreement with the Insured to pay the premiums in return for sharing the death benefit proceeds with the Insured's family, Ashkenazi, a stranger to the policies, was unaware of the Insured's financial misrepresentations. In the absence of proof of intent to deceive defendant, or reasonable reliance, the fraud claim fails.

In reply, defendant argues that it did not ignore (nor has a practice of ignoring) conflicting financial information on the applications, its underwriting guidelines did not require it to request any of the additional information plaintiff suggests, and the financial information provided during the underwriting process was consistent with the Insured's representation of her net worth. Plaintiff does not deny the material misrepresentations made on the applications. And, the caselaw demonstrates that the death of the actual underwriter does not bar summary judgment. The actual underwriting file at issue, and not the underwriting files in other matters, governs, and

establishes that the financial information was material to defendant's decision on the Insured's policies. For example, the Insured's request for an additional $5 million policy was denied as financially unjustified, and a policy of only $3 million was approved. And, the purported comparable policies were either for different purposes or adequately supported by truthful, documented financial statements. Further, there is no evidence that defendant ignored its guidelines, and newspaper articles (which do not mention defendant) and rhetoric does not constitute admissible evidence to raise an issue of fact. The issue is whether defendant would have issued the policies had the truth about the Insured's financial statements been disclosed to defendant. Nor was there any information provided to defendant that gave notice of the unrevealed true financial condition. And, any return of premiums paid is premature in light of the remaining fraud claim, which precludes plaintiff from recovering the premiums paid. Also, courts allow insurers to retain premiums paid if a policy is deemed void *ab initio* based on an owner's lack of an insurable interest.[4]

In a further reply, plaintiff argues that defendant cannot establish its burden of proving fraud against Ashkenazi. Defendant over-insured the elderly at figures inconsistent with its guidelines. The uncorroborated affidavit of defendant's underwriter as to the financial information it considered on the comparable, similar insurance policies and failure to obtain a credit report, tax returns, financial statements, and bank records shows that defendant's reliance

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[4] Plaintiff's caselaw from other jurisdictions appears to conflict with New York caselaw in this regard (*see Halberstam v. United Stated Life Ins. Co. in City of New York,* 36 Misc.3d 497, 945 N.Y.S.2d 513 [Supreme Court, Kings County, New York 2012] (stating, "The Eastern District in *Berkshire Settlements, Inc. v. Ashkenazi,* 09–CV–0006 FB JO, 2011 WL 5974633 [EDNY 2011]), applying New York Law and relying on the Court of Appeals case of *New England Mut. Life Ins. Co. v. Caruso,* 73 N.Y.2d 74, 78, 538 N.Y.S.2d 217, 535 N.E.2d 270 (1989), determined that contracts without an insurable interest or consent of the insured are not void ab initio, but may be challenged within the two year contestability period)).

on the financial representations was unreasonable. There is no evidence that Ashkenazi was involved in any fraudulent practices in other instances as alleged and no evidence that any representations were knowingly made by him. And, defendant must also pay interest on the premiums it is obligated to return to void the policy from its inception.

Discussion

It is well settled that where a defendant is the proponent of a motion for summary judgment, the defendant must establish that the "cause of action . . . has no merit" (CPLR § 3212[b]), sufficient to warrant the court as a matter of law to direct judgment in his or her favor (*Bush v St. Claire's Hosp.*, 82 NY2d 738, 739 [1993]; *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985]; *Wright v National Amusements, Inc.*, 2003 NY Slip Op. 51390 [Sup Ct New York County 2003]). Thus, defendant must make a *prima facie* showing of entitlement to judgment as a matter of law, by advancing sufficient "evidentiary proof in admissible form" to demonstrate the absence of any material issues of fact (*Winegrad v New York Univ Med. Ctr.*; *Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]; *Silverman v Perlbinder*, 307 AD2d 230, 762 NYS2d 386 [1st Dept 2003]; *Thomas v Holzberg*, 300 AD2d 10, 11, 751 NYS2d 433, 434 [1st Dept 2002]).

To defeat a motion for summary judgment, the opposing party must demonstrate by admissible evidence the existence of a factual issue requiring a trial of the action, or to tender an acceptable excuse for his or her failure to do so (CPLR §3212[b]; *Vermette v Kenworth Truck Co.*, 68 NY2d 714, 717 [1986]; *Zuckerman, supra* at 560, 562; *Forrest v Jewish Guild for the Blind*, 309 AD2d 546, 765 NYS2d 326 [1st Dept 2003]). The opponent "must assemble and lay bare [its] affirmative proof to demonstrate that genuine issues of fact exist" (*Kornfeld v NRX*

Technologies, Inc., 93 AD2d 772 [1st Dept 1983], *affd*, 62 NY2d 686 [1984]).

New York Insurance Law § 3105(b) provides:

> No misrepresentation shall avoid any contract of insurance or defeat recovery thereunder unless such misrepresentation was *material. No misrepresentation shall be deemed material unless knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to make such contract.*
> (Emphasis added).

"A misrepresentation is defined by statute as a false 'statement as to past or present fact, made to the insurer . . . at or before the making of the insurance contract as an inducement to the making thereof" (*Mutual Benefit Life Ins. Co. v JMR Electronics Corp.,* 848 F.2d 30, 32 [2d Cir. 1988] *quoting* NY Ins. Law § 3105(a)).

It is noted that defendant relies on the same evidence submitted on its previous motion, and adds the affidavit of its underwriter Barbara Peterson ("Peterson"), and the recent depositions of Ashkenazi, Peterson, and defendant's former Chief Underwriter, Robert Lapierre ("Lapierre").

It is uncontested that the representations made in both applications concerning the Insured's financial worth, namely, that the Insured's net worth was $10.1 million and annual investment income was $825,000, were false. The record establishes that the Insured worked as a factory bookkeeper making $23,000 per year, lived in a rental apartment for $500 per month, and at the time of her death had only $7,100 in the bank and co-op shares worth approximately $225,000 (which was purchased in her name, but on behalf of her son, for $67,000). As indicated in the Petition for Letters of Administration signed by Martin, when the Insured passed away the only surviving relatives were the Insured's three children, Martin, Gary and Sheryl and the value of any of her real property "is less than $225,000." In his "Affidavit for Dispension of

Bond," Martin stated that "based on conversation [he] had with [his] mother *prior to her death*," she "was not engaged in any business." Martin also gave a statement in connection with defendant's investigation in 2007, that his mother was a bookkeeper but was unemployed since 1983; the Insured's income derived from Social Security, and that Gary went through their mother's apartment and found nothing indicating her assets; "no stocks were found"; and "no broker statements (for stocks or bonds), nothing." According to Martin, the Insured "she did not own any property - anywhere"; "had no other residence and no vacation home. She owned no vehicles." In the "Affidavit in Relation to Settlement of Estate Under Article 13, SCPA" Gary stated that Insured had $7,100 in her savings and checking account. Gary testified that he did not know of any assets, including real estate or investment property, held by the Insured, and that he cleaned out his mother's studio apartment after her death. Gary did not recall finding any papers, bank account statements, deeds, evidence of a safe deposit box, or any documents reflecting his mother's financial condition. And, at Ashkenazi's deposition in April 2013, he testified that he did not have any knowledge of the Insured's net worth and did not know where she lived, or whether she had a net worth of $10.1 million (EBT, p. 624). Plaintiff submitted no documentary evidence or affidavit to corroborate the financial representations made in the applications.

With respect to the $3 million policy, it is uncontested that the representation by the Insured that there were no other policies in force or pending except as to the defendant's $5 million policy was also false.[5]

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[5] In opposition, the Trustee states that if defendant was lied to with regard to the Insured's net worth or income, Ashkenazi was lied to as well (Opp., pp. 3-4).

And, it is uncontested that the "charitable" purpose of these policies was also undisclosed. According to the Ashkenazi's earlier 2009 deposition, the Trust at issue was one of the beneficiaries of the life insurance policies at issue, and the Trusts have a charitable purpose, *i.e.*, to donate monies to an organization entitled "Mesamche Lev."

Defendants also established that these misrepresentations were "material" to defendant.

A misrepresentation is material if it "seriously interferes with the exercise of the insurance company's right to accept or reject the application" (*New England Life Ins. Co. v Taverna*, 2002 WL 718755 [EDNY 2002] *citing Process Plants Corp.*, 53 AD2d 214, 216 [1st Dept 1976]), and "knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to make such contract" (*New England Life Ins. Co.* citing *Mutual Benefit Life Ins. Co.*, 848 F2d at 32 (quoting NY Ins. Law § 3105(b)).

The burden is on the insurer, defendant, to establish that it would have rejected the applications if it had known the undisclosed information (*to wit*: true financial information of the Insured and existence of other insurance), and summary judgment cannot be granted unless the insurer comes forward with proof that it would not have issued the policy had it known the undisclosed facts (*First Financial Ins. Co. v Allstate Interior Demolition Corp.*, 193 F3d 109 [2d Cir 1999] *citing Feldman v Friedman*, 241 AD2d 433, 661 NYS2d 9 [1st Dept 1997]).

A "court, in finding a material misrepresentation as a matter of law, generally relies upon two categories of evidence, an affidavit or testimony from the insurer's underwriter who testifies that the insurer would not have issued the particular contract it did had the facts been disclosed and the insurer's underwriting manual, guideline manuals or rules (*New England Life Ins.*; *Kroski v Long Island Sav Bank FSB*, 261 AD2d 136, 689 NYS2d 92 [1st Dept 1999] [underwriter's affidavit and guidelines demonstrated insurer's underwriting practices and were fact specific to the non-discretionary denial of coverage for persons with non-insulin dependent diabetes mellitus and peripheral vascular disease, the conditions at issue]; *Feldman v Friedman*, 241 AD2d 433,

661 NYS2d 9 [1st Dept 1997]; *Crotty v State Mutual Life Assurance Co. of* statements by insurance company employees, unsupported by document *America*, 80 AD2d 801 [1st Dept 1981]). As the court may not rely merely on statements by the insurer that it would not have issued the policy but for the representation (*see Feldman*, at 433; *Curanovic v New York Cent. Mut. Fire Ins. Co.*, 307 AD2d 435, 437 [3d Dept 2003] [conclusory evidence is insufficient to establish materiality as a matter of law]), the insurer must present documentation concerning its underwriting practices, such as underwriting manuals, bulletins or rules pertaining to similar risks, to establish that it would not have issued the same policy if the correct information had been disclosed in the application (*Curanovic* [where insurer had no written underwriting policies on the topic of plaintiff's misrepresentations and the conclusory affidavits by its employees were insufficient as they did not identify a written underwriting policy or any specific applicants with similar histories that were denied coverage] citing Insurance Law § 3105 [c]; *Precision Auto Accessories, Inc. v Utica First Ins. Co.*, 52 AD3d 1198, 859 NYS2d 799 [4th Dept 2008], *citing Curanovic; Courtney v Nationwide Mut. Fire Ins. Co.*, 179 F Supp2d 8 [NDNY 2001]; *see also Cohen v Mutual Ben. Life Ins. Co.*, 638 F Supp 695 [EDNY 1986]). To this end, and in accordance with the First Department's decision on appeal, it must be shown that defendant did not routinely ignore its own requirement to confirm an insured's financial net worth *via* an inspection report, and that the financial information or any additional existing policies was material to defendant's underwriting decisions regarding similarly situated applicants.

According to Peterson, life insurance is designed to replace or preserve wealth or income that is lost due to an insured's death, rather than create wealth or income (Affidavit, ¶9).

Defendant's Underwriting Guidelines also explain the purpose of financial underwriting,

which describes the underwriter's process in using "both formula and process method" to determine whether "to accept or not accept the risk." (See, Financial Underwriting Guidelines, Introduction, Peterson Affidavit Exh. A, AZA 00724). In defining "financially justified," the Underwriting Guidelines state that

> the theory behind financial underwriting is to have a method that screens out potential antiselection in the areas of speculation or selective lapse. The signs are weakly defined motivation or overinsurance . . . . No matter what the plan or purpose of insurance, as long as there is a death benefit, the underwriter must have some economic-related basis of selection. The process underwriters utilize is called financial underwriting.
> (Exh. A, Peterson Affidavit, AZA 00724)

For non-professionals, the table is as follows:

Ages	Factor x Income
18-45	15
46-55	10
56-60	7
61-65	5
66 and over	*IC [Individual Consideration]*

As to "Older Ages" applicants, the Guidelines explain:

> Special attention should be paid to all circumstances of the application on older aged individuals, at ages when the need for insurance is usually diminished and the prospect of death is less unpredictible. *Those* who are still self-supporting with dependents or *with estate tax problems can be considered for amounts within the PERSONAL INSURANCE GUIDELINES when the need for coverage is clear. Higher amounts may be considered for estate tax problems with knowledge of the approximate value of the estate.* Underwrite with caution when insurance history shows little or prior interest in insurance or medical history is virtually nonexistent with no attending physician listed on the examination
> (Emphasis added).

As such, defendant relied on the financial representations made in the applications, as follows:

> We look at the client's age, their medical underwriting, so we can have a rough estimate of what their potential *life expectancy* is. We also need to know what their *net worth* is,

> and then the formula, essentially, calculates out, based on half the life expectancy, *how that estate would grow* at a seven percent, usually seven percent, it can vary, how that estate will grow out over half of that client's life expectancy, using that growth factor, that seven percent growth factor, and then *we calculate what the estate taxes would be on future estate value*. It's usually 55 percent is what we incorporate. We know that there's Federal estate taxes, as well as estate taxes at the State level.
> (Emphasis added).

As explained by Peterson, an elderly person would ordinarily qualify for coverage only if the amount applied for was either "(1) . . . an acceptable multiple of his or her stated annual income (income replacement purposes)," or (2) "consistent with the estate taxes that would be due based on the likely net worth of the insured at the time of death (estate preservation purposes)." The notes taken by then-Chief Underwriter Godin (who reviewed the Insured's applications) indicate that the Insured represented her net worth as over $10 million and an annual income of $835,000, and "no insurance in force" (¶19). An inspection report was also generated, which report included an interview of the Insured, a family member, and a banking source (¶21).[6] Further, as to the Insured's second application, he "used the estate tax calculator to estimate the amount of estate taxes that would likely be due at the time of [the Insured's] death, in order to determine the maximum amount of insurance that would be appropriate from all companies" (¶25). According to Peterson, this approval was well within defendant's Financial Underwriting Guidelines since the estate tax due "would likely have well-exceeded the amount of insurance for which [the Insured] applied" (¶24).

In approving the policy for $3 million (instead of $5 million as requested), Godin reviewed the representations made in the Insured's application, including her representations that

[6] In the inspection report dated December 16, 2005 contains the following, in "Additional Remarks": "The applicant provided financial information which is stated to be in line with outside sources. These sources regard the applicant as a capable manager of her finances who appears to live within her income level" (AZA 00122).

she had no other pending or in force insurance and a net worth of over $10 million, applied defendant's practice of determining the projected estate tax that would be due on the Insured's estate, and determined that it would be approximately $8,255,500. Thus, the maximum permitted insurance from all companies would be approximately $8 million. Accordingly, Godin indicated that only a $3 million policy was "OK per Estate Tax Calculator"(¶¶25-27).

The record adequately demonstrates that in approving the $5 million and $3 million policies, defendant applied its Guidelines, including the estate planning financial underwriting practice of attempting to approximate the amount of estate taxes that would likely be due on the insured's estate (at the time of death), in order to determine the maximum amount of life insurance that would be appropriate.

The record also establishes that the representations made by the Insured were material: Peterson attests that the representations regarding [the Insured's] net worth and income were highly *material, indeed, critical*, to [defendant's] issuance of the policies (¶3) (emphasis added). Peterson also attests that defendant would not have issued these two Policies if it had known that the Insured "had modest annual income (principally social security payments), and net worth of less than $250,000." (¶29). According to Peterson, defendant would not have issued the $3 million Policy it had the Insured been truthful about the existence of another pending Lincoln Life insurance policy. The Underwriting Guidelines herein, *i.e.*, the economic-related basis and tables, support the affidavits of the underwriters wherein they explain that the policies at issue would not have been approved but for the misrepresentations made by the Insured.

The discovery completed after the prior motion was denied on appeal also demonstrates that the financial information or any additional existing policies was material to defendant's

underwriting decisions regarding similarly situated applicants, and that defendant did not routinely ignore its own requirement to confirm an insured's financial net worth *via* an inspection report. Defendant's former Chief Underwriter Lapierre testified at his deposition that defendant "absolutely" relied on the financial representations made on insurance *applications* to justify the amount of insurance in order to "cover the tax situation" presented by *estate taxes*, which was "one of the primary purposes." (EBT, p. 52). Lapierre testified that income and net worth were both factors considered with respect to *individuals over 70* years of age (EBT, p. 51). And, that underwriters *had no discretion* to refrain from applying the formula set forth in the Guidelines and tables, and were required to adhere strictly to the formula (EBT, p. 57).

Therefore, the effect of these misrepresentations especially in combination, must be said to have deprived defendant of freedom of choice in determining whether to accept or reject the risk.

In opposition, plaintiff fails raise an issue of fact as to whether the underwriting guidelines submitted are complete, whether defendant routinely ignored its own requirement to confirm an insured's financial net worth, or whether the financial information or additional existing policies was material to defendant's underwriting decisions *regarding similarly situated applicants.*

First, there is no dispute that defendant submitted complete versions of the relevant underwriting guidelines.

Second, plaintiff's reliance on four out of 104 policy files exchanged in discovery,[7] which four fail to include an "inspection report," is insufficient to establish that defendant routinely

[7] Defendant provided plaintiff applications for polices were accepted *and rejected, 104 in total.*

ignored its guidelines to confirm an applicant's financial net worth.[8] (See policies ending in 7422, 7312, 4665, and 3453). In one instance (7312), the applicant reported income in the form of "Financial Statement" and provide policy numbers of four existing policies, and an accountant's contact information on a Supplement to Financial Professional's Report. And, the purpose of the policy was for "Estate Settlement." Another of the four applicants also provided income in the form of a financial statement (3453). And, plaintiff's contention that defendant issued these four high value insurance policies notwithstanding that the applications did not identify any financial information (Memorandum of Law, p. 8) is factually incorrect. All of these applications indicate the existence of other policies or pending policies. And two as noted above, make reference to a financial statement to report the applicants' income. That two are from retired applicants, with no indication of income, does not indicate that defendant "routinely ignored" its own requirement to confirm an insured's financial net worth.

Finally, defendant failed to raise an issue of fact as to whether the financial information or additional existing policies was not material to defendant's underwriting decisions regarding similarly situated applicants. Although plaintiff claims that defendant issued insurance policies at amounts that did not comport with the other insurance guidelines, the basis of plaintiff's claim that defendant over-insured the applicants, is factually incorrect. Plaintiff bases its claim on calculations derived from the net worth of an applicant as reported on the application, to argue that the defendant routinely over-insured the applicants and failed to follow the guidelines that limit life insurance amounts to up to "half of the insured's net worth." However, according

[8] Reference to docket number 99 for policy ending in 3453 fails to include the docket number 98 (pages 93-100), which contains the application for the insured, and which indicates the financial information contained therein.

Peterson's affidavit, an underwriter would "appreciate the present value of the proposed insured's estate at a rate of 7% for half of the insured's life expectancy, and apply the appropriate tax rate, which was generally 50-55% , to estimate the estate taxes that would likely be due at the time of death. The resulting figure would generally be the maximum amount of insurance, from all carriers, that would be considered for approval" (¶17). Therefore, the guidelines do not limit an insured's insurance amount to 50% of the net worth at the time of the application; the guidelines attempt to limit the insurance amounts to half of the projected value of the insured's net worth *at the time of death*, which is substantially higher. And, the formula to be strictly applied to determine potential estate tax exposure does not obviate the Individual Consideration guideline given to applicants 66 years or older. Further, plaintiff's claim fails to raise an issue of fact as to the notes made in the Insured's file, which expressly indicate that her request for $5 million in additional insurance *was financially unwarranted*.[9]

Therefore, plaintiff failed to raise an issue of fact as to whether the financial information or existence of other, or other pending insurance, was immaterial in the case of the Insured herein.

Plaintiff's remaining claims of defendant's neglect in employing other methods to confirm an applicant's financial information are insufficient to raise an issue of fact to defeat summary judgment. Neither defendant's underwriting guidelines nor statements of defendants' underwriters establish that a credit report was ever required (Peterson EBT, 134; Guidelines, bates stamped 3141). The record also establishes that tax returns, financial statements, and bank

[9] The deposition testimony and affidavit of defendant's underwriter Peterson, which confirm the notes taken by Godin concerning the Insured's application, sufficiently support the motion for summary judgment.

records are also not required and is uncommon in this industry (Peterson EBT, 122-123, 130-131). Thus, the failure to obtain these financial reporting items does not raise an issue of fact as to whether defendants ignored guidelines or that financial statements were not material to defendant's decision to approve the Insured's applications.

It is also noted that the Guidelines and bulletin associated with the Guidelines, indicate that the same requirements apply for an 80-year old applicant seeking a $5 million policy as for an $8 million policy. Thus, there were no additional verification procedures required when the Insured sought the second policy (Peterson Affidavit).

Furthermore, contrary to plaintiff's contention, the numerous policy files submitted indicate that applications for high value insurance policies were made by applicants who reported substantial net worth. In other words, plaintiff points to no instance in which defendant issued a high value insurance policy to an applicant with incomes and/or a net worth similar to that of the Insured herein.[10]

As to plaintiff's cross-motion, plaintiff's mere contention that it is entitled to the return of premiums paid upon the Court's finding that defendant is entitled to rescind the Policies, is premature. Defendant's have a viable claim for fraud (*see* below). Moreover, although plaintiff is entitled to a return of premiums upon a rescission of an insurance policy (*see Myers v Equitable Life Assur. Soc. of U. S.*, 60 AD2d 942, 401 NYS2d 325 [3d Dept 1978]; *Kiss Const. NY, Inc. v Rutgers Cas. Ins. Co.*, 61 AD3d 412, 877 NYS2d 253 [1st Dept 2009] (where policy was void *ab initio* based on the material misrepresentations in the insurance application, insurer

[10] The Court does not reach the issue of whether the Trustee used the proceeds for his personal benefit, or, failed to disclose the fact that his charities were the true beneficiaries of the insurance proceeds.

is obligated to refund plaintiff's premium payments), the Court declines to grant plaintiff's request under the circumstances. As this Court previously held in a previous Memorandum Decision in this very same matter:

> . . . the grant of such relief [return of premium] is premature, in light of any potential set off defendant may be entitled to by virtue of its pending claim of fraud against plaintiff, *i.e.*, the alleged commissions defendant paid to agents on the policies that have now been rescinded, which commission payments exceed the premium payments made on the policies. Thus, such claim for the return of premiums, though not properly before the Court, is premature.
> (Memorandum Decision, May 10, 2010, pp. 11-12).[11]

Plaintiff also failed to establish entitlement to dismissal of the fraud claim.

The elements of fraudulent misrepresentation are: (1) a material false representation, (2) made with the intent to defraud defendant, (3) defendant reasonably relied upon the representation, and (4) defendant suffered damage as a result of his or her reliance (*Swersky v. Dreyer and Traub,* 219 A.D.2d 321, 326, 643 N.Y.S.2d 33 [1st Dept. 1996]).

Here, plaintiff failed to demonstrate that defendant's reliance upon the representations made in the subject applications were unreasonable, as a matter of law (*see generally, Philadelphia Indemnity Insurance Company v. Horowitz, Greener & Stengel, et. al.*, 379 F.Supp.2d 442, 453 [SDNY 2005] ("An insurer is entitled to rely on the representations of the insured and ... is under no duty to investigate the truthfulness of the representations.")).

Plaintiff contends that justifiable reliance cannot be shown in light of *Gluck v Executive*

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[11] *See also Soanes v. Empire Blue Cross/Blue Shield*, 970 F.Supp. 230 [SDNY 1997] (where unions fund trustees sued group health insurer for, *inter alia*, breach of insurance contract, and sought enforcement of contract or, in alternative, return of insurance premiums, court recognized that where "an insurance company rescinds on grounds of fraud, it may, before returning premiums, offset losses incurred on the policy which was obtained by fraud")), citing *Mincho v. Bankers' Life Ins. Co.*, 129 A.D. 332, 113 N.Y.S. 346, 348 [1908] (affirming the position that " if the defendant actually sustained provable damages in consequence of the plaintiff's fraud in inducing it to issue the policy, it was entitled to offset those damages against the premium received, and could, in those circumstances, effectually rescind the contract as against a suit in equity without restoring the premium in toto")).

Risk Indemn., Inc., 680 F Supp2d 406 [EDNY 2010]) and *HSH Nordbank AG v UBS AG*, 95 A.D.3d 185, 941 N.Y.S.2d 59 [1st Dept 2012]), which charges defendant with knowledge of the facts that it would have obtained had it exercised due diligence and made further inquiry of the representations made. However "[t]his principle . . . requires that the insurer have a reason to undertake further inquiry in the first place" and was held inapplicable where the representation arose out of statement that was "affirmatively false" (*see Gluck v Executive Risk Indemn., Inc.*, 680 F Supp2d at 415) (stating that, the "outright falsity did not create a duty of inquiry"), *citing Philadelphia Indem.*, 379 F.Supp.2d at 454). And, while "sophisticated parties have 'a duty to exercise ordinary diligence and conduct an independent appraisal of the risk they [are] assuming,'" defendant's reliance on its Guidelines and the representations made in the applications, as verified by outside sources, is sufficient, at this juncture, to support its claim for fraud.

As to plaintiff's claim that defendant cannot establish that Ashkenazi was aware of the misrepresentations sufficient to establish the intent element of fraud, "[F]raudulent intent, by its very nature, is rarely susceptible to direct proof and must be established by inference from the circumstances surrounding the allegedly fraudulent act" (*Setters v. AI Properties and Developments (USA) Corp.*, 139 A.D.3d 492, 32 N.Y.S.3d 87 [1st Dept 2016]).

The record indicates Ashkenazi's pattern of involvement of similar applications for high value, million-dollar policies, naming him as the Trustee, and for which the charity he controls received the insurance proceeds (May 2009 EBT, pp. 56-60). In the instant matter, Ashkenazi (along with the Insured) signed the subject applications acknowledging the truthfulness (to the best of their knowledge) of the representations made therein; yet, he admitted that he did not

know the Insured before he signed the applications, did not know anything about her possessions or finances, and did not review the applications beforehand (May 2009 EBT, pp. 120-121; April 2013 EBT, pp.624-625). When asked how the two policies came about, who suggested that the Insured take out these policies, why the Insured applied for these policies, whether he had any conversations with the Insured about the applications, or how the amounts were chosen, Ashkenazi repeated, "I don't recall", notwithstanding that he was named the Trustee (May 2009 EBT, p. 113-116, 153-159).[12] For all of the policies naming him as Trustee, Ashkenazi did not recall who prepared the trust documents (May 2009 EBT, p. 112).

Plaintiff utterly failed to provide any evidence to negate the inferences of intent. Therefore, dismissal of defendant's fraud counterclaim is unwarranted.

Conclusion

Based on the above, it is hereby

ORDERED that the motion by defendant AXA Equitable Insurance Company for summary judgment on its second counterclaim for rescission, is granted; and it is further

ORDERED that the branch of the cross-motion by plaintiff, Alexander Ashkenazi as Trustee of the Zablidowsky Life Insurance Trust, to dismiss defendant's counterclaim for fraud is denied; and it is further

ORDERED that the branch of the cross-motion by plaintiff for the return of premiums in

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[12] Similar answers were given in regard to the other insurance policies, except where he was able to state that the insured was interested in leaving funds for charity (see May 2009 EBT, pp. 75). The record also indicates that although the million-dollar proceeds of the various insurance policies of which he was named Trustee were deposited into his Trust bank account, Ashkenazi was the sole person who controlled the bank accounts, and yet, did not maintain any related bank records, or recall how he spent these millions of dollars (May 2009 EBT, pp. 64-66). Nor could he recall any which part of the 12 million was used for charitable purposes (May 2009, EBT, 70-71).

the event rescission is awarded, is denied; and it is further

ORDERED that AXA Equitable Insurance Company serve a copy of this order with notice of entry upon all parties within 20 days of entry.

This constitutes the decision and order of the Court.

Dated: October 5, 2016

Hon. Carol Robinson Edmead, J.S.C.

HON. CAROL R. EDMEAD
J.S.C.