APPENDIX

APPENDIX

TABLE OF CONTENTS

APPENDIX A

In the United States Court of Appeals
For the Seventh Circuit

Nos. 18-3527 & 18-3583

[Filed March 26, 2019]

NORMA L. COOKE,
Plaintiff-Appellee, Cross-Appellant,

v.

JACKSON NATIONAL LIFE INSURANCE COMPANY,
Defendant-Appellant, Cross-Appellee.

Appeals from the United States District Court for the Northern District of Illinois, Eastern Division.
No. 15 C 817 — **Rubén Castillo**, *Chief Judge.*

SUBMITTED MARCH 12, 2019 —
DECIDED MARCH 26, 2019

Before EASTERBROOK and BARRETT, *Circuit Judges*, and STADTMUELLER, *District Judge.*[*]

[*] Of the Eastern District of Wisconsin, sitting by designation.

EASTERBROOK, *Circuit Judge*. In this suit under the diversity jurisdiction, a district court ordered Jackson National Life Insurance to pay about $191,000 on a policy of life insurance. 243 F. Supp. 3d 987 (N.D. Ill. 2017). The court added that the insurer had litigated unreasonably and ordered it to reimburse Cooke's legal fees under 215 ILCS 5/155. (Throughout this opinion "Cooke" refers to plaintiff Norma Cooke, the widow of decedent Charles Cooke.) The insurer paid the death benefit and appealed to contend that the court should not have tacked on attorneys' fees. But because the district court had not specified how much the insurer owes, we dismissed the appeal as premature. 882 F.3d 630 (7th Cir. 2018).

The district court then awarded $42,835 plus interest. 2018 U.S. Dist. LEXIS 197908 (N.D. Ill. Nov. 20, 2018). The insurer filed another appeal (No. 18-3527), which we resolve using the briefs filed in its initial appeal (No. 17-2080). Cooke filed a cross-appeal (No. 18-3583). Her lead contention is that the district court should have awarded a higher death benefit, but that argument comes too late. As our first decision explains, a judgment on the merits and an award of attorneys' fees are separately appealable. *Budinich v. Becton Dickinson & Co.*, 486 U.S. 196 (1988). Cooke did not appeal within 30 days of the district court's order specifying the amount payable on the policy, and a later award of attorneys' fees does not reopen that subject.

Instead of seeking additional fees, Cooke's brief in No. 18-3583 is principally devoted to contending that the judge did the right thing for the wrong reason. She

made a similar argument in response to the insurer's initial appeal. We turn to the award under §5/155 and consider all of the arguments in all of the briefs filed in Nos. 17-2080 and 18-3583.

Section 5/155(1) provides:

> In any action by or against a company wherein there is in issue the liability of a company on a policy or policies of insurance or the amount of the loss payable thereunder, or for an unreasonable delay in settling a claim, and it appears to the court that such action or delay is vexatious and unreasonable, the court may allow as part of the taxable costs in the action reasonable attorney fees, other costs, plus an amount not to exceed any one of the following amounts:
>
> > (a) 60% of the amount which the court or jury finds such party is entitled to recover against the company, exclusive of all costs;
> >
> > (b) $60,000;
> >
> > (c) the excess of the amount which the court or jury finds such party is entitled to recover, exclusive of costs, over the amount, if any, which the company offered to pay in settlement of the claim prior to the action.

The district judge understood this statute to allow an award either for pre-litigation conduct or for behavior during the litigation. 243 F. Supp. 3d at 1006. He wrote that "Jackson's denial of coverage was based on a good-faith dispute regarding the nature of Cooke's

payments" (*ibid.*) and that the insurer could not properly be penalized for insisting that a judge resolve the parties' dispute. But, the judge added, "Jackson's behavior in this litigation has been much less reasonable." *Id.* at 1007.

The judge faulted the insurer because it opposed Cooke's motion for judgment on the pleadings without attaching the full policy to its papers. Jackson observed that Cooke had not supplied the court with all of the pertinent writings (which included an electronic funds transfer agreement as well as the policy) but failed to do so itself, until the summary-judgment stage, and the judge thought this unreasonable. *Ibid.* The judge summed up (*ibid.*):

> This Court believes that this case could have been resolved on Plaintiff's motion for judgment on the pleadings one year ago. This is a straightforward insurance policy dispute with essentially undisputed facts, and the primary issue is the interpretation of the policy. Had Jackson provided with its response the full document to be construed, or clearly identified those documents it had already turned over that it contended were necessary to interpret the policy, this case may have been resolved one year ago. By frustrating Plaintiff's motion solely by pointing to the incomplete policy and then coyly refusing to identify the deficiency for months thereafter, Defendant unnecessarily and unreasonably extended this litigation for no reason related to its good-faith position on the merits.

The district court assumed that §5/155 governs the conduct of litigation in federal court. It did not explain why. Many cases hold that federal, not state, rules apply to procedural matters—such as what ought to be attached to pleadings—in all federal suits, whether they arise under federal or state law. See, e.g., *Shady Grove Orthopedic Associates, P.A. v. Allstate Insurance Co.*, 559 U.S. 393 (2010); *Burlington Northern R.R. v. Woods*, 480 U.S. 1 (1987); *Walker v. Armco Steel Corp.*, 446 U.S. 740 (1980); *Mayer v. Gary Partners & Co.*, 29 F.3d 330 (7th Cir. 1994). Federal rules and doctrines provide ample means to penalize unreasonable or vexatious conduct in federal litigation. The district court's decision to rely on state rather than federal law was a mistake.

Cooke tells us that *TKK USA, Inc. v. Safety National Casualty Corp.*, 727 F.3d 782, 795 (7th Cir. 2013), has established that §5/155 regulates the conduct of federal litigation. We do not read it so. The district judge in *TKK* cited §5/155 in support of an award against an insurer that filed unnecessary and unreasonable papers. In contesting that award, the insurer did not rely on *Shady Grove* and its predecessors. Instead it argued that its litigation strategy had been reasonable. We agreed with the district court on that score, and by doing so we did not resolve an issue (the extent to which state law governs the conduct of federal litigation) that was neither briefed by the parties nor mentioned in the opinion.

It has long been understood that federal judges have a common-law power (sometimes called an inherent power) to impose sanctions on parties that needlessly

run up the costs of litigation. See *Chambers v. NASCO, Inc.*, 501 U.S. 32 (1991). The parties and the panel in *TKK* understandably did not focus on the source of law, when §5/155 and *Chambers* came to the same thing. But the district court in our case did not invoke *Chambers* or treat §5/155 as a doppelganger of the *Chambers* doctrine. Instead it penalized Jackson for failing to attach evidence to a document at the pleading stage.

The initial question should have been whether the Rules of Civil Procedure require a defendant to attach documents to a filing that opposes a plaintiff's request, under Rule 12(c), for judgment on the pleadings. The answer is no. Quite the contrary. Although attaching documents is permissible, the usual consequence is to defeat the motion and require the case to proceed to summary judgment. Rule 12(d) reads:

> RESULT OF PRESENTING MATTERS OUTSIDE THE PLEADINGS. If, on a motion under Rule 12(b)(6) or 12(c), matters outside the pleadings are presented to and not excluded by the court, the motion must be treated as one for summary judgment under Rule 56. All parties must be given a reasonable opportunity to present all the material that is pertinent to the motion.

Courts occasionally hold that, despite the word "must" in Rule 12(d), presenting the court with matters outside the pleadings does not inevitably move the suit to the summary-judgment stage. See, e.g., *Yassan v. J.P. Morgan Chase & Co.*, 708 F.3d 963, 975 (7th Cir. 2013). But conversion to summary judgment is the norm under Rule 12(d), which makes it hard to see how

Jackson can be penalized for taking a step (*not* attaching documents) that had the same effect as attaching them: moving to summary judgment. If the district judge believed that §5/155 changes the rules for what documents must be attached to which filings, and with what effect, it was giving state law forbidden priority over a federal rule.

Perhaps the district judge did not mean to penalize the insurer just for its failure to attach documents to papers opposing Cooke's motion. Several passages in the judge's opinion imply that the problem was Jackson's failure to *identify* all of the pertinent documents, which had already been turned over under Fed. R. Civ. P. 26(a), so that the parties could focus their efforts on them. We agree with the district judge that Jackson could and should have done this earlier than it did. Imposing sanctions for failing to point to the right documents could have been justified under *Chambers*. But Cooke has not used this doctrine to defend the district court's decision or asked us to remand so that the judge can consider *Chambers*. Instead she relies on Fed. R. Civ. P. 11, 26(g)(3), and 37(b)(2)(C), plus 28 U.S.C. §1927.

Rule 11 concerns the pleadings, and neither Cooke nor the district judge identified any problem with the insurer's pleadings. Nor did Cooke make the motion required by Rule 11(c)(2).

Rule 26(g)(3) reads:

> If a certification violates this rule without substantial justification, the court, on motion or on its own, must impose an appropriate sanction

> on the signer, the party on whose behalf the signer was acting, or both. The sanction may include an order to pay the reasonable expenses, including attorney's fees, caused by the violation.

Rule 26(g)(1), to which Rule 26(g)(3) refers, requires a party or her attorney to certify that its disclosures are complete and that any requested discovery is legally appropriate and not presented to harass the opponent or needlessly increase the cost of litigation. A false certificate is a good reason for a financial penalty—but Cooke does not develop an argument that Jackson's lawyers signed a false certificate, let alone that the district court found any violation of Rule 26. Jackson turned over the policy and related papers as part of its Rule 26 disclosures. Cooke says that Jackson did not identify, clearly enough, just what parts of its disclosures it was relying on when opposing her motion, but that's outside the scope of Rule 26.

Rule 37(b)(2)(C) provides that any litigant who disobeys a judge's order with respect to discovery must pay the other side's costs, including attorneys' fees. Yet Cooke does not contend that it requested, or that the district judge issued, any order requiring Jackson to produce additional documents in discovery. Rule 37 is irrelevant.

So is §1927. It allows a court to penalize a lawyer who "multiplies the proceedings in any case unreasonably and vexatiously". But liability under §1927 is personal to the lawyer; the client may not be ordered to pay for counsel's misconduct. See, e.g., *Byrne v. Neshat*, 261 F.3d 1075, 1106 (11th Cir. 2001); *Matter*

v. May, 118 F.3d 410, 413–14 (5th Cir. 1997). The district court's award of attorneys' fees against Jackson therefore cannot be supported by §1927.

Cooke contends that the award of fees should be affirmed for a reason that the district court rejected: that Jackson acted unreasonably and vexatiously before litigation began. Illinois asks whether an insurer's conduct was objectively unreasonable or vexatious. See *West Bend Mutual Insurance v. Norton*, 406 Ill. App. 3d 741, 745 (2010); *Norman v. American National Fire Insurance Co.*, 198 Ill. App. 3d 269, 303–05 (1990). (Other decisions articulate a subjective standard. See, e.g., *Deverman v. Country Mutual Insurance Co.*, 56 Ill. App. 3d 122, 124 (1977). For current purposes we assume that an objective approach governs.) In writing that Jackson's pre-suit denial of coverage "was based on a good-faith dispute regarding the nature of Cooke's payments" (243 F. Supp. 3d at 1006), Cooke contends, the judge asked and answered a question about Jackson's state of mind.

It is possible to read the district court's bottom line as Cooke does, but we do not think it the best reading. The bulk of the analysis is objective.

Charles Cooke had a policy of life insurance. For 15 years he paid premiums by monthly electronic transfers from his bank account, though the policy itself called for either annual or quarterly premiums. In May 2013 Jackson informed Charles that his premium for the next year (beginning in July) would be $2,835.85 a month. Toward the end of July the insurer sent the usual transfer request to Charles's bank, which rejected it because the account lacked sufficient

funds. This started a 31-day grace period under the policy: Charles had until August 28 to make good the July payment or the policy would be cancelled. On August 15 Jackson sent Charles a letter telling him that he now owed a quarterly payment of $8,637.94. This letter specified a (retroactive) due date of July 28, which again implied that the grace period would end on August 28. But Charles did not pay anything that month—not the $2,835.85 for July, not the payment for August, and not the $8,637.94 for the quarter. Charles died on September 10, 2013, and Jackson declined to pay the death benefit, telling his widow that the policy had lapsed because of non-payment plus the expiration of the grace period.

When the suit began in 2015 Cooke contended that Jackson had waived its right to enforce the policy's payment terms or was estopped to do so. She filed an amended complaint in 2016 changing her theory. The amended complaint asserted that the letter of mid-August created a new grace period, running through September 15, even though the grace period (and thus the policy) otherwise would have expired on August 28, and even though the letter gave a due date implying that the end of the grace period remained August 28. The district judge eventually agreed with Cooke's contention, after conceding that neither the policy nor any state statute or decision said that a switch from monthly to quarterly premium collection would extend the grace period. (Recall that Charles did not pay the premium for either July or August and died on September 10, which made it look like he was well over 31 days in arrears.) The district judge concluded that the lack of language in the policy or state law about

how to handle an unpaid monthly premium, followed by a demand for a quarterly premium, made it improper to apply the label "vexatious and unreasonable" to the insurer's decision to litigate rather than pay on demand. 243 F. Supp. 3d 1006–07. That is an objective analysis—it turns on the events in the world, and on the (lack of) applicable law, not on the contents of anyone's head.

This means that an award under §5/155 could be justified only by Jackson's conduct during the litigation. For the reasons we have already given, federal rather than state law governs how federal litigation is conducted, plus when (and who) may be penalized for misconduct. As we have rejected Cooke's arguments under federal law, the award must be reversed. And this means that we must reject Cooke's argument that §5/155 entitles her to legal fees incurred in opposing Jackson's appeals.

REVERSED

APPENDIX B

In the United States Court of Appeals
For the Seventh Circuit

No. 17-2080

[Filed February 9, 2018]

NORMA L. COOKE,
Plaintiff-Appellee,

v.

JACKSON NATIONAL LIFE INSURANCE COMPANY,
Defendant-Appellant.

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.
No. 15 C 817 — **Rubén Castillo**, *Chief Judge.*

ARGUED JANUARY 11, 2018 —
DECIDED FEBRUARY 9, 2018

Before EASTERBROOK and BARRETT, *Circuit Judges*, and STADTMUELLER, *District Judge.*[*]

[*] Of the Eastern District of Wisconsin, sitting by designation.

EASTERBROOK, *Circuit Judge*. In this suit under the diversity jurisdiction, the district court entered summary judgment for Norma Cooke. The judge ordered two kinds of relief: first, that Jackson National Life Insurance Co. pay Cooke the death benefit on her husband Charles's policy; second, that Jackson reimburse Cooke's legal expenses. The first kind of relief rested on a conclusion that Charles died before the end of a grace period allowed for late payments of premiums. The second rested on a conclusion that Jackson should have expedited the litigation by attaching documents to its answer to the complaint and by making some arguments sooner. See 243 F. Supp. 3d 987 (N.D. Ill. 2017). The district court then entered this order, which the parties have treated as the final judgment:

> Enter Memorandum Opinion and Order. Plaintiff's motion for summary judgment [47] is granted and Defendant's motion for summary judgment [42] is denied. The Court awards attorney fees to Plaintiff for cost of preparing and responding to these motions. This case is hereby dismissed with prejudice.

This document set the stage for the problems we must now resolve.

This document is self-contradictory, declaring that Cooke is entitled to two forms of relief while also declaring that the case is "dismissed with prejudice", which means that the plaintiff loses. Suppose we disregard the last sentence—and the first, which is surplusage. There remains the rule that a judgment must provide the relief to which the prevailing party is

entitled. See, e.g., *Foremost Sales Promotions, Inc. v. Director, Bureau of Alcohol, Tobacco & Firearms*, 812 F.2d 1044 (7th Cir. 1987); *Waypoint Aviation Services Inc. v. Sandel Avionics, Inc.*, 469 F.3d 1071, 1073 (7th Cir. 2006); *Rush University Medical Center v. Leavitt*, 535 F.3d 735, 737 (7th Cir. 2008). This document does not provide relief. It states that one motion has been granted, another denied, and an award made, but it does not say who is entitled to what.

We have held many times that judgments must provide relief and must not stop with reciting that motions were granted or denied—indeed that it is inappropriate for a judgment to refer to motions at all. See, e.g., *Otis v. Chicago*, 29 F.3d 1159, 1163 (7th Cir. 1994) (en banc) ("[The judgment] should be a self-contained document, saying who has won and what relief has been awarded, but omitting the reasons for this disposition, which should appear in the court's opinion."). See also Fed. R. Civ. P. 54(a) ("A judgment should not include recitals of pleadings … or a record of prior proceedings."). This document transgresses almost every rule applicable to judgments.

The same day it entered the order we quoted above, the court entered a second order on a standard form used for judgments. This one provides:

> Judgment is entered in favor of plaintiff, Norma L. Cooke and against the defendant, Jackson National Life Insurance Company, which includes an award of reasonable attorney fees in accordance with the Court's Memorandum Opinion and Order.

This second document avoids the internal contradiction but still lacks vital details. Unlike the first document, which is signed by the district judge, this one bears only the names of the district court's Clerk of Court and one Deputy Clerk—though Fed. R. Civ. P. 58(b)(2)(B) provides that every judgment other than a simple one on a jury verdict (or one fully in defendants' favor) must be reviewed and approved by the judge personally.

Recognizing that she did not have an enforceable judgment, Cooke filed a motion under Fed. R. Civ. P. 59(e) asking the court to specify how much money Jackson must pay. The court did so—but only in part. It entered an order providing that Jackson must pay $191,362.06 on the insurance policy, plus 10% per annum simple interest running from September 10, 2013. The amount of attorneys' fees was left dangling. Cooke also filed a formal petition asking the court to specify the amount of fees. The district court left the subject open for nine months—until after this case had been orally argued in this court. On January 25, 2018, the district court denied the motion with leave to renew it after we decide the appeal.

Within 30 days of the district court's order on Cooke's Rule 59 motion, Jackson filed a notice of appeal. It has thrown in the towel on the merits and paid the $191,362 plus interest but contends that Cooke is not entitled to attorneys' fees. Yet how can it appeal from an award of attorneys' fees that has yet to be quantified? A declaration of liability lacking an amount due is not final and cannot be appealed. See *Liberty Mutual Insurance Co. v. Wetzel*, 424 U.S. 737

(1976). This rule applies to awards of attorneys' fees as fully as it does to decisions about substantive relief. See, e.g., *Lac Courte Oreilles Band of Lake Superior Chippewa Indians v. Wisconsin*, 829 F.2d 601 (7th Cir. 1987); *McCarter v. Retirement Plan for District Managers*, 540 F.3d 649, 652–54 (7th Cir. 2008); *General Insurance Co. v. Clark Mall Corp.*, 644 F.3d 375, 380 (7th Cir. 2011). To allow an appeal before quantification would set the stage for multiple appeals from a single award: one appeal contesting the declaration of liability and another contesting the amount. The final-decision rule of 28 U.S.C. §1291 is designed to prevent multiple appeals on different issues in a single case.

We directed the parties to file supplemental memoranda on appellate jurisdiction. Cooke's memorandum states the obvious: the absence of a dollar figure makes the award of attorneys' fees non-final. Jackson's memorandum, by contrast, tells us that decisions on the merits and awards of attorneys' fees are separately appealable. That's true enough, see *Budinich v. Becton Dickinson & Co.*, 486 U.S. 196 (1988), but irrelevant to the question whether an award of attorneys' fees may be appealed before the judge has decided how much is due. If Jackson were contesting the award on the policy, we would have appellate jurisdiction to consider that issue, but this does not make the district court's bare statement about attorneys' fees appealable. As *Budinich* held, a decision on the merits and an award of legal expenses are independent for the purpose of appellate jurisdiction.

Cooke wants more than an order dismissing Jackson's appeal. She has filed a motion under Fed. R. App. P. 38 seeking attorneys' fees that she has incurred in responding to what she now calls a frivolous appeal.

We deny this motion, because any costs that Cooke has incurred are largely self-inflicted. Cooke could have filed a motion months ago (before briefing) asking us to dismiss Jackson's premature appeal, but she did not do so. Indeed, the jurisdictional section of Cooke's brief on the merits does not point out that an unquantified award isn't final. Not until this court raised the issue at oral argument did Cooke address the significance of the district judge's failure to say how much Jackson owes. If it were permissible for a court to order *both* sides to pay a penalty—say, into the law clerks' holiday-party fund—we would be inclined to do so. But there's no such appellate power and no good reason for us to order Jackson to pay something to Cooke as a result of a problem that both sides missed.

Jackson's appeal is dismissed for want of jurisdiction. Any successive appeal from an order quantifying the award will be heard by this panel and decided without a new oral argument. (The merits were covered during the argument already held.) Unless either side wants to contest the amount of the award, it should be possible to submit a successive appeal for decision on the existing briefs. The parties should inform us promptly after any new appeal is taken whether they want to supplement the briefs already on file.

APPENDIX C

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

No.15 C 817
Chief Judge Rubén Castillo

[Filed March 20, 2017]

NORMA L. COOKE,	)
Plaintiff,	)
	)
v.	)
	)
JACKSON NATIONAL LIFE INSURANCE COMPANY (successor to Southwestern Life Insurance Company and Reassure America Life Insurance Company),	)
Defendant.	)

MEMORANDUM OPINION AND ORDER

Norma Cooke ("Plaintiff") brings this diversity action against Jackson National Life Insurance Company ("Jackson"), alleging that it breached her late husband's life insurance policy by denying benefits after he died during the grace period for a missed premium payment. Presently before the Court are the

parties' cross-motions for summary judgment.[1] (R. 42; R. 47.) For the reasons stated below, judgment is entered in favor of Plaintiff.

RELEVANT FACTS

The following facts are undisputed unless otherwise stated. Plaintiff is an Illinois citizen whose late husband, Charles Cooke ("Cooke"), took out a life insurance policy from Southwestern Life Insurance Company on July 28, 1998. (R. 52, PL's Resp. to Facts ¶¶ 1, 5.) Jackson is a Michigan life insurance and annuity corporation and is the successor in interest to the policy.[2] (*Id.* ¶¶ 2, 6.)

Cooke's policy had a death benefit of $200,000, naming Plaintiff as the beneficiary. (*Id.* ¶ 5; *see also* R. 37-1, Policy.) The policy had level premiums for a 15-year period, after which it could be renewed at a significantly higher premium rate. (R. 52, Pl.'s Resp. to Facts ¶¶ 14-16.) The Policy Data Page, which set forth the basic facts and terms of the policy such as its premium and coverage amount, notes that the

---

[1] Plaintiff accurately observes that Jackson failed to comply with this Court's standing order by serving the opposing party with a letter summarizing the legal and factual grounds for its motion. (R. 51, Pl.'s Resp. at 7.) In the interest of judicial efficiency, the Court has elected to decide this motion on its merits rather than dismiss it without prejudice for failing to comply with the standing order. Jackson is nonetheless strongly admonished to review and follow this Court's rules in any future filings.

[2] Although Jackson was not the insurer from the origination of the policy, the Court will uniformly refer to the policy's insurer as "Jackson" in the interest of simplicity.

premium frequency was to be quarterly.[3] (R. 37-1, Policy at 9.) The policy also provided that Cooke could pay his premiums by "any other mode or method" with Jackson's consent. (R. 52, Pl.'s Resp. to Facts ¶ 9; *see also* R. 37-1, Policy at 17.) Shortly after taking out the policy, Cooke submitted a form titled, "Request for Payment of Premiums by the Automatic Bank Deduction Program" ("EFT application"), which provided Cooke's bank account information to allow him to pay his premium by monthly bank draft on the 28th of every month. (R. 52, Pl.'s Resp. to Facts ¶¶ 9-10; *see also* R. 37-1, Policy at 33.) The EFT application was not signed by any employee of the insurer, (R. 37-1, Policy at 33), but the parties do not dispute that Cooke made monthly payments with Jackson's consent for the first 15 years of the policy until it expired on July 28, 2013, (R. 52, Pl.'s Resp. to Facts ¶ 13). Over the life of the policy, Cooke completed two more EFT applications. (*Id.* ¶ 10.)

The policy provided that, at the end of the initial coverage term of 15 years, the policy could be renewed for subsequent one-year periods. On each such date, Jackson could adjust the premiums up to a maximum annual premium for each year as set forth on the Policy Data Page. The policy also stated that the first

---

[3] Although the Policy Data Page as submitted in this case has a handwritten addendum listing "Monthly Bank $348.70" under the word "Quarterly," (R. 37-1, Policy at 9), neither patty addresses this note or makes arguments concerning its author. Even though the note is present on a copy with a Bates stamp from Jackson—indicating that Jackson produced the policy copy—the Court will ignore the addendum as there is no evidence that it was part of the negotiated agreement between Cooke and the insurer.

premium for a new term would be due at the end of the previous term and that "[p]remiums for the new term will be due and payable at the premium frequency shown on a Policy Data Page." (R. 37-1, Policy at 18.)

The renewal provision also stated that the policy would be renewed if the premium were paid within the grace period. (*Id.*) The grace-period provision guaranteed Cooke a 31-day period "beginning on the due date to pay the premium due." (*Id.*) The policy would remain in force during a grace period, and if Cooke died during a grace period the unpaid premium would be deducted from the policy's proceeds. (*Id.*) By the same token, if a premium that was not paid "on or before its due date" were also not paid before the end of the grace period, the policy would be terminated. (*Id.*)

On May 30, 2013, Jackson issued a letter to Cooke, titled "IMPORTANT NOTICE – PREMIUM CHANGE," informing Cooke that his premium would increase beginning July 28, 2013: "Your new premium of $2,835.85 will be billed at the same frequency or mode as your current premium. This is your new modal premium amount." (R. 37-2, May 30 Letter at 1.) On or about July 28, 2013, Jackson attempted to automatically withdraw the $2,835.85 payment from Cooke's bank account, but the withdrawal failed for a lack of sufficient funds. (R. 52, Pl.'s Resp. to Facts ¶ 26.) This failed withdrawal triggered a 31-day grace period, which would expire on August 28, 2013, during which Cooke was required to pay the overdue premium or the policy would lapse. (*Id.* ¶ 29.) Jackson notified Cooke of his account deficiency in a letter dated August 9, 2013. (R. 37-3, Aug. 9 Letter at 1.) The letter

informed Cooke that the policy would "terminate if the renewal premium [was] not received by the last day of the grace period." (*Id*.) The letter also notified Cooke that his billing had been changed to direct, rather than automatic withdrawal. (*Id*.)

On August 15, 2013, Jackson sent Cooke a payment notice demanding a quarterly premium of $8,637.94. (R. 37-4, Aug. 15 Letter at 1.) The notice listed the due date for this quarterly premium as July 28, 2013. (*Id.*) The August 15 notice also stated that "[p]ayment must be received by the due date shown above or your policy will enter its grace period and will terminate if the renewal premium is not received by the last day of the grace period." (*Id.*)

Cooke failed to make any payments before August 28, 2013. (R. 52, Pl.'s Resp. to Facts ¶ 36.) On September 10, 2013, Cooke passed away. (*Id.* ¶ 39.) On September 12, 2013, Plaintiff, without informing Jackson that her husband had passed away, mailed the demanded quarterly premium to Jackson, which Jackson received the next day. (*Id.* ¶ 41.) Because Jackson had not yet processed Plaintiff's check, it issued a notice of policy termination on September 16, 2013, which stated that Jackson would reinstate the policy if all past premiums were paid within 61 days of the defaulted premium, provided that Cooke was still alive when the premiums were received. (R. 54, Def.'s Resp. to Facts ¶ 36; *see also* R. 37-6, Sept. 16 Letter at 1.) When Jackson processed the quarterly payment, it reinstated the policy. (R. 52, Pl.'s Resp to Facts ¶ 42.) After Plaintiff notified Jackson of Cooke's death and submitted a claim on September 20, 2013, Jackson

issued a letter on October 23, 2013, denying her claim because the premium was not paid during Cooke's lifetime and the policy was thus not eligible for reinstatement. (*Id.* ¶¶ 43-44.)

PROCEDURAL HISTORY

Plaintiff filed her breach-of-contract complaint on January 27, 2015. (R. 1, Compl.) Plaintiff alleged that Jackson breached the insurance contract in various ways, that its mid-grace-period request for a higher premium payment modified the contract, that Jackson waived its right to demand quarterly payments, and that Jackson was estopped from requiring a quarterly payment because Plaintiff reasonably relied on its earlier representations that she would have 31 days to pay the monthly amount required to reinstate the policy. (*Id.* ¶¶ 28-61.) Jackson answered on March 24, 2015. (R. 10, Answer.)

Plaintiff filed a motion for judgment on the pleadings on July 2, 2015. (R. 18, Motion.) On March 15, 2016, this Court entered a memorandum opinion and order denying Plaintiff's motion, in large part because Jackson denied that the entire policy was before this Court and claimed that additional contracts that were part of the policy allowed Cooke to pay monthly subject to specific terms and conditions.[4] (*See*

[4] Jackson made various statements about these contracts, later revealed to be the EFT Applications, in its response to the motion for judgment on the pleadings, both describing them as "a separate contract," (*e.g.*, R. 24, Resp. at 4), and claiming that these contracts constituted part of the policy itself, (*e.g., id.* at 5 ("[U]nder the complete Policy, including the Additional Contract," the quarterly

id. at 10-11, 13.) Jackson argued that "additional contractual terms and documents, including, but not limited to, the Additional Contract, were not attached to the Complaint . . . and contain additional applicable terms, including as to the premium 'due' upon default of a monthly installment payment." (R. 24, Resp. at 6.)

On April 25, 2016, Plaintiff filed her first amended complaint, abandoning her waiver and estoppel counts and proceeding on one count of breach of contract and one count of vexatious and unreasonable conduct. (R. 37, First Am. Compl.) Plaintiff alleges that, by demanding a quarterly premium 18 days into the 31-day grace period, Jackson was required to provide a new 31-day grace period and that its failure to pay benefits when Cooke died during this second grace period constitutes a breach of the policy. (*Id.* ¶¶ 28-42.) Plaintiff also alleges that Jackson's conduct was vexatious and unreasonable in a variety of ways under the Illinois Insurance Code, 215 ILL. COMP. STAT. 5/155. (*Id.* ¶¶ 43-53.) Jackson answered on May 16, 2016. (R. 38, Answer.) Discovery has now closed, and the parties each move for summary judgment in their favor. (R. 42, Def.'s Mot.; R. 47, Pl.'s Mot.)

In support of its motion, Jackson argues that it never breached the policy by terminating it for failure

---

premium was due.)). (*See also* R. 43, Def.'s Mem. at 4 ("The Insured subsequently entered into additional EFT Contracts" which "are agreements to allow a policy owner to pay his/her premiums via monthly installments toward the total premium due that is stated on a policy data page."); *id.* at 10 ("Put simply, the Insured was bound to all provisions of the Policy, including the EFT Contracts.").)

to pay the premium. Jackson argues generally that a quarterly premium was due from the beginning, by the terms of the policy, and so it was not required to provide a second grace period when it demanded that quarterly premium after Cooke's default. (R. 43, Def.'s Mem. at 9-14.) Jackson refers to the Policy Data Page, which lists the premium frequency as quarterly, and argues that Cooke was only able to pay monthly installments toward that quarterly premium by virtue of the EFT contracts. (*Id*. at 9-10.) Because the policy states that "[p]remiums for the new term will be due and payable at the premium frequency shown on a Policy Data Page" and "at the end of the previous term," (R. 37-1, Policy at 18), Jackson concludes that the quarterly premium was due on July 28, 2013, notwithstanding its voluntary agreement to allow Cooke to pay monthly installments toward that quarterly premium. (R. 43, Def.'s Mem. at 9-10.) Jackson also argues that neither its letters to Plaintiff nor any phone call with a call center representative could have modified the policy, as any such modifications must be made in writing by the president, vice president, secretary, or assistant secretary of Jackson.[5] (*Id*. at 11-14 (citing R. 37-1,

[5] In her amended complaint, Plaintiff alleges that she spoke with a customer service representative on or about August 15, 2013, and that this representative informed her that Jackson had withdrawn its consent for Cooke to pay monthly premiums and was demanding a quarterly premium. (R. 37, First Am. Compl. ¶ 16.) Plaintiff also alleged that this representative told her that the quarterly premium must be paid before September 15, 2013, for the policy to remain active. (*Id*.) Although Plaintiff alleges that "Insurers breached the contract by not honoring its verbal agreement," (*id*. at 41), she abandons this claim in her motion for

Policy at 14).) Finally, Jackson argues that, because it did not breach the policy, there can be no vexatious and unreasonable conduct under the Illinois Insurance Code. (*Id*. at 14.)

Plaintiff meanwhile argues that Jackson breached the policy in several ways. Most simply, Plaintiff argues that "[t]he premium that was overdue, up until the August 15, 2013 notice of quarterly premium due, was monthly." (R. 48, Pl.'s Mem. at 10.) Because neither the policy, the EFT applications, nor any correspondence between Jackson and Cooke referred to the monthly premiums as "monthly installments toward the quarterly premium," Plaintiff argues that both the monthly payment amount and the quarterly payment amount are rightly considered premiums. (*Id*. at 9-10.) To the extent that the policy's grace-period provision's mention of the "premium due" can be read as applying to either the original monthly premium or the later-demanded quarterly premium, Plaintiff argues that such ambiguity must be resolved in favor of the insured. (*Id*. at 8.) Plaintiff also argues that Jackson breached the contract by reinstating the policy prior to learning of Cooke's death without an application from Cooke, as set forth in the policy, and that Jackson's lapse notices did not comply with the requirements of the Illinois Insurance Code. (*Id*. at 11-15.) Plaintiff finally argues that Jackson's conduct in denying her claim was vexatious and unreasonable in numerous ways. (*Id*. at 15-19.)

---

summary judgment. Accordingly, the Court leaves this argument and its attendant factual disputes aside.

LEGAL STANDARD

Federal Rule of Civil Procedure 56 provides that "[t]he court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." FED. R. CIV. P. 56(a). Summary judgment is proper "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986) (citation omitted). "A genuine dispute as to any material fact exists if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Kvapil v. Chippewa Cty.*, 752 F.3d 708, 712 (7th Cir. 2014) (citation and internal quotation marks omitted). In deciding whether a dispute exists, the Court must "construe all facts and reasonable inferences in the light most favorable to the non-moving party." *Nat'l Am. Ins. Co. v. Artisan & Truckers Cas. Co.*, 796 F.3d 717, 723 (7th Cir. 2015) (citation omitted). When considering cross-motions for summary judgment, the Court must "construe all facts and inferences in favor of the party against whom the motion under consideration is made." *Orr v. Assurant Emp. Benefits*, 786 F.3d 596, 600 (7th Cir. 2015).

The movant has the initial burden of establishing that a trial is not necessary. *Sterk v. Redbox Automated Retail, LLC*, 770 F.3d 618, 627 (7th Cir. 2014). "That burden may be discharged by showing . . . that there is an absence of evidence to support the nonmoving

party's case." *Id.* (citation and internal quotation marks omitted). If the movant carries this burden, the nonmovant "must make a showing sufficient to establish the existence of an element essential to that party's case." *Id.* (citation and internal quotation marks omitted). The nonmovant "must go beyond the pleadings (*e.g.*, produce affidavits, depositions, answers to interrogatories, or admissions on file) to demonstrate that there is evidence upon which a jury could properly proceed to find a verdict in [their] favor." *Id.* (citation and internal quotation marks omitted). "The existence of a mere scintilla of evidence, however, is insufficient to fulfill this requirement." *Wheeler v. Lawson*, 539 F.3d 629, 634 (7th Cir. 2008). Nor can "speculation and conjecture" defeat a motion for summary judgment. *Cooney v. Casady*, 735 F.3d 514, 519 (7th Cir. 2013).

The Court cannot weigh conflicting evidence, assess the credibility of the witnesses, or determine the ultimate truth of the matter, as these are functions of the trier of fact. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986); *Omnicare, Inc. v. UnitedHealth Grp., Inc.*, 629 F.3d 697, 704-05 (7th Cir. 2011). Instead, the Court's role is simply "to determine whether there is a genuine issue for trial." *Tolan v. Cotton*, 134 S. Ct. 1861, 1866 (2014) (quoting *Anderson*, 477 U.S. at 249).

ANALYSIS

I. Breach of Contract

Although there are numerous points of dispute between the parties, the main issue in this case is whether Jackson was required under the policy to

grant Cooke a full 31-day grace period as a result of its August 15 demand for a full quarterly premium.[6] The Court finds that the August 15 letter constituted a demand for a new premium, and thus the policy required Jackson to provide Cooke with 31 days to pay the premium due.

Under Illinois law, "the essential elements of a breach of contract are: (i) the existence of a valid and enforceable contract, (ii) performance by the plaintiff, (iii) breach of contract by the defendant, and (iv) resultant injury to the plaintiff." *Batson v. Oak Tree, Ltd.*, 2 N.E.3d 405, 414 (Ill. App. Ct. 2013). Insurance contracts embody the agreements of the parties and the terms of the policy constitute the scope of the insurer's liability. *See Pekin Ins. Co. v. Precision Dose, Inc.*, 968 N.E.2d 664, 679 (Ill. App. Ct. 2012). "Provisions that limit or exclude coverage will be interpreted liberally in favor of the insured and against the insurer." *Id.* at 673. An insurance policy is a contract solely between the insured and the insurer, and the named beneficiary has no interest under the policy while the insured is alive. *See Pritza v. Vill. of Lansing*, 940 N.E.2d 1164, 1173 (Ill. App. Ct. 2010) (stating that an insurance policy is a contract between

---

[6] Jackson criticizes Plaintiff for raising different legal theories during the course of this litigation as to how it allegedly breached the policy. (*See* R. 53 at 4-5.) To the extent Plaintiff has done so, her actions were not improper. *See Albiero v. City of Kankakee*, 122 F.3d 417, 419 (7th Cir. l 997)("[M]atching facts to a legal theory was an aspect of code pleading interred in 1938 with the adoption of the Rules of Civil Procedure . . . . [A] plaintiff may substitute one legal theory for another without altering the complaint." (internal citation omitted)).

an insurer and an insured). However, a named beneficiary of a life insurance policy obtains a vested and absolute right to the proceeds upon the death of the insured, as provided by the terms of the policy. *See Reliance Standard Life Ins. Co. v. Magli-Grant*, 503 F. Supp. 2d 1050, 1053 (N.D. Ill. 2007) (citing *Bank of Lyons v. Schultz*, 318 N.E.2d 52, 57 (Ill. App. Ct. 1974)).

Under Illinois law, contracts "must be construed as a whole, viewing each provision in light of the other provisions." *United States v. Rogers Cartage Co.*, 794 F.3d 854, 861 (7th Cir. 2015) (citation omitted); *see also Smith v. Am. Heartland Ins. Co.*, --- N.E.3d ---, 2017 WL 499838, at *4 (Ill. App. Ct. 2017) ("An insurance policy, like any other contract, must be construed as a whole, giving effect to every provision."). "[I]nstruments executed at the same time, by the same parties, for the *same purpose*, and in the course of the same transaction are regarded as one contract and will be construed together." *Dearborn Maple Venture, LLC v. SCI Ill. Servs., Inc.*, 968 N.E.2d 1222, 1232 (Ill. App. Ct. 2012) (citation omitted).

"If the words used in the policy are unambiguous, then they are given their plain, ordinary, and popular meaning." *Cty. Mut. Ins. Co. & Livorsi Marine, Inc.*, 856 N.E.2d 338, 343 (Ill. 2006). But if the terms of an insurance policy are ambiguous, they will be construed strictly against drafter of the policy. *See Pekin Ins. Co. v. Wilson*, 930 N.E.2d 1011, 1017 (III. 2010). A term or phrase in an insurance policy is ambiguous if it is "susceptible to more than one meaning," *id.*, but not simply because it is "undefined," *Levy v. Minn. Life Ins.*

Co., 517 F.3d 519, 524 (7th Cir. 2008). Once the Court finds an ambiguity, then extrinsic evidence may be considered to determine the meaning of the words included in the insurance policy. *Cty. Mut. Ins. Co.*, 856 N.E.2d at 343.

Based on the plain language of the policy, it is clear that a 31-day grace period must be provided for any premium that was not paid on or before its due date and the policy may not be terminated during the grace period. The policy's grace-period provision states that:

> [W]e allow a Grace Period of 31 days beginning on the due date to pay the premium due. The policy will remain in force during the Grace Period. If the Insured dies during the Grace Period, the unpaid premium will be deducted from the Proceeds.
>
> Any premium not paid on or before its due date is a premium in default. If a premium in default is not paid before the end of the Grace Period, the policy will terminate.

(R. 37-1, Policy at 18.) Accordingly, the question before the Court is whether the monthly payment on which Cooke defaulted qualifies as a "premium" under the policy, and if so whether later requiring the full quarterly payment changed the premium that was "due."

Plaintiff argues that the monthly payment was the premium due on July 28, while Jackson argues that it was merely a monthly installment toward the underlying quarterly premium that was due on that date. The policy never defines "premium" or "due," but

the Court finds that based on their "plain, ordinary and popular meaning" the monthly required payment was a premium. *Cty. Mut. Ins. Co.*, 856 N.E.2d at 343. According to Black's Law Dictionary, a premium is "[t]he amount paid at designated intervals for insurance; esp., the periodic payment required to keep an insurance policy in effect." *Premium,* BLACK'S LAW DICTIONARY (10th ed. 2014); *see also Premium*, OXFORD ENGLISH DICTIONARY (defining "premium" as "[t]he amount payable for an insurance policy; *spec.* an amount paid regularly to maintain cover against particular contingencies"). There is nothing to suggest that a premium is a special kind of payment, as opposed to other less-special payments, and Jackson points to no cases holding otherwise. Instead, when a payment is required to maintain an insurance policy, and when making that payment is sufficient to maintain the policy for some period without requiring some additional payment, it qualifies as a premium under that term's common meaning.

Additionally, the Court must interpret the policy as a whole. *Rogers Cartage Co.*, 794 F .3d at 861. The policy consistently speaks of payments made at different frequencies as "premiums." In relevant part, the premium payments provision states that:

> The first premium for this policy is due on the Policy Date. Subsequent premiums are due in advance of the period to be covered. Premium(s), . . . and the premium frequency you have selected, are shown on a Policy Data Page. Premiums may be paid on any mode shown on a

> Policy Data Page. Premiums may be paid by any other mode or method with our consent.
>
> . . .
>
> On any Term Expiry Date, we may adjust the premiums for this policy. . . . We will notify you prior to any such adjustment. The annual premium will never be greater than the Guaranteed Maximum Annual Premium shown on a Policy Data Page. . . . The Initial Annual Premium and Guaranteed Maximum Annual Premiums have been determined on a uniform basis for Insureds of the same age, sex, and classification.

(*Id.* at 17.) The Policy Data Page lists these guaranteed maximum annual premiums and explains that "[t]he annual premiums shown above may be converted to premium amounts payable more frequently by multiplication of the annual premium by the modal factors on a policy data page."[7] (*Id.* at 11.) Finally, the renewal option provision states that:

> This policy may be renewed without evidence of insurability on each Term Expiry Date for a new term period by payment of the premium then due. Guaranteed Maximum Annual Premiums

---

[7] These modal factors are used to convert the annual premium amount into the amount actually due based on the frequency of payments. Paying annually, the modal factor is 1, meaning that an insured simply pays the annual premium amount. The modal factor for quarterly payments is 0.265, and for monthly payments by automatic bank withdrawal it is 0.087. (R. 37-1, Policy at 9.)

> for renewal periods are shown on a Policy Data Page. . . .
>
> The first premium for a new term will be due at the end of the previous term. This policy will renew if this premium is paid within the Grace Period. Premiums for the new term will be due and payable at the premium frequency shown on a Policy Data Page.

(*Id*. at 18.) The Policy Data Page lists the premium frequency as "quarterly." (*Id*. at 9.)

Although the policy defaults to assuming premiums will be paid at the same frequency as is listed on the Policy Data Page, it repeatedly references annual premiums while acknowledging that payments made at other frequencies are also premiums. Most notably, the Policy Data Page that sets forth the policy's quarterly premium frequency only lists the actual premium *amount* in the form of the annual premium. (*Id*.) It also states that "annual premiums . . . may be converted to premium amounts paid more frequently." (*Id*. at 11.) Further, the modal factor chart lists the conversion rate for premiums charged at different frequencies, *(id.* at 9); this suggests that payments made to keep the policy current, which are made at the listed frequency with the listed ratio to the annual premium, are themselves premiums. The policy makes no reference to or provision for the payment of installments toward a larger premium that are not themselves premiums.

Jackson argues that the Policy Data Page lists the premium frequency as quarterly, and that changing the frequency of the premium due under the policy would

require the written approval of one of its senior officers to modify the policy. (R. 43, Def.'s Mem. at 9.) Because no such written approval was made, Jackson argues that the premium that was due was the quarterly one, even if Cooke paid it in monthly installments. Jackson's interpretation of the provision requiring written approval for modification is too broad. The provision Jackson cites only applies to changes in the contract language, not to changes made *in accordance with* the contract language. For instance, Jackson was permitted to change the annual premium amount after Cooke's initial 15-year term expired, because the policy states that "[o]n any Term Expiry Date, we may adjust the premiums for the policy." (R. 37-1, Policy at 17.) Even though the premium is stated on the Policy Data Page, Jackson did not require written approval of a senior officer to change this amount, because such a change was explicitly contemplated. By the same token, the premium payments provision states that "[p]remiums may be paid on any mode shown on a Policy Data Page" and "[p]remiums may be paid by any other mode or method with our consent." (*Id*.) Since five premium frequencies—from annual to monthly bank draft—are shown in the modal factor chart on the Policy Data Page, it could be argued that the policy provides for monthly premiums without any required consent. (*Id*. at 9.) Regardless, the provision clearly provides that the premium mode can be changed with consent, as it apparently was through Jackson's approval of the EFT applications. Because the policy explicitly provides for this change in its administration, changing the policy's premium frequency did not require written approval from a senior officer any more than changing the policy's premium amount did. Even

though this changes information set forth on the Policy Data Page, it does so in the same way as the premium amount change: as contemplated by the policy's provisions.

For the reasons set forth above, the Court finds that the monthly payments Cooke made for approximately 15 years, and the monthly payment demanded at the outset of the new policy period, were unambiguously "premiums" when that term is given its "plain, ordinary, and popular meaning." *Smith*, 2017 WL 499838, at *4. Because Jackson demanded the July 28 premium be paid, and would have maintained the policy if this premium were paid, the July 28 premium was "due" for purposes of the grace-period provision. Although Jackson had consented to allow Cooke to pay monthly premiums for many years, it was entitled under the policy to revoke its consent and insist on the original quarterly premium frequency when Cooke failed to pay the monthly premium. (*See* R. 37-1, Policy at 17, 33.) However, when it did so 18 days into the grace period on August 15, the result was that a new premium was due. Jackson had never requested a quarterly premium prior to its August 15 letter, it never disclosed the amount of the quarterly premium prior to this letter, and it has acknowledged that paying the monthly premium would have been sufficient to maintain the policy. Jackson has provided no definition of "due" that would include a payment that has not been requested and need not be paid, as would be necessary to include the quarterly premium before the August 15 letter. The Court finds that only on August 15 did the quarterly premium amount become due, and thus Jackson was required to give

Cooke 31 days to pay that premium in accordance with the grace-period provision.

Even if Jackson had sufficiently shown that an undemanded, undisclosed premium were also due based on the policy's plain language, the grace-period provision would still require a new grace period beginning on August 15. Jackson argues that "the 'premium due' pursuant to the Policy Data Page from the inception of the Policy to the expiration of the Grace Period was always the Quarterly Premium." (R. 43, Def.'s Mem. at 9.) However, Jackson neglects that the grace-period provision requires it to provide 31 days "*beginning on the due date* to pay the premium due." (R. 37-1, Policy at 18.) The grace-period provision states that the "premium due" is the one that was to be paid "on the due date." (*Id.*) Even if the monthly payment and the quarterly payment were both premiums that were due in some sense, the monthly premium is the only one that Jackson required to be paid on July 28. Given that neither party expected Cooke to pay the quarterly premium on July 28, that Jackson did not communicate the amount of the quarterly premium prior to July 28, and that Jackson attempted to collect only the monthly premium on July 28, the Court can see no basis for concluding that July 28 was the "due date" for the quarterly premium.

Jackson's theory, that the quarterly premium was due on July 28 and thus its 31-day grace period expired on August 28, is also untenable as a matter of policy. Jackson argues, in essence, that only the quarterly premium was ever due, that premiums are due prior to their period of coverage, and thus that the quarterly

premium was due on July 28 notwithstanding Jackson's consent to make monthly payments toward the quarterly premium. While perhaps this theory could be credited on the facts of this case in isolation, where the insured failed to make the first monthly payment of a quarter, it cannot apply generally. Suppose that Cooke had paid the July 28 premium but defaulted on the August 28 premium. Under Jackson's interpretation, it could immediately demand a quarterly premium, which it would contest was due on July 28, meaning that its grace period would expire on the very day of the default.[8] This reading of the grace-period provision is plainly inconsistent with the Illinois Insurance Code, which explicitly requires that a one-month grace period be given "within which the payment of any premium after the first may be made." 215 ILL. COMP. STAT. 5/224(1)(b). If the grace period has expired by the time a default occurs, then there was never a grace period at all.

Even if Jackson could show that the policy did not require it to provide a new grace period upon its higher

---

[8] Jackson suggests that Cooke need not even have defaulted on a monthly payment for Jackson to be able to revoke the policy, arguing that "although it was its custom to do so . . . , Jackson was not required to revoke the privilege of paying monthly drafts in order for the Quarterly Premium—the premium owed as set forth in the Policy—to be considered 'due' by the due date (July 28)." (R. 53 at 12.) Taking Jackson's arguments together, it would appear that Jackson could, at any time after August 28, revoke the policy at will for failure to pay the "due" quarterly premium within the grace period even though it had never requested the quarterly premium. This at-will revocability stands in direct conflict with the Illinois Insurance Code's protections and is not a reasonable interpretation of the policy itself.

quarterly premium demand, the policy would still be ambiguous, which would permit the Court to consider extrinsic evidence. The only interpretation of the policy that makes sense of Jackson's premium billing practices is that any amount demanded to keep the policy current qualifies as a premium. As noted, under the policy the premium for a payment period is due on or before the first day of that period. If that premium is not paid prior to the relevant period, it is "a premium in default," triggering a 31-day grace period and termination of the policy if the premium is not paid within those 31 days. (*Id.* at 18.) Although the record does not definitively show whether Jackson collected the three monthly payments prior to the covered quarter or during the covered quarter for the first 15 years, it is undisputed that the first monthly payment at the higher renewal rate was due on July 28, 2013, which is the first day of that renewal policy. (R. 52, Pl.'s Resp. to Facts ¶ 20.) This fact strongly suggests that Jackson had previously billed on the same schedule.

If these monthly payments were in fact installments toward the quarterly premium, however, then Cooke's policy was in default for two-thirds of every quarter and subject to termination for one-third of every quarter. Under Jackson's theory, the entire quarterly premium would be due on the first day of the covered period; when only one-third of that premium is paid through the monthly "installment"—as it apparently was every quarter for 15 years—the policy is in default by its own terms. When the second installment toward the quarterly premium is paid the next month, the entire premium has still not been paid and the grace period has expired, warranting termination under the

policy. Only two-thirds of the way through each quarterly payment period is the policy brought current, for one month before the next quarter begins. By Jackson's account, the policy would presumably be terminable at will by Jackson for the insured's failure to pay between the second and third monthly installments, despite the insured paying according to Jackson's billing demands.[9] This cannot be how the policy operates. *Bd of Educ. of Waukegan Cmty. Unit Sch. Dist. No. 60 v. Orbach*, 991 N.E.2d 851, 857 (Ill. App. Ct. 2013) (setting forth "the principle that a contract should be construed to avoid absurd results").

Jackson does not directly address this feature of its billing practices, but it does raise it to respond to one of Plaintiff's arguments. Jackson argues that "Plaintiff's forced interpretation that only the monthly electronic bank draft was 'due' by the end of the Grace Period" is inconsistent with the policy: "If only the monthly electronic bank draft was paid by the end of the Grace Period, that payment would have been made at the same time the Insured owed a second monthly installment. Thus, the insured would have remained a

---

[9] Jackson confirms this result of its theory, stating that "although it was its custom to do so . . . , Jackson was not required to revoke the privilege of paying monthly drafts in order for the Quarterly Premium—the premium owed as set forth in the Policy—to be considered 'due' by the due date (July 28)." (R. 53, Def.'s Resp. at 12.) Despite its repeated insistence that it was Cooke's failure to pay the monthly premium that prompted the present dispute, this statement by Jackson suggests that the quarterly premium was the only one that was "due," and that Cooke's failure to pay this due premium in advance of the period it covers would have rendered the policy terminable.

month behind and would not have provided payment 'in advance of the period to be covered,' *i.e.*, the portion of the quarterly term." (R. 53, Def.'s Resp. at 12.) Leaving aside that this reasoning would apply just as well to an insured who signed up under a monthly premium, which the policy provides as a possibility, (R. 37-1, Policy at 9), Jackson here takes the position that the monthly payments, under the terms of the policy, must be made in advance of the period to be covered, which it argues is the monthly period. The sentence of the policy that Jackson quotes states, in full, that "Subsequent premiums are due in advance of the period to be covered." (*Id*. at 17.) By taking the position that Cooke's "monthly installments" must be paid in advance to accord with a policy provision that applies to "premiums," by identifying the month-long portion of a quarterly term to be "the period to be covered," and by arguing that defaulting on a monthly payment was a sufficient default to trigger the grace-period provision before a quarterly payment was even demanded, Jackson describes a "monthly installment toward a quarterly premium" that is in every relevant way identical to a monthly "premium."

Accordingly, Jackson is unconvincing in its argument that "[w]hen an insured, pursuant to an EFT Contract, elects to pay the premium stated in his/her policy in monthly installments via automatic electronic bank withdrawals . . . , Jackson provides a slight discount in payment because having premiums paid in advance by automatic electronic monthly bank drafts is more efficient for the company." (R. 53, Def.'s Resp. at 13 n.7.) The only premium that was demanded in advance of a period of coverage was Cooke's monthly

premium, demanded in advance of the first month of coverage under the new policy rate. Jackson does not argue that it would grant a premium reduction for the convenience of having its quarterly premium paid later than contractually required; because the quarterly premium would not be paid in full until two months into the quarter, this also suggests that the monthly payment was a premium, as it was paid in advance of a month to be covered in accordance with the policy.

Additionally, every communication between Jackson and Cooke suggests that the monthly payments made by Cooke were, in fact, premiums. The EFT applications do not state that the monthly payments would be installments toward a quarterly premium; instead, they state that "Premium Payments will be debited from your account on or about the premium due date."[10] (*See, e.g.*, R. 37-1, Policy at 39.) For

---

[10] Jackson disputes the value of Plaintiffs "observation" that the EFT applications do not state that they authorize monthly installments toward a premium, not monthly premiums, arguing that "[t]hat observation is not 'evidence' to rebut Jackson's unrebutted testimony as to the purpose of the EFT Contracts. (R. 53, Def.'s Resp. at 13.) The Court observes that the portions of Linda Woodell's deposition that Jackson cites as unrebutted testimony consists of Woodell asserting without support or explanation that these payments were merely installments. (*See* R. 44, Def.'s Facts ¶¶ 11-12.) Woodell is certainly qualified to testify as to her understanding of the relationship between the policy and the EFT applications, but her statements asserting a legal conclusion are not unrebutted evidence of the truth of that legal conclusion. *See United States v. Blount*, 502 F.3d 674, 680 (7th Cir. 2007) ("There is a difference between stating a legal conclusion and providing concrete information against which to measure abstract legal concepts.").

15 years after Cooke completed the first EFT application, Jackson debited funds from his account on or about the 28th of every month, suggesting that this was the "premium due date." (R. 52, Pl.'s Resp. to Facts ¶ 9.) More directly, the letter Jackson sent to Cooke on May 30, 2013, explaining that it was increasing Cooke's premiums at the expiration of the policy's initial term, repeatedly refers to his new monthly payment as a premium. For instance, the letter states, "Your new premium of $2,835.85 will be billed at the same frequency or mode as your current premium. This is your new modal premium amount." (R. 37-2, May 30 Letter at 1.) The letter does not refer to a quarterly premium, does not mention installments toward greater premiums, and clearly identifies $2,835.85—the amount of the alleged monthly installment—as "[y]our new premium."[11] (*Id.*) Further, although Jackson changed Cooke's premium amount at the end of the initial term of the policy, it never

[11] There are two references in the correspondence between the parties prior to the quarterly premium being demanded that refer to "premium payments," although neither clearly suggests that these are payments *toward* a premium rather than payments *of* a premium. The EFT applications list as conditions that "[p]remium payments will be debited from your account on or about the premium due date" and "[p]ayment of premium under the Plan may be discontinued by the Company or the Undersigned upon thirty (30) days written notice," (*e.g.*, R. 37-1, Policy at 33), and Jackson's August 9 letter states that "[w]e are writing regarding your recent premium payment," (R. 37-3, Aug. 9 Letter at 1). The August 9 letter also, however, refers to the defaulted bank draft as "the uncollected premium." (*Id.*) The Court finds that these ambiguous references to "premium payments" are not sufficient to overcome the clear indications set forth above that the monthly payment was, in fact, a premium itself.

disclosed the amount of the $8,637.94 quarterly premium until its August 15 payment notice, which was sent after Cooke's default on the monthly premium and 18 days into the new policy's term. (R. 37-4, Aug. 15 Letter at 1.) The only way that Cooke could have determined the amount of the quarterly premium that was, according to Jackson, always due would have been to convert the monthly premium amount into the annual premium and back into a quarterly premium using the modal factor chart on the Policy Data Page. (R. 37-1, Policy at 9.) The applicability of this chart would not be obvious if the monthly payment were not a premium. Further, the quarterly premium amount would seem sufficiently irrelevant that it need not be disclosed if and only if the monthly payment amount were a monthly premium, as Jackson had been treating it for 15 years.

The renewal option provision does state that, when the policy is renewed at the end of the initial term, "[p]remiums for the new term will be due and payable at the premium frequency shown on a Policy Data Page." (*Id.* at 18.) Because the Policy Data Page identifies the premium frequency as quarterly, this suggests that a quarterly payment would be due at the beginning of a new term. However, the premium adjustment provision states that "[o]n any Term Expiry Date, we may adjust the premiums for this policy. . . . We will notify you prior to any such adjustment." (*Id.* at 17.) Cooke was informed that his premium would be changed to a $2,835.85 monthly payment; he was not informed that it would be changed to a $8,637.94 quarterly payment. While the renewal option provision suggests that the policy would revert to a quarterly

premium being due, Jackson's notification in accordance with the premium adjustment provision confirms that it continued to treat a monthly premium as due.

Even if both premiums were due on July 28, this would at best render the grace-period provision ambiguous. The policy does not clearly establish that the monthly payment was not a premium, nor does it on its face militate the conclusion that default on the monthly premium constitutes default on the quarterly premium even before it is demanded. Jackson cites no case law establishing that required payments may not be premiums or that even undemanded premiums are "due." The Court can also find no such cases. Instead, Jackson merely cites the testimony of its Policy Administration Oversight Manager that the EFT applications allow a policy owner to pay their listed premiums by installments without changing the underlying premium that is due. (R. 53, Def.'s Resp. at 11; *see also* R. 44, Def.'s Facts ¶ 11; R. 44-4, Woodell Dep. at 19, 20, 62.) By all appearances, Jackson never communicated this view until after litigation had been initiated, either in word or in deed. Jackson's undisclosed understanding of the effects of its agreements cannot govern the present dispute. *Ortony v. Nw. Univ.*, 736 F.3d 1102, 1104 (7th Cir. 2013) ("[T]he construction of a contract is an objective exercise; private beliefs and meanings do not matter. Even a Professor of English who agrees with Jacques Derrida about the uncertain meaning of most language is bound by his contracts." (internal citation omitted)). The policy does not define what does or does not qualify as a premium, whether undemanded premiums are

"due" or have "due dates" under the grace-period provision, or the legal effect of Jackson consenting to allow a policyholder to pay a premium with a different frequency with Jackson's consent. The policy can plausibly be read to require that a new grace period must be provided when a new premium payment is demanded; assuming that it can be read otherwise, as Jackson contends, this renders the policy ambiguous. This Court must resolve such ambiguities in favor of the insured. *Hanson*, 932 N.E.2d at 1182. Accordingly, the Court finds that the grace-period provision requires that Jackson provide 31 days to pay from the date of demanding a new, higher premium amount.

In its response, Jackson argues that if "Plaintiff is again attempting to claim only a monthly payment was owed," then "that [monthly] payment was never made and the Insured therefore failed to substantially perform under the Policy." (R. 53 at 11.) To be clear, the Court finds that, on July 28, Cooke was only required to pay a monthly premium in order to keep the policy current; accordingly, July 28 was the "due date" for a monthly premium. On July 28, Cooke was not required to pay a full quarterly premium in order to keep the policy current; accordingly, July 28 was not the "due date" for a quarterly premium. On August 15, Jackson communicated to Cooke that it was revoking its consent to pay monthly premiums and that he would have to pay the full quarterly premium to keep the policy current; as a result, the "due date" for the quarterly premium was, at the earliest, August 15.

For these reasons, the Court finds that under the policy, only the monthly premium was due on July 28. When Cooke defaulted on this payment, he was entitled to a 31-day grace period to pay the overdue monthly premium of $2,835.85. When Jackson revoked its consent to pay monthly premiums on August 15, as it was entitled to do under the policy and the terms of the EFT applications, a different premium became due, and thus Cooke was entitled to a new 31-day grace period. Further, even if Jackson is correct that this result is not strictly required by the policy, it has failed to establish that the policy clearly provides that under the facts of this case the grace period for a quarterly premium would expire on August 28. At best, the policy is ambiguous, and this Court must resolve ambiguities in favor of the insured. *Hanson*, 932 N.E.2d at 1182. Because Cooke died before the grace period governing his policy expired, Jackson was required to honor the policy under the grace-period provision. Accordingly, Plaintiff is entitled to summary judgment in her favor.

II. Section 234

Although the Court finds in favor of Plaintiff based on her grace-period provision claim, it will briefly address another argument that would entitle her to summary judgment in the alternative. Plaintiff argues that Jackson declared the policy lapsed within six months after default without providing Cooke with

sufficient notice under Illinois law.[12] (R. 48, Pl.'s Mem. at 12-15.) The Illinois Insurance Code requires that:

> (1) No life company doing business in this State shall declare any policy forfeited or lapsed within six months after default in payment of any premium installment or interest or any portion thereof, nor shall any such policy be forfeited or lapsed by reason of nonpayment when due of any premium, installment or interest, or any portion thereof, required by the terms of the policy to be paid, within six months from the default in payment of such premium, installment or interest, unless a written or printed notice stating the amount of such premium, installment, interest or portion thereof due on such policy, the place where it shall be paid and the person to whom the same is payable, shall have been duly addressed and mailed . . . to the person whose life is insured . . . at least fifteen days and not more than forty-five days prior to the day when the same is due and payable, before the beginning of the period of grace . . . . Such notice shall also state that unless such premium or other sums due shall be

---

[12] Jackson argues in its response that, because Plaintiff never articulated a claim under Section 234 previously, she should not be permitted to do so for the first time at summary judgment. (R. 53, Def.'s Resp. at 4.) The Court notes that Plaintiff pled breach of contract, and Plaintiff's Section 234 claim is ultimately an alternative breach-of-contract theory. The fact that Plaintiff did not fully articulate this theory previously does not preclude her from doing so now, especially as Jackson has had an opportunity to respond to it. *Albiero v.*, 122 F.3d at 419.

> paid to the company or its agents the policy and all payments thereon will become forfeited and void . . . .
>
> (2) This section shall not apply . . . to any policies upon which premiums are payable monthly or at shorter intervals.

215 ILL. COMP. STAT. 5/234. Plaintiff argues that Jackson's premium notices did not include the statutorily required language, and that the quarterly premium notice was not sent at least fifteen days prior to the day when the premium was due. (R. 48, Pl.'s Mem. at 13.) Accordingly, Plaintiff contends that Jackson was proscribed from declaring the policy lapsed within six months of the default, and thus the policy was in effect when Cooke died on September 10. (*Id*. at 13-15.) Although the statute does not apply when premiums are payable monthly, Plaintiff argues that "[o]nce Defendant revoked its consent to pay the premiums by anything other than quarterly, the notice law applied." (*Id*. at 14.)

Jackson responds that Section 234 only applies to pre-default notices, not post-default notices, so any infirmities in the language of its August 9 and August 15 letters, both sent after Cooke's July 28 default on the monthly premium, are irrelevant to Section 234. (R. 53, Def.'s Resp. at 5.) Jackson further argues that "Jackson, regardless, was exempt from complying with that section for any notice because the Insured was making monthly installment payments toward the Quarterly Premium owed." (*Id*. at 6 n.4.) Jackson opposes Plaintiff's argument that the notice law applied once Jackson revoked consent to pay

monthly, arguing that "[s]etting aside that the EFT Contracts had no effect on the Policy premium . . . , again Section 234 applies to *pre-default* notices, and pre-default (*i.e.*, before July 28, 2013) the Insured was paying by monthly automatic bank drafts." (*Id.*)

The first question is whether Section 234 applies to Cooke's policy at all such that it prohibits declaring the policy lapsed within six months of default without a sufficient notice. The Court finds that Section 234 does not apply, under the plain terms of the statute, when policy premiums are payable monthly, whether those monthly payments are premiums or not. The statute does not state that it is inapplicable only when premiums are *due* monthly, but rather when they are *payable* monthly. *See Waldschmidt v. Reassure Am. Life Ins. Co.*, 271 S.W.3d 173, 177 (Tenn. 2008) (finding that monthly installments toward an annual premium qualified as premium payments "payable monthly" for purposes of a functionally identical Tennessee statute). So long as Cooke was satisfying his premiums by paying on a monthly basis, Section 234 does not apply.

A harder question is whether Section 234 applies on the facts of this case, where the insured paid monthly until his July 28 default and the insurer reverted to quarterly premiums after this default. The Court finds that Section 234 does apply in this case. Leaving aside the parties' dispute about whether a monthly or quarterly premium was due on July 28, or both, the parties agree that the policy's premium was no longer payable monthly after Jackson's August 15 demand for a quarterly premium. Because Jackson had revoked its consent for Cooke to pay monthly, he would not have

complied with his contractual premium obligations had he remedied his monthly default and continued paying monthly premiums as he always had. Jackson had changed the manner of his premium payments, under its contractual rights. Although Section 234 did not apply to Cooke's policy before August 15, because he was able to pay his premiums monthly, it did apply to the policy after August 15, because he was not able to pay his premiums monthly.

Jackson mistakenly argues that Section 234 does not apply because "Section 234 applies to *pre-default* notices, and pre-default (*i.e.*, before July 28, 2013) the Insured was paying by monthly automatic bank drafts." (R. 53, Def.'s Resp. at 6 n.4.) More accurately, Section 234 applies to *policies* with premiums that are not payable monthly. 215 ILL. COMP. STAT. 5/234(2) ("This section shall not apply . . . *to any policies* upon which premiums are payable monthly[.]" (emphasis added)). And the statute does not require insurers to send pre-default notices, as Jackson appears to interpret it, but instead *prohibits* insurers from declaring policies lapsed within six months of default *if they did not send* such notices. 215 ILL. COMP. STAT. 5/234(1) ("No life company . . . shall declare any policy forfeited or lapsed within six months after default . . . unless a written or printed notice" containing the requisite information has been sent.). In other words, Section 234 does not prohibit sending noncompliant notices or require sending compliant notices; it forbids insurers from terminating a policy within six months *unless* they sent a compliant notice.

Boiled down to its essence, the statute mandates that: (1) if a policy's premiums are not payable monthly, (2) the insurer cannot terminate the policy for defaulted premium payments within six months, (3) unless it sent the proper notice 15 to 45 days earlier. In this case, the premiums were not payable monthly after August 15 and Jackson never sent the proper notice,[13] so Jackson was prohibited by Section 234 from terminating the policy until six months had passed. Having not sent a statutorily required notice, Jackson needed to wait six months to terminate the policy. *See Clarin Corp. v. Mass. Gen. Life Ins. Co.*, 44 F.3d 471, 477 (7th Cir. 1994) ("Since § 234(1) notice is not mandatory, the insurer must only comply with the statute if it desires to terminate a policy within six months after default of payment." (citing *First Nat'l Bank v. Mutual Tr. Life Ins. Co.*, 522 N.E.2d 70, 72 (Ill. 1988))). "[Section] 234(1) notice is designed to provide a warning to the insured so that the insurance company cannot 'keep [] silent and induc[e] the insured to forget to pay the premium.' " *Id.* (quoting *DC Elecs., Inc. v. Empl'rs Modern Life Co.*, 413 N.E.2d 23, 28 (Ill. App. Ct. 1980)). Similarly, in this case Jackson kept silent and did not disclose the fact that the quarterly

---

[13] Jackson disputes whether Section 234 applies to its August 9 and August 15 notices, because they were issued post-default rather than pre-default. (R. 53, Def.'s Resp. at 5-6.) This is beside the point. The burden of showing that a compliant notice has been issued falls upon the insurer, *Cullen v. N. Am. Co.*, 531 N.E.2d 390, 392 (Ill. App. Ct. 1988), and Jackson has failed to show that it sent any notice that complied with the statute. The Court notes in particular that Section 234 requires such a notice to include the amount of the premium due, while Jackson never disclosed the amount of the quarterly premium prior to its August 15 letter.

premium would be immediately due if Cooke defaulted on a monthly premium. Thus Section 234 prohibited Jackson from terminating the policy.

Because Section 234 applied to the policy before the expiration of the grace period established by Cooke's July 28 default on the monthly premium, Jackson was prohibited from declaring it lapsed whether or not a second grace period was provided. As the policy was still in operation when Cooke died on September 10, 2013, Jackson breached the policy by failing to pay the policy's benefits to Plaintiff.

III. Vexatious and Unreasonable Delay

Finally, Plaintiff argues that Jackson has acted vexatiously and unreasonably, justifying an award of costs, legal fees, and punitive damages. (R. 48, Pl.'s Mem. at 15-19.) Plaintiff lists numerous actions that she contends were vexatious and unreasonable, including demanding a higher premium payment 18 days into the grace period, reinstating the policy without an application, entering a new lapse date into its automated system, and failing to send notices compliant with the Illinois Insurance Code. (*Id*. at 17-18.) Jackson responds that its basis for denial rests on a *bona fide* dispute and that Plaintiff's claims of breach generally lack merit. (R. 53, Def.'s Resp. at 14-15.)

"Section 155 of the Illinois Insurance Code allows an insured to recover attorney fees when the insurer's denial of coverage or delay in payment is 'vexatious and unreasonable,' or when the insurer behaves vexatiously and unreasonably during the course of coverage litigation." *TKK USA, Inc. v. Safety Nat. Cas. Corp.*,

727 F.3d 782, 793 (7th Cir. 2013). "A court should consider the totality of the circumstances when deciding whether an insurer's conduct is vexatious and unreasonable, including the insurer's attitude, whether the insured was forced to sue to recover, and whether the insured was deprived of the use of his property." *Ill. Founders Ins. Co. v. Williams*, 31 N.E.3d 311, 317 (Ill. App. Ct. 2015) (citation omitted). If an insurer did not violate its obligations under the policy, "there can be no finding that the insurer acted vexatiously and unreasonably in denying the claim." *Rhone v. First Am. Title Ins. Co.*, 928 N.E.2d 1185, 1196 (Ill. App. Ct. 2010). Where an insurer denies coverage based upon a *bona fide* dispute, its denial does not constitute vexatious and unreasonable conduct under Section 155. *Ill. Founders Ins. Co.*, 31 N.E.3d at 317-18.

The Court finds that Jackson's denial of coverage was based on a good-faith dispute regarding the nature of Cooke's payments, which premiums were due and when, and how these issues interacted with the grace-period provision of the contract. As the Court has noted, Jackson was entitled under the policy to demand that Cooke revert to paying quarterly premiums when he defaulted on his monthly payment. Jackson's subsequent actions followed from a reasonable position on an unsettled issue of law, as evidenced by the fact that neither party nor this Court were able to locate an Illinois case directly on point. Further, the Court finds that the legal basis for Jackson's denial has remained consistent throughout this litigation, suggesting Jackson's good-faith belief in the merit of this argument. The purpose of Section 155 was to provide a remedy for insurer misconduct and to prevent an

insured from seeing "practically his whole claim wiped out by expenses if the company compels him to resort to court action, although the refusal to pay the claim is based upon the flimsiest sort of a pretext." *Cramer v. Ins. Exchange Agency*, 675 N.E.2d 897, 901 (Ill. 1996) (citation omitted). Jackson's denial of coverage does not appear to have been pretextual, unreasonable, or unfounded, and thus awarding costs and fees for handling Cooke's policy under Section 155 would be inappropriate.

However, the Court finds that Jackson's behavior in this litigation has been much less reasonable. Although the majority of Section 155 cases turn on the insurer's good faith in denying coverage, Section 155 also prohibits "unreasonable delay in settling a claim." 215 ILL. COMP. STAT. 5/155(1). And while most actions taken in litigation can be justified by the existence of a good-faith dispute on the merits of a claim, Section 155 allows for the awarding of costs for unnecessary motions that unreasonably delay a case. *See, e.g., TKK*, 727 F.3d at 795 (granting costs under Section 155 for meritless motion to reconsider, noting that "the fees were not assessed here because an attorney acted unethically. They were assessed because the decision to file the motion was unreasonable.").

The Court finds that Jackson has unreasonably delayed the resolution of this case for no good-faith purpose. In particular, Jackson opposed Plaintiff's motion for judgment on the pleadings, contending in large part that the policy attached to the complaint was not complete and that there were additional contracts containing the terms on which Cooke was permitted to

pay his premiums monthly. (*See, e.g.*, R. 24, Resp. at 3-4.) Jackson devoted three pages of its response solely to disputing that the entire policy had been submitted, including quoting more than a page's worth of its answers to the complaint, without once stating which documents were missing. (*See, e.g.*, *id.* at 6 ("Indeed, additional contractual terms and documents, including, but not limited to, the Additional Contract, were not attached to the Complaint[.]").) Jackson attached no exhibits to its response, such as a complete copy of the policy or the "Additional Contract." In fact, nearly eight months later—after this Court had denied Plaintiff's motion for judgment on the pleadings—Jackson still would not clearly identify to Plaintiff what it believed constituted the complete policy. At a status hearing before this Court, Plaintiff's counsel represented that Jackson still had not clearly identified the bounds of the policy and Jackson's counsel represented that Jackson had provided all the relevant documents prior to the motion for judgment on the pleadings. (R. 36, Tr. of Proceedings.) In an email on April 18, 2016, Jackson finally communicated its understanding of which documents must be submitted to constitute the entire policy: in addition to the policy attached to the complaint, Jackson identified several pages of endorsement letters notifying Cooke that the company administering his insurance policy had changed and several pages relating to correcting a typo in Cooke's name in the policy. (*See* R. 51-5, Corr. at 4; *compare* R. 1-1, Policy, *with* R. 37-1, Policy.) Jackson also identified the EFT applications. (R. 51-5, Corr. at 4.)

This Court believes that this case could have been resolved on Plaintiff's motion for judgment on the

pleadings one year ago. This is a straightforward insurance policy dispute with essentially undisputed facts, and the primary issue is the interpretation of the policy. Had Jackson provided with its response the full document to be construed, or clearly identified those documents it had already turned over that it contended were necessary to interpret the policy, this case may have been resolved one year ago. By frustrating Plaintiff's motion solely by pointing to the incomplete policy and then coyly refusing to identify the deficiency for months thereafter, Defendant unnecessarily and unreasonably extended this litigation for no reason related to its good-faith position on the merits.

As noted above, the purpose of Section 155 is to prevent a Plaintiff's recovery from being "wiped out by expenses if the company compels him to resort to court action, although the refusal to pay the claim is based upon the flimsiest sort of a pretext." *Cramer*, 675 N.E.2d at 901 (citation omitted). Jackson unreasonably extended this litigation by one year for no apparent purpose other than delay. Plaintiff incurred significant costs in filing this motion for summary judgment and in responding to Jackson's motion. In keeping with Section 155's purpose, the Court awards attorney fees to Plaintiff for the cost of preparing and responding to the present cross-motions for summary judgment. *See TKK USA*, 727 F.3d at 795 (upholding award of fees for an unnecessary and unreasonable motion, notwithstanding that the insurer's underlying coverage denial was based on a *bona fide* dispute).

CONCLUSION

For the foregoing reasons, Plaintiff's motion for summary judgment (R. 47) is GRANTED and Jackson's motion for summary judgment (R. 42) is DENIED. The Court awards attorney fees to Plaintiff for the cost of preparing and responding to these motions. The clerk is directed to enter a final judgment in favor of Plaintiff Norma Cooke, which includes an award of reasonable attorney fees in accordance with this opinion.

ENTERED: **/s/ Rubén Castillo**
Chief Judge Rubén Castillo
United States District Court

Dated: March 20, 2017

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

Case No. 15 C 817

[Dated April 13, 2016]

NORMA L. COOKE, Plaintiff, -vs- JACKSON NATIONAL LIFE INSURANCE COMPANY (successor to Southwestern Life Insurance Company and Reassure America Life Insurance Company), Defendant.	)

Chicago, Illinois
April 13, 2016
9:52 a.m.

TRANSCRIPT OF PROCEEDINGS
BEFORE THE HONORABLE CHIEF JUDGE
RUBEN CASTILLO

APPEARANCES:

For the Plaintiff:

MR. STEVEN B. POLLACK
Law Office of Steven B. Pollack
49 Sherwood Terrace
Suite 49-X
Lake Bluff, IL 60044
(847) 436-9566
E-mail: Efile@ecoesq.com

For the Defendant:

MR. ALEXANDER DAVID MARKS
MR. FREDERIC A. MENDELSOHN
Burke, Warren, MacKay & Serritella, P.C.
330 North Wabash Avenue
22nd Floor
Chicago, IL 60611
(312) 840-7000
E-mail: Amarks@burkelaw.com
Fmendelsohn@burkelaw.com

Court Reporter:

KATHLEEN M. FENNELL, CSR, RPR, RMR, FCRR
Official Court Reporter
United States District Court
219 South Dearborn Street, Suite 2524-A
Chicago, Illinois 60604
Telephone: (312) 435-5569
Kathleen_Fennell@ilnd.uscourts.gov

[p.2]

(Proceedings heard in open court:)

THE CLERK: 15 C 817, Cooke versus Jackson National Life Insurance.

THE COURT: Good morning.

MR. POLLACK: Good morning, your Honor. Steven Pollack on behalf of plaintiff, Norma Cooke.

MR. MENDELSOHN: Good morning, your Honor. Fred Mendelsohn, Alex Marks for defendant Jackson National Life Insurance Company.

THE COURT: Okay. Any new developments in this case?

MR. POLLACK: We did have a meeting to discuss settlement.

THE COURT: Okay.

MR. POLLACK: I don't think that the case is going to settle. I believe that we did exhaust settlement possibilities.

THE COURT: Do you think it's worthwhile talking to Magistrate Judge Rowland about the settlement or not?

MR. POLLACK: I don't think so.

THE COURT: Okay.

MR. POLLACK: I think both sides have addressed an interest in getting to dispositive motions.

THE COURT: Okay. Is there any discovery that's going to occur?

MR. MENDELSOHN: Yes.

[p.3]

THE COURT: Because I think that's what was lacking last time.

MR. MENDELSOHN: Right. We were before you I think on April 1st. We had a status.

THE COURT: Right.

MR. MENDELSOHN: We were going to engage in some relatively quick discovery, and you wanted us to come back about June of last year to report on potential for an early resolution --

THE COURT: Right.

MR. MENDELSOHN: -- at least those discussions.

Shortly thereafter, the motion for judgment on the pleadings got filed. That sort of derailed what we had planned, which included the plaintiff's deposition, which was a key part of what we would do next --

THE COURT: I agree.

MR. MENDELSOHN: -- to further your then-articulated goals.

So we're sort of back where we started, yet --

THE COURT: Yeah, it's very frustrating because I think it was a premature motion for judgment on the pleadings, as my opinion points out.

MR. MENDELSOHN: We saw that language, and we nonetheless followed your directives. We had a meeting on Friday to exhaust settlement discussions following an exchange

[p.4]

of written demands, if you will.

We also used that meeting as an opportunity to talk about a just recently served amended Rule 30(b)(6) deposition notice, which we have issues with, which we have not had a chance to fully digest, are in the process of it and anticipate bringing a motion for a protective order with respect to that 30(b)(6) deposition.

I could go into some detail if you need to, but --

THE COURT: Don't need detail.

MR. MENDELSOHN: -- I'm only expressing that because I know you needed to set some time for us to have depositions. We need to take the plaintiff for sure.

There's a possibility of one or two other witnesses, depending on what the plaintiff says from Jackson's standpoint.

THE COURT: Okay.

MR. MENDELSOHN: Of course, we have this 30(b)(6) issue --

THE COURT: Right.

MR. MENDELSOHN: -- which could be anywhere from two to ten witnesses, and we need to address these issues with --

THE COURT: No, it won't be ten, I'll tell you that.

MR. MENDELSOHN: No, I mean in terms of the topics, the way they've been set out.

We're not clear on what we need to do, which is why

[p.5]

we want to bring this motion for protective order and anticipate doing so shortly, as soon as we hear back from counsel.

THE COURT: I'll tell you this, given what I know about this case having written the opinion that we issued, 30(b)(6) depositions in this case shouldn't be more than two people at best.

MR. MENDELSOHN: I have people for sure in three states that I believe at a minimum would be required, given the scope of the topics, and maybe more.

THE COURT: Okay. Well, the first thing I'm going to do, just given the opinion that I issued in this case, is I'm going to enter automatic disclosure orders.

I probably should have done that earlier, so I admit that prior mistake.

I'm going to require you to disclose to each other under Rule 26(a)(1) by April 25th so that you have some of these materials that I think were lacking from the Court's review in ruling on the earlier motion.

There's allegations of some new payment arrangement and some materials that relate to that.

Whatever they are, they should be turned over so that each side can have all of these documents.

And then I'm going to cut off all discovery in the case by June 30th. And I am, under the rules of

[p.6]

proportionality that now apply, I'm going to limit the depositions in this case right now to six depositions, three per side, and we'll proceed from that point on.

MR. POLLACK: Your Honor, can I just --

THE COURT: Yeah.

MR. POLLACK: Based on your ruling where you discussed several of our alternate --

THE COURT: Right.

MR. POLLACK: -- counts, we agree, and we'd like to have leave to amend our complaint to remove the waiver and estoppel and one of the breach of contracts and just move forward on one breach of contract and one bad faith claim. The problem is --

THE COURT: Okay. If you're going to narrow the complaint, I'll certainly allow that.

MR. POLLACK: Well --

THE COURT: I'm not going to let you amend the complaint to add any new causes of action.

MR. POLLACK: Right, there won't be any new causes of action, but what we'd like to do is to also amend the Exhibit 1, which is the policy because that's

the issue that came up that defense -- defendant asserted that we hadn't provided the full policy.

We asked in interrogatories for defendant to identify and produce the complete policy --

[p.7]

THE COURT: Right.

MR. POLLACK: -- and what --

THE COURT: Well, now you're going to get them pursuant to the automatic disclosure.

MR. POLLACK: Well, we've gotten substantial discovery, we've gotten about 500 pages, but what they identified was 31 pages, which looks like the policy that we had already put in as our Exhibit 1, but also another 150 pages that they say --

THE COURT: Okay. Why don't you wait and see, why don't you wait and see what they turn over as a result of the order that I entered, and then you're free to amend the complaint to reduce the number of claims in this case. That I will allow.

MR. POLLACK: Okay.

MR. MENDELSOHN: Your Honor, if I might?

THE COURT: Go ahead.

MR. MENDELSOHN: I'm not clear if the Court is under the impression that we have not complied with Rule 26(a)(1) and written discovery.

THE COURT: I'm under that impression, yes, because there were documents that were lacking in the Court's analysis that were just not in the record.

MR. MENDELSOHN: We did exchange 26(a)(1) disclosures.

[p.8]

THE COURT: Okay. So let me just say this --

MR. MENDELSOHN: Hundreds of pages.

THE COURT: -- if you're comfortable that you've fully complied with Rule 26(a)(1), then you have nothing to worry about, but I'm not comfortable with that.

MR. MENDELSOHN: We've turned over our stuff, Judge.

THE COURT: Okay.

MR. MENDELSOHN: And we did this before the --

THE COURT: Okay.

MR. MENDELSOHN: -- motion for judgment on the pleadings. Whether it was tactically the correct -- whether it was the correct motion or not to resolve the case is a different issue.

We need --

THE COURT: I agree with that.

MR. MENDELSOHN: -- to go back to where we were at, which is --

THE COURT: I agree that that's a different issue.

MR. MENDELSOHN: But we have taken substantial written discovery, including from third parties.

So I believe that there's a lot of documents that have been turned over in the case, and I think all the documents have been turned over in the case.

THE COURT: And you disagree, right?

MR. POLLACK: Well, we are going to be today issuing

[p.9]

a second request for production that's very limited. But otherwise, I believe that the documents have been turned over -- what --

THE COURT: This is a simple insurance case. There shouldn't be this much intrigue and mystery to turning over the documents.

MR. POLLACK: I don't know that it's not -- that it's the documents haven't been turned over. We've asked them to identify what they consider to be the full policy, and they've resisted doing that --

THE COURT: Okay.

MR. POLLACK: -- and so we've noticed that as one of the topics for the deposition, which was also objected to.

THE COURT: Well, the full policies have to be turned over pursuant to the automatic disclosure. If

that, for whatever reason, hasn't been done, that should be done by April 25th. That's all I'm going to say about that.

You need to proceed with discovery, and then we're going to come back at this case hopefully in a motion for summary judgment, but I'm not going to set those dates yet.

I will next see you at the end of June, and we'll see where the case is, but we need to get going with this case.

If you could give me a date, Mrs. O'Shea.

THE CLERK: June 23rd at 9:45.

THE COURT: Thank you. I will see you then.

[p.10]

MR. MENDELSOHN: Thank you, your Honor.

MR. MARKS: Thank you, your Honor.

MR. POLLACK: Thank you.

THE COURT: Thank you.

(Which were all the proceedings heard.)

CERTIFICATE

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

/s/Kathleen M. Fennell
Kathleen M. Fennell
Official Court Reporter

April 19, 2016
Date

APPENDIX E

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

No. 15 C 817
Chief Judge Rubén Castillo

[Dated March 15, 2016]

NORMA L. COOKE,	)
Plaintiff,	)
	)
v.	)
	)
JACKSON NATIONAL LIFE INSURANCE COMPANY	)
Defendant.	)
	)

MEMORANDUM OPINION AND ORDER

In this diversity breach of contract case, Norma L. Cooke ("Plaintiff") seeks payment of a life insurance policy obtained by her late husband, Charles E. Cooke ("Cooke"). Plaintiff, the policy's beneficiary, alleges that Jackson National Life Insurance Company ("Defendant") breached the terms of the policy by increasing the premium payment due while Cooke's account was in a grace period following a missed payment. (R. 1, Compl. ¶ 31.) Presently before the Court is Plaintiff's motion for judgment on the

pleadings pursuant to Federal Rule of Civil Procedure 12(c). (R. 18, Pl.'s Mot.) For the reasons stated below, Plaintiff's motion is denied.

RELEVANT FACTS

On July 28, 1998, Southwestern Life Insurance Company issued a life insurance policy to Cooke. (R. 10, Answer ¶ 7.) Under the policy, Cooke received $200,000 of coverage for a term of fifteen years. (*Id.* ¶ 8.) The policy also gave Cooke the option to renew his policy at a higher premium once the initial fifteen-year term ended. (R. 1-1. Compl. Ex. A at 13.) At some point during Cooke's coverage, Defendant acquired the policy. (R. 10, Answer ¶ 4.) The policy included a grace period provision for missed payments, containing the following language:

> Except for the first premium, we allow a Grace Period of 31 days beginning on the due date to pay the premium. The policy will remain in force during the Grace Period. If the Insured dies during the Grace Period, the unpaid premium will be deducted from the Proceeds.
>
> Any premium not paid on or before its due date is a premium in default. If a premium in default is not paid before the end of the Grace Period, the policy will terminate.

(R. 1-1 , Compl., Ex. A at 13.) The policy provides for quarterly premium payments. (*Id.* at 4.) However, according to Defendant, "[Cooke] entered into a separate and additional contract . . . which authorized the withdrawal of premiums on a monthly basis" subject to "specific terms and conditions." (R. 10,

Answer ¶ 46.) Both parties agree that Cooke paid his premium on a monthly basis via automatic bank withdrawal for roughly fifteen years. (*Id.* ¶ 47.)

As Cooke neared the end of his fifteen-year term, Defendant issued him a notice dated May 30, 2013, informing him that his premium would increase to $2,835.85 beginning July 28, 2013. (*Id.* ¶ 11.) The letter also informed Cooke that he would "be billed at the same frequency or mode" as the current premium and that $2,835.85 would be his "new modal premium amount." (R. 1-2, Compl., Ex. B.)

On July 28, 2013, Defendant attempted to withdraw $2,835.85 from Cooke's bank account, but the withdrawal failed due to insufficient funds. (R. 10, Answer ¶ 12.) The missed payment triggered a grace period ending on August 28, 2013. (*Id.* ¶ 18.) Defendant notified Cooke of his account deficiency in a letter dated August 9, 2013. (*Id.* ¶ 14.) The letter informed Cooke that the policy would "terminate if the renewal premium [was] not received by the last day of the grace period." (R. 1-3, Compl., Ex. C.) Plaintiff also claims that she called Defendant on or about August 15, 2013, to determine the final date for payment under the grace period provision. (R. 1, Compl. at ¶¶ l5-16.) In this conversation, Defendant allegedly informed Plaintiff that it was withdrawing its consent to pay monthly premiums and that a quarterly payment would be due by September 15, 2013. (*Id.* ¶ 16) Defendant, however, denies all of Plaintiff's allegations regarding this telephone call. (R. 10, Answer ¶ 16.)

At some point, Defendant also mailed a separate payment notice to Cooke informing him that he owed a

quarterly payment of $8,637.94 by July 28, 2013. (*Id.* ¶ 17.) The notice indicated that if Defendant did not receive payment by that date, the policy "[would] enter its grace period and [would] terminate if the renewal premium [was] not received by the last day of the grace period." (R. 1-4, Compl., Ex. D at 2.) Plaintiff claims the payment notice was issued on or about August 15, 2013, but the notice attached to Plaintiff's complaint does not display a date. (R. 1, Compl. at ¶ 17.) Defendant only admits that the letter exists, but it does not agree that it was sent on or about August 15, 2013. (R. 10, Answer ¶ 17.)

Cooke failed to make any payments before August 28, 2013, the last day of the grace period. (*Id.* ¶ 18.) On September 10, 2013, Cooke passed away. (*Id.* ¶ 19.) Three days later, on September 13, 2013, Defendant received a check from Plaintiff for $8,637.94. (*Id.* ¶¶ 20-21.) Three days after that, on September 16, 2013, Defendant issued a letter to Cooke stating that the policy had lapsed for failure to pay the premium within the grace period. (*Id.* ¶ 22.)

Plaintiff filed her complaint on January 27, 2015. (R. 1, Compl.) Plaintiff alleges that Defendant breached the policy in either of two ways: (1) by misrepresenting that an increased quarterly payment was due to satisfy the grace period despite that provision's requirement that "the premium due" at the time of default would suffice, (R. 1, Compl. ¶ 31); or (2) by not extending the grace period by 31 days when it demanded a larger quarterly payment, (*id.* ¶ 33). Plaintiff also asserts that Defendant waived its right to demand quarterly payments because the May 30 letter changed Cooke's

premium frequency to monthly. (*Id*. ¶¶ 51, 54.) In addition, Plaintiff claims that Defendant should be estopped from enforcing the original grace period and denying that a new grace period was created by the quarterly payment demand. (*Id*. ¶ 61) Lastly, Plaintiff asks this Court to find that Defendant's actions allegedly changing the terms and dates of required payments were "vexatious and unreasonable" in various ways in violation of the Illinois Insurance Code, 215 ILL. COMP. STAT. 5/155. (*Id*. ¶¶ 63-70.) Defendant answered on March 24, 2015. (R. 10, Answer.) Defendant denies that Plaintiff was entitled to a new grace period, that it waived its right to demand quarterly payments, and that it is bound by promissory estoppel. (*Id*. ¶¶ 35, 51.) Defendant also denies that it acted in a vexatious and unreasonable manner. (*Id*. ¶ 66.)

Without seeking any discovery, Plaintiff filed the present motion for judgment on the pleadings on July 2, 2015.(R. 18, Pl.'s Mot.) Plaintiff argues that Defendant has admitted the validity of the documents attached to the complaint and, thus, all that remains is to interpret these documents as a matter of law. (*Id*. at 2-3.) Defendant responded on August 13, 2015. (R.24, Def.'s Resp.) Defendant argues that it has denied that the contract attached to the complaint is complete, as there is "a separate contract . . . that set forth the terms governing [Cooke's] monthly installment payment election." (*Id*. at 4.) Defendant also argues that Plaintiff's motion relies on facts that Defendant has explicitly denied. (*Id*. at 8-9.) Plaintiff filed her reply on August 30, 2015. (R. 26, Pl.' s Reply.)

LEGAL STANDARD

Federal Rule of Civil Procedure 12(c) permits a party to "move for judgment on the pleadings after the filing of the complaint and answer." *Supreme Laundry Serv., L.L.C. v. Hartford Cas. Ins. Co.*, 521 F.3d 743, 746 (7th Cir. 2008). The pleadings consist of "the complaint, the answer, and any written instruments attached as exhibits." *Hous. Auth. Risk Retention Grp., Inc. v. Chi. Hous. Auth.*, 378 F.3d 596, 600 (7th Cir. 2004). A Rule 12(c) motion is typically "governed by the same standards as a motion to dismiss for failure to state a claim under Rule l2(b)(6)." *Lodholtz v. York Risk Servs. Grp., Inc.*, 778 F.3d 635, 639 (7th Cir. 2015).

However, when a party uses a Rule 12(c) motion to attempt to win its case "on the basis of the underlying substantive merits," the correct standard "is that applicable to summary' judgment, except that the court may consider only the contents of the pleadings." *Alexander v. City of Chi.*, 994 F.2d 333, 336 (7th Cir. 1993). Under this standard, judgment on the pleadings will not be granted unless "there is no genuine issue as to any material fact and . . . the moving party is entitled to a judgment as a matter of law." *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986) (citation omitted). "A genuine dispute as to any material fact exists if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Kvapil v. Chippewo Cty., Wis.*, 752 F.3d 708, 712 (7th Cir. 2014) (citation and internal quotation marks omitted). In deciding whether a dispute exists, the Court must "construe all facts and reasonable inferences in the

light most favorable to the non-moving party." *Nat'l Am. Ins. Co. v. Artisan & Truckers Cas. Co.*, 796 F.3d 717, 723 (7th Cir. 2015) (citation omitted).

The Court cannot weigh conflicting evidence, assess the credibility of the witnesses, or determine the ultimate truth of the matter, as these are functions of the jury. *Anderson v. Liberty Lobby, Inc.*, 477 U.5. 242, 255 (1986); *Omnicare, Inc. v. UnitedHealth Grp., Inc.*, 629 F.3d 697, 104-05 (7th Cir. 2011). In other words, a motion for judgment on the pleadings "cannot be used to resolve swearing contests between litigants." *Payne v. Pauley*, 337 F.3d 767, 770 (7th Cir. 2003). Instead, the Court's role is simply "to determine whether there is a genuine issue for trial." *Tolan v. Cotton*, 134 S. Ct. 1861, 1866 (2014) (quoting *Anderson*, 477 U.S. at 249).

ANALYSIS

I. Choice of Law

As a preliminary matter, the parties dispute which state's laws apply to the insurance policy. Plaintiff argues that Illinois law is appropriate, as the policy's beneficiary lived in Illinois. (R. 26, Pl.'s Reply at 1.) Although Plaintiff does not provide specific dates, she alleges that Cooke was domiciled at all times in Illinois and simply maintained a separate residence in South Carolina for work purposes. (*Id.* at 3.) As all of the correspondence to Cooke from May 30, 2013, onward was addressed to him in Illinois, the Court concludes that he had given notice to Defendant of his change in residence prior to this date. Defendant argues that because the policy was issued in South Carolina while Cooke resided there, South Carolina law should apply.

(R.24, Def.'s Resp. at 5-6.) The Court must thus determine which state's laws govern this action.

"Federal courts hearing state law claims under diversity . . . jurisdiction apply the forum state's choice of law rules to select the applicable state substantive law." *McCoy v. Iberdrola Renewables, Inc.*,760 F.3d 674, 684 (7th Cir. 2014); *Klaxon Co. v. Stentor Electric Mfg. Co.*, 313 U.S. 487, 496 (1941). Illinois only requires a choice-of-law determination "when a difference in law will make a difference in the outcome." *Townsend v. Sears, Roebuck & Co.*, 879 N.E.2d 893, 898 (Ill. 2007). When such a determination is necessary, Illinois follows the Restatement (Second) of Conflict of Laws ("Restatement") for contract actions. *Midwest Grain Prods. of Ill., Inc. v. Productization, Inc.*, 228 F.3d 784, 787-88 (7th Cir. 2000); *Swanberg v. Mutual Ben. Life Ins. Co.*, 398 N.E.2d 299, 301-02 (Ill. 1979) (applying Restatement in life insurance dispute). The Restatement states that in the absence of a contractual choice-of-law provision, a life insurance policy is governed by "the local law of the state where the insured was domiciled at the time the policy was applied for" unless "some other state has a more significant relationship under the principles stated in § 6 to the transaction and the parties." RESTATEMENT (SECOND) OF CONFLICT OF LAWS § 192. Section 6 provides "multiple and diverse principles [that] are not listed in any order of priority, and some of them point in different directions." *Townsend*, 878 N.E.2d at 900. These principles include "the relevant policies of the forum, . . . the relevant policies of other interested states and the relevant interests of those states in the determination of the particular issue, . . . the protection

of justified expectations, . . . certainty, predictability and uniformity of result." RESTATEMENT (SECOND) OF CONFLICT OF LAWS § 6. "While section 6 enunciates the guiding principles of the choice-of-law process, the most-significant-relationship formula describes the *objective* of that process: to apply the law of the state that, with regard to the particular issue, has the most significant relationship with the parties and the dispute." *Townsend*, 879 N.E.2d at 901 (citation omitted).

As Defendant notes repeatedly, the differences between South Carolina and Illinois law are unlikely to be outcome-determinative on most issues in this case. (R. 24, Def.'s Resp. at 6, 9, 10.) Indeed, the basic elements of common law contract doctrine, breach, waiver, and promissory estoppel are governed by the same principles in both states. However, Plaintiff's vexatious and unreasonable conduct count under § 5/155 differs from South Carolina's corresponding "bad faith" cause of action. Plaintiff alleges that Defendant acted in bad faith by demanding payments and denying coverage in an unreasonable or predatory manner. (R. 1, Compl. ¶¶ 63-69.) Most significantly, although both causes of action provide for recovery of attorney's fees and costs, the Illinois statute limits punitive damages to at most $60,000 while the South Carolina statute does not contain any such limitation. 215 ILL. COMP. STAT. 5/155; S.C. CODE ANN. § 38-59-20; *see also Townsend*, 879 N.E.2d at 899 (finding that different statutory caps on compensatory damages constitute an outcome-determinative conflict). Thus, the Court must conduct a conflict-of-laws analysis regarding Plaintiff's claim that Defendant has

vexatiously and unreasonably obstructed her collection of insurance benefits.

The Restatement recommends that life insurance policies should generally be governed by the law of the state in which the insured lived when the contract was executed. RESTATEMENT (SECOND) OF CONFLICT OF LAWS § 192. It also notes in a comment, however, that when the insured changes his residence after application for the policy, "the insured's new domicil will have the dominant interest in him" especially when "the substantial obligations of the insurance company under the policy" are not at issue. RESTATEMENT (SECOND) OF CONFLICT OF LAWS § 192 cmt. d. Where there is no significant danger of upsetting the insurance company's justified expectations with regard to contractual obligations, the subsequent state of residence will likely have the most significant relationship to the dispute. *See id.* (law of new state of residence may apply "particularly with respect to acts—such as the giving of notice of default by the insurance company—which are done following notice to the company of a change of domicil"). Although a choice-of-law analysis begins with the state in which the policy was signed, this single factor is not determinative.

The Court concludes that South Carolina has no significant relationship to Defendant's alleged bad faith in handling Cooke's policy. All of the relevant conduct pertaining to Plaintiff's claims occurred after May 30, 2013, and the record suggests that Cooke had resided in Illinois for some time prior to that date. (R. 26, Pl.'s Reply at 3.) While South Carolina surely has an

interest in governing the terms of contracts that are entered into within its borders, it would seem to have little interest in policing the collections practices of Michigan-based insurers seeking premium payments from long-time residents of Illinois. Further, Defendant does not and cannot credibly claim that its justified expectations that any alleged bad faith on its part would be governed by South Carolina's law were prejudicially ignored; Illinois's statute, with its cap on punitive damages, would seem to protect Defendant from unlimited liability more than the law that it proposes should apply. Simply put, the Court cannot identify any reason why Defendant would object to the application of Illinois law to this case in its entirety, and Defendant has not provided any such reason. Because the Court also cannot identify any reason why South Carolina has a more significant relationship to the claim of vexatious or unreasonable conduct than does Illinois, the Court will apply Illinois law to this dispute.

II. Breach of Contract

In her motion, Plaintiff argues that Defendant breached the contract as a matter of law by increasing the amount due during the grace period. (R. 18, Pl.'s Mot. at 5.) Plaintiff relies on the language of the grace-period provision, which allows "a Grace Period of 31 days beginning on the due date to pay the premium due." (R. 1-1, Compl., Ex. A at 13.) According to Plaintiff, the "premium due" was only the amount due on July 28, 2013, in the amount of $2,835.85. (R. 18, Pl.'s Mot. at 7.) Plaintiff argues that, because the grace period provision allows 31 days to pay "the premium

due" when the insured failed to make a payment, the amount of the premium due cannot possibly be increased during the grace period. (*Id.*) Her first theory of breach, therefore, is that during the grace period the Defendant misrepresented that a larger, quarterly payment was due. (R. 1, Compl. ¶ 31.)

In her alternative theory, Plaintiff argues that even if the premium due could be increased during a grace period, the grace period provision would have required a *new* grace period of 31 days beginning on the day the premium was thus increased; as there is a new premium due, Plaintiff urges, there should be a new 31 days in which to pay "the premium due." (*Id.* ¶ 33) According to Plaintiff, the premium was increased on August 15, 2013, and this newly due premium should have created a new grace period that would expire on September 15, 2013. (*Id.* ¶ 35) Under Plaintiff's alternative grace-period theory, she argues that Defendant would have been required to pay the policy benefits when Cooke passed away on September 10, 2013, because the grace period provision required the policy to "remain in force during the Grace Period." (R. 1-1, Compl., Ex. A at 13.)

Under Illinois law, contracts "must be construed as a whole, viewing each provision in light of the other provisions." *United States v. Rogers Cartage Co.*, 794 F.3d 854, 861 (7th Cir. 2015) (citation omitted). "[I]nstruments executed at the same time, by the same parties, for the *same purpose*, and in the course of the same transaction are regarded as one contract and will be construed together." *Dearborn Maple Venture, LLC*

v. SCI Ill. Servs., Inc., 968 N.E.2d 1222, 1232 (Ill. App. Ct. 2012) (citation omitted).

Both of Plaintiff's theories of breach rely entirely on the grace period provision being the sole contractual language governing the payments due after a missed payment. According to Plaintiff, the grace period provision either cements the amount of the premium due for the entire grace period or it requires a new grace period to be extended when the premium due is increased from a monthly to a quarterly sum. However, Plaintiff appears to ignore the fact that Defendant denies that the policy attached to Plaintiff's complaint "is the complete Policy." (R. 10, Answer ¶ 7.) Instead, Defendant claims that "a separate and additional contract . . . authorized the withdrawal of premiums on a monthly basis," subject to additional "terms and conditions." (R. 10, Answer ¶ 46.) Although Plaintiff argues that Defendant has admitted the existence of the contract attached to her complaint, the Court cannot interpret the contract as a matter of law without having the parties' entire agreement. *See Founders Ins. Co. v. Munoz*, 930 N.E.2d 999, 1004 (Ill. 2010) ("[A]n insurance policy must be considered as a whole; all of the provisions, rather than an isolated part, should be examined to determine whether an ambiguity exists."); *Dearborn Maple*, 968 N.E.2d at 1232. Drawing all reasonable inferences in favor of Defendant, the nonmovant, the Court must credit Defendant's claim that a relevant portion of the contract is not in the record. *Nat'l Am. Ins. Co.*, 796 F.3d at 723. For this reason, Plaintiff cannot prevail on her breach of contract claims as a matter of law at this early stage.

Even if the policy submitted by Plaintiff were the complete agreement, the Court still could not grant Plaintiff's motion on her breach of contract claim. Under Illinois law, "[t]he elements of a claim for breach of contract are (1) the existence of a valid and enforceable contract; (2) substantial performance by the plaintiff; (3) breach of contract by the defendant; and (4) resultant injury to the plaintiff." *Avila v. CitiMortgage, Inc.*, 801 F.3d 777, 786 (7th Cir. 2015) (citing *W.W. Vincent & Co. v. First Colony Life Ins. Co.*, 814 N.E.2d 960, 961 (Ill. App. Ct. 2004)).

Assuming there is a valid and enforceable contract and Plaintiff was injured, there are additional factual issues relevant to Cooke's performance and Defendant's alleged breach. If, as Plaintiff alleges in her first theory of breach, Defendant was not allowed to increase the amount due during the original grace period, then Cooke would have needed to pay his monthly premium by August 28, 2013, in order to perform his part of the contract. However, it is undisputed that "the original Grace Period ended with no payment by [Cooke]." (R. 1, Compl. ¶ 8; R. 10, Answer ¶ 18.) Accordingly, Cooke would not have substantially performed and Plaintiff's breach claim would not succeed based on the pleadings.

The Court also could not grant relief on Plaintiff's second theory of breach due to factual disputes regarding the date of Defendant's demand for a quarterly payment. If the grace period provision required Defendant to honor a new grace period when it demanded a quarterly payment, then the date of this demand is central to resolution of this claim. The grace period would last for 31 days from the date of the

demand, and if Cooke neither paid the premium nor passed away within those 31 days, his policy would lapse. In Plaintiff's motion, she asserts that Defendant "admits sending [Cooke] another notice, undated, on August 15, 2013," demanding a quarterly payment. (R. 18, Pl.'s Mot. at 5.) However, when answering Plaintiff's complaint, Defendant only "admit[ted] the existence of the notice" and "denie[d] all remaining allegations contained in [the] paragraph." (R. 10, Answer ¶ 17.) Because Defendant denied that the undated notice was sent on August 15, any theory of breach based on the date of this notice cannot succeed at this stage. Even if Plaintiff could establish as a matter of law that the notice required a new grace period, there is a material dispute of fact about whether Cooke died within 31 days of the undated notice.

III. Waiver

Plaintiff also argues that she is entitled to judgment as a matter of law because Defendant waived its right to demand quarterly payments. (R. 18, Pl.'s Mot. at 6.) Both parties agree that the written policy "required quarterly payments." (R. 10, Answer ¶ 46.) Both parties also agree that Cooke's premium was paid on a monthly basis for roughly fifteen years. (*Id*. ¶ 47). Defendant claims that the "monthly payments were withdrawn pursuant" to a separate and additional contract. (*Id*.) According to Plaintiff, notwithstanding that separate and additional agreement, Defendant waived its right to demand quarterly payments when it sent the May 30 letter stating that Cooke would "be billed at the same frequency or mode" as the current

premium and that $2,835.85 would be his "new modal premium amount." (R. 1-2, Compl., Ex. B; R. 26, Pl.'s Reply at 4.) Thus, according to Plaintiff, even if Defendant had the right to withdraw consent to make monthly payments under the original policy, it could not go back to demanding quarterly payments after waiving this right.

"Waiver is either an express or implied voluntary and intentional relinquishment of a known and existing right." *Midway Park Saver v. Sarco Putty Co.*, 976 N.E.2d 1063, 1071 (Ill. App. Ct. 2012) (citation omitted). "[W]aiver may be established by conduct indicating that strict compliance with . . . contractual provisions will not be required." *Bd. of Library Trs. of Midlothian v. Bd. of Library Trs. of Posen Pub. Library Dist.*, 34 N.E.3d 602, 614 (Ill. App. Ct. 2015) (citation omitted).

Drawing all reasonable inferences in favor of Defendant, the potential existence of a separate contract memorializing the terms of Cooke's monthly payments prevents this Court from granting Plaintiff's waiver claim as a matter of law. Without the separate contract, this Court cannot determine what specific rights Defendant had regarding monthly payments and whether Defendant voluntarily and intentionally relinquished those rights. Defendant may not have had the right to demand quarterly payments once Cooke defaulted, but without a clear picture of what

Defendant's rights were regarding monthly payments, Plaintiff's waiver claim cannot succeed at this stage.[1]

Even if the additional contract did not exist, however, Plaintiff's waiver argument would still not entitle her to judgment under Rule 12(c). The original policy agreement contemplated quarterly premiums and allowed Defendant to consent to different payment modes at its discretion. The May 30 letter that Plaintiff relies on as evidence of Defendant's waiver states, "Your new premium of $2,835.85 will be billed at the same frequency or mode as your current premium. This is your new modal premium amount." (R. 1, Compl., Ex. B.) Plaintiff argues that "Defendant waived the quarterly mode, foregoing its prior consent for monthly billing in favor of making monthly the new frequency or mode." (R. 18, Pl.'s Mot. at 6.) However, the letter could be interpreted in either of two ways. It is possible, as Plaintiff suggests, that this letter represents Defendant's intentional relinquishment of its right to withdraw consent to make monthly payments and to change the baseline payment frequency from quarterly to monthly. However, the letter contains no mention of changing the policy terms, and the original policy's renewal provision establishes that "[t]he new policy will be on the same plan of insurance . . . as this policy." (R. 1-1, Ex. A at 15.) In

---

[1] Even if Defendant did waive its right to demand quarterly payments as a matter of law, Plaintiff would still be unable to show that she is entitled to relief under Rule 12(c). If Defendant waived its right to demand quarterly payments, Cooke still would have needed to pay his monthly premium before August 28, 2013, which the parties agree he did not do. (R. 1, Compl. ¶ 18; R. 10, Answer ¶ 18.)

other words, the new term of the policy would be governed by the same contract, including its quarterly payment provision and Defendant's discretionary consent to allow monthly payments. The other possible meaning of the May 30 letter's language was that Defendant was communicating to Cooke, at the outset of the new term, that it would continue to provide its consent for him to make monthly payments. What is certain is that neither reading is strictly compelled by the letter; further factual development is required to determine whether it constitutes waiver or consent. Because the Court must draw all reasonable inferences in Defendant's favor, Plaintiff cannot establish waiver on her motion under Rule 12(c).

IV. Estoppel

In Count IV of her complaint, Plaintiff claims that Defendant should be estopped from enforcing the original grace period begun when Cooke failed to pay his monthly premium on July 28 and estopped from denying the creation of a new grace period on the date of its demand for a quarterly premium amount. (R. 1, Compl. ¶ 61.) Although Plaintiff fails to present any argument addressing this count in her motion, she does mention estoppel at the end of her reply. (R. 26, Pl.'s Reply at 6.)

Under Illinois law, to claim estoppel, a party must demonstrate that:

> (1) the other person misrepresented or concealed material facts; (2) the other person knew at the time he or she made the representations that they were untrue; (3) the party claiming estoppel

> did not know that the representations were untrue when they were made and when they were acted upon; (4) the other person intended or reasonably expected that the party claiming estoppel would act upon the representations; (5) the party claiming estoppel reasonably relied upon the representations in good faith to his or her detriment; and (6) the party claiming estoppel would be prejudiced by his or her reliance on the representations if the other person is permitted to deny the truth thereof.

W. Bend Mut. Ins. Co. v. Procaccio Painting & Drywall Co., 794 F.3d 666, 679 (7th Cir. 2015) (quoting *Geddes v. Mill Creek Country Club, Inc.*, 751 N.E.2d 1150, 1157 (Ill. 2001)). "Estoppel is ordinarily a question of fact and only becomes a question of law where there is no dispute as to the material facts and only one inference can be drawn from those facts." *Bd. of Library Trs.*, 34 N.E.3d at 611.

The pleadings in this case contain no undisputed facts regarding Defendant's alleged knowledge that its representations were untrue or its expectation that Cooke would rely on them. In fact, there is only one allegation relating to Defendant's knowledge or intention: Plaintiff claimed that Defendant "made a knowingly false statement" when it demanded a quarterly premium without creating a new grace period. (R. 1, Compl. ¶ 55.) However, Defendant explicitly denied this fact. (R. 10, Answer ¶ 55.) Because Defendant's knowledge and intention in making allegedly false representations to Plaintiff comprise essential elements of a promissory estoppel

claim, the existence of a genuine issue of material fact on these issues precludes judgment on the pleadings in favor of Plaintiff. *Nat'l Am. Ins. Co.*, 796 F.3d at 722-23.

V. Vexatious and Unreasonable Conduct

Lastly, Plaintiff claims that Defendant engaged in vexatious or unreasonable behavior in its handling of Cooke's policy. See 215 ILL. COMP. STAT. 5/155. In her motion, Plaintiff appears to argue that Defendant's alleged breach constituted per se vexatious and unreasonable conduct; she observes that lllinois law calls for a totality of the circumstances test, *Marchesi v. Ill. Farmers Ins. Co.*, 698 N.E.2d 683, 688 (Ill. App. Dist. 1998), notes that violations of insurance regulations can be factors in finding the requisite bad faith, *Meier v. Aetna Life & Cas. Standard Fire Ins. Co.*, 500 N.E.2d 1096, 1102 (Ill. App. Ct. 1986), and realleges her claim that Defendant breached the policy as evidence that it violated such insurance regulations. (R. 18, Pl.'s Mot. at 8-9.) Defendant responds that vexatious and unreasonable conduct is a question of fact and thus unfit for determination as a matter of law at the pleadings stage. (R. 24, Def.'s Resp. at 10.)

"Section 155 of the Illinois Insurance Code allows an insured to recover attorney fees when the insurer's denial of coverage or delay in payment is 'vexatious and unreasonable,' or when the insurer behaves vexatiously and unreasonably during the course of coverage litigation." *TKK USA, Inc. v. Safety Nat'l Cas. Corp.*, 727 F.3d 782, 793 (7th Cir. 2013); *see also* 215 ILL. COMP. STAT. 5/155. "The question of vexatious and unreasonable action or delay is a factual issue" and

"best left to the determination of the finder of fact." *Boyd v. United Farm Mut. Reinsurance Co.*, 596 N.E.2d 1344, 1349 (Ill. App. Ct. 1992). "A court should consider the totality of the circumstances when deciding whether an insurer's conduct is vexatious and unreasonable[.]" *Ill. Founders Ins. Co. v. Williams*, 31 N.E.3d 311, 317 (Ill. App. Ct. 2015) (citation omitted). Where an insurer "did not violate its obligations under the policy, it cannot be held liable for engaging in bad faith or improper practices under § 155." *Olivet Baptist Church v. Church Mut. Ins. Co.*, No. 13C 1625, 2016 WL 772787, at *11 (N.D. Ill. Feb. 29, 2016) (citing *Rhone v. First Am. Title Ins. Co.*, 928 N.E.2d 1185, 1196 (Ill. App. Ct. 2010) ("Where the policy is not triggered, there can be no finding that the insurer acted vexatiously and unreasonably in denying the claim.")).

The Court has concluded above that Plaintiff cannot establish breach, waiver, or estoppel in light of the material disputes of fact lingering in this case. An insurer does not engage in vexatious and unreasonable conduct in denying policy benefits that it is entitled to deny, and Plaintiff has not yet shown that Defendant was not entitled to deny her benefits. Because Plaintiff cannot show, at this stage in the proceedings, that Defendant had an obligation to pay the policy benefits, she is not entitled to judgment on her vexatious and unreasonable conduct claim. *Rhone*, 928 N.E.2d at 1196.

CONCLUSION

For the foregoing reasons, Plaintiff's motion for judgment on the pleadings (R. 18) must be DENIED.

This Court sadly concludes that Plaintiff has prematurely filed for a judgment on the pleadings when there are serious factual disputes that need to be resolved through the discovery process. While Defendant has not been obliged to submit additional documents until this time, the Court hopes that all parties will henceforth work toward efficient resolution, and not delay, of this case. It may be that summary judgment may be obtainable following discovery, but this Court cannot presently enter judgment in this case for the reasons indicated herein.

The parties shall appear for a status hearing on April 13, 2016, at 9:45 a.m., and shall be prepared to set a firm litigation schedule for this lawsuit, including setting discovery dates. The parties are DIRECTED to reevaluate their settlement positions in light of this opinion and to exhaust all settlement possibilities prior to the status hearing.

ENTERED: **/s/ Rubén Castillo**
Chief Judge Rubén Castillo
United States District Court

Dated: March 15, 2016