

No. 26-

IN THE
Supreme Court of the United States

DENISE J. CHILD,

Petitioner,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

STEVEN M. DUNN
Counsel of Record
STEVEN M. DUNN, P.A.
11900 Biscayne Boulevard,
Suite 600
Miami, FL 33181
(305) 868-1400
sdunn@smdunnlaw.com

BRUCE H. STOLTZE
STOLTZE & STOLTZE, PLC
300 Walnut Street,
Suite 260
Des Moines, IA 50309
(515) 244-1473
bruce.stoltze@stoltzelaw.com

Counsel for Petitioner

QUESTION PRESENTED

Whether, under *Erie R.R. Co. v. Tompkins*, a federal court sitting in diversity may displace Iowa's National Association of Insurance Commissioners (NAIC)-modeled statutory and regulatory prohibition against postclaims underwriting, which exempts guaranteed-issue coverage from health inquiry at issuance and bars an insurer from performing that omitted inquiry at claim time — by applying a judge-made known-loss doctrine to permit a health-condition determination made only at claim time to support a claim denial.

PARTIES TO THE PROCEEDING

Petitioner Denise J. Child was Plaintiff-Appellant in the court below. Respondent Unum Life Insurance Company of America was Defendant-Appellee in the court below.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Supreme Court Rule 29.6, Petitioner Denise J. Child is an individual and has no corporate parent, subsidiary, or affiliate. No publicly held company owns 10% or more of any interest in Petitioner.

Respondent Unum Life Insurance Company of America is a wholly owned subsidiary of Unum Group, which is publicly traded on the New York Stock Exchange under the ticker symbol UNM.

RELATED PROCEEDINGS

The proceedings directly related to this petition are: *Child v. Unum Life Insurance Company of America*, No. 6:22-cv-02071-LTS (N.D. Iowa), reported at 735 F. Supp. 3d 1061 (N.D. Iowa 2024); and *Child v. Unum Life Insurance Company of America*, No. 24-2347 (8th Cir.), reported at 174 F.4th 1101 (8th Cir. 2026).

TABLE OF CONTENTS

Question Presented	i
Parties to the Proceeding	ii
Corporate Disclosure Statement	ii
Related Proceedings	ii
Table of Contents	iii
Table of Authorities	v
Opinions Below	1
Jurisdiction.....	1
Statutory and Regulatory Provisions Involved.....	2
Introduction.....	3
Statement of the Case.....	6
A. Factual Background	6
B. The NAIC Two-Track Regulatory Framework	9
C. Proceedings Below	11
Reasons for Granting the Writ	14
I. The Eighth Circuit Displaced Iowa’s Regulatory Choice in Violation of <i>Erie</i>	14
II. The Question Is National, Not Iowa-Specific.....	21
III. The Decision Produces a Result No Court Has Sanctioned.....	25

IV. At a Minimum, the Eighth Circuit Should Have Certified the Determinative Iowa-Law Question.....	26
Conclusion	29

APPENDIX TABLE OF CONTENTS

Appendix A: Eighth Circuit Panel Opinion, 174 F.4th 1101 (8th Cir. 2026), May 11, 2026.....	App. 1
Appendix B: District Court Memorandum Opinion and Order, 735 F. Supp. 3d 1061 (N.D. Iowa 2024), May 31, 2024.....	App. 13
Appendix C: Order Denying Petition for Rehearing En Banc, June 17, 2026.....	App. 44
Appendix D: Survey of State Adoption of the NAIC LTCI Guaranteed-Issue and Post- Claims Underwriting Framework.....	App. 45

TABLE OF AUTHORITIES

Cases

<i>Arizonans for Official English v. Arizona</i> , 520 U.S. 43 (1997)	27
<i>Child v. Unum Life Ins. Co. of Am.</i> , 174 F.4th 1101 (8th Cir. 2026)	1, 6, 12-14, 17, 19, 21
<i>Clay v. Sun Ins. Off. Ltd.</i> , 363 U.S. 207 (1960)	27
<i>Erie R.R. Co. v. Tompkins</i> , 304 U.S. 64 (1938)	4, 5, 14-16, 21, 26, 28
<i>Lehman Bros. v. Schein</i> , 416 U.S. 386 (1974)	4, 14, 26
<i>McKesson v. Doe</i> , 592 U.S. 1 (2020)	27
<i>Nassen v. National States Ins. Co.</i> , 494 N.W.2d 231 (Iowa 1992)	20
<i>Postell v. American Family Mutual Insurance Co.</i> , 823 N.W.2d 35 (Iowa 2012)	17
<i>Ritrama, Inc. v. HDI-Gerling Am. Ins. Co.</i> , 796 F.3d 962 (8th Cir. 2015)	15, 19
<i>Salve Regina Coll. v. Russell</i> , 499 U.S. 225 (1991)	21, 28
<i>Semtek Int'l Inc. v. Lockheed Martin Corp.</i> , 531 U.S. 497 (2001)	14, 21
<i>St. Joseph's Hosp. & Med. Ctr. v.</i> <i>Reserve Life Ins. Co.</i> , 742 P.2d 808 (Ariz. 1987)	19

<i>United Capitol Ins. Co. v. Hoodco, Inc.</i> , 974 S.W.2d 572 (Mo. Ct. App. 1998)	18
<i>Uslife Credit Life Ins. Co. v. McAfee</i> , 630 P.2d 450 (Wash. Ct. App. 1981).....	18, 20

Statutory and Regulatory Provisions

28 U.S.C. § 1254(1).....	1
28 U.S.C. § 1332	1
Iowa Code § 514G.7(3)(b) (2003).....	2, 10, 11, 12, 16, 17, 26, 28, 29
Iowa Code § 684A.1	26
2008 Iowa Acts ch. 1175 (H.F. 2694)	10, 23
Iowa Admin. Code r. 191-39.6(2)(b).....	2, 10, 11, 17
Iowa Admin. Code r. 191-39.8	2, 3, 12-15, 18, 19, 21, 24, 26, 28

Rules

Sup. Ct. R. 13.3	1
Iowa R. App. P. 6.1101	26

Other Authorities

NAIC, <i>Long-Term Care Insurance Model Act</i> (#640) (2000).....	2
NAIC, <i>Long-Term Care Insurance Model</i> <i>Regulation</i> (#641) (2000).....	2, 9
NAIC, <i>Long-Term Care Insurance Regulation</i> <i>Provisions</i> (Spring 2024).....	11, 22

Dawn E. Helwig, <i>Long-Term-Care Underwriting</i> , Session 55PD, Record of the Society of Actuaries, Vol. 25, No. 2 (June 1999).....	6
Jeremy Pincus, <i>Voluntary Long-Term Care Insurance: Best Practices for Increasing Employee Participation</i> , EBRI Issue Brief No. 221 (Employee Benefit Research Institute, May 2000)	6
43 Am. Jur. 2d Insurance § 730, at 717 (1969)	18
Gary Schuman, <i>Post-Claim Underwriting: A Life & Health Insurer's Right to Investigate or Bad Faith?</i> , 45 Tort Trial & Ins. Prac. L.J. 697 (2010)	9
W. Shernoff et al., <i>Insurance Bad Faith Litigation</i> § 5.22[2] (1984)	19-20

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Eighth Circuit, authored by Judge Stras, dated May 11, 2026, is reported at 174 F.4th 1101 (8th Cir. 2026). A copy is attached as Appendix A. The opinion of the United States District Court for the Northern District of Iowa is reported at 735 F. Supp. 3d 1061 (N.D. Iowa 2024). A copy is attached as Appendix B. The Eighth Circuit denied panel rehearing and rehearing en banc by order dated June 17, 2026. Judge Kelly did not participate. No judge dissented or wrote separately. A copy of the denial order is attached as Appendix C.

JURISDICTION

The Eighth Circuit entered judgment against Petitioner at 174 F.4th 1101 (8th Cir. 2026). Petitioner timely sought panel rehearing and rehearing en banc, which were denied on June 17, 2026. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1). The district court had diversity jurisdiction under 28 U.S.C. § 1332. Under Supreme Court Rule 13.3, the time to file this petition runs from the denial of rehearing — June 17, 2026 — and not from the issuance of the mandate.

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The following Iowa statutes and regulations are relevant to this case. Each is modeled on the National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Act (#640) and Model Regulation (#641):

**Iowa Admin. Code r. 191-39.8(1) (titled
"Prohibition against postclaims
underwriting"):**

"All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant."

Iowa Code § 514G.7(3)(b) (2003):

"A policy or certificate may not exclude coverage for a loss or confinement which is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person."

Iowa Admin. Code r. 191-39.6(2)(b):

"A preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in § 514G.7(3)(b) expires."

INTRODUCTION

Iowa's regulatory scheme, which tracks the National Association of Insurance Commissioners (NAIC) model regulations for long-term care insurance, establishes a prohibition against postclaims underwriting which bars an insurer from performing at claim time a health inquiry omitted at issuance, and which bars any post-claim health inquiry where no health inquiry was conducted at issuance — as part of a two-track framework that governs when and how a long-term care insurer may determine an applicant's health condition. For individually underwritten policies, insurers must ask clear health questions at application consistent with individual underwriting standards. For group guaranteed-issue coverage, the health inquiry requirement is expressly omitted. *See* Iowa Admin. Code r. 191-39.8. An insurer that chooses the group guaranteed-issue track deliberately forgoes individual health inquiry at issuance, prices the group risk actuarially, and accepts all enrollees. The prohibition against postclaims underwriting completes the framework: Having waived health inquiry at issuance, an insurer may not conduct that inquiry after a claim has been made by an insured and deny the claim based on the insured's pre-issuance health status.

Unum chose the guaranteed-issue track. It issued guaranteed-issue group coverage to Denise Child in 2003 without determining her health condition, and collected premiums for eighteen years. Only after she filed a claim in 2021 did Unum perform the health determination it had purposely omitted at

issuance. That determination found that Child had been quadriplegic since 1980 — a condition that existed on the effective date of coverage — and Unum denied her claim on that basis. Yet Unum's corporate representative and expert confirmed that guaranteed-issue coverage is designed to attract and accept enrollees with disabilities and to expect immediate claims from some percentage of the group.

The Eighth Circuit nonetheless held that Iowa law permitted Unum to deny benefits based on that retroactive post-claim health analysis. The court reached that result not by interpreting and applying Iowa's statutory and regulatory text, but by invoking a judge-made known-loss doctrine that no Iowa appellate court has adopted or applied, much less in a group guaranteed-issue case. In doing so, the Eighth Circuit removed guaranteed-issue group coverage from the regulatory track Iowa law and the NAIC standards assign it — treating it instead as though it were individually underwritten coverage subject to a judge-made known-loss doctrine that no Iowa appellate court has adopted and that no reported appellate decision has applied to guaranteed-issue group coverage.

As this Court recognized in *Lehman Bros. v. Schein*, 416 U.S. 386, 391 (1974), the risk that federal judges acting as ‘outsiders’ will displace a State’s own choices is particularly acute in fields that States regulate through detailed statutes rather than open-ended common-law doctrines. Insurance is that type of field. This case therefore presents an *Erie* question of federal judicial methodology, not merely a dispute over Iowa insurance law. The question is whether a

federal court sitting in diversity may displace Iowa's NAIC-modeled prohibition against postclaims underwriting by applying a judge-made known-loss doctrine to permit the health-condition determination Iowa law bars.

The question presented is not limited to Iowa. Every American jurisdiction regulating long-term care insurance has adopted the same NAIC two-track framework, pairing the guaranteed-issue exemption with a prohibition against postclaims underwriting. Appendix D confirms that this pairing is consistently adopted across all surveyed jurisdictions. When a federal court sitting in diversity alters that nationally adopted regulatory architecture by substituting a judge-made doctrine for a state's enacted framework, the resulting inequitable administration of state law violates *Erie* and undermines the uniformity the NAIC model was designed to achieve.

The Eighth Circuit's decision warrants this Court's review.

STATEMENT OF THE CASE

A. Factual Background

There is no dispute that Denise Child has been quadriplegic since a 1980 accident and has since required assistance with bathing, dressing, toileting, transferring, and continence (ADLs), the functional limitations for which the policy provides long-term care benefits. (J.A. 54, 59). Despite her disability, she completed graduate school and worked full time as a speech pathologist for Area Education Agency 267 (AEA) for over three decades. See *Child v. Unum Life Ins. Co. of Am.*, 174 F.4th 1101, 1103 (8th Cir. 2026).

In 2003, AEA offered a Unum group long-term care policy. Active employees could elect up to \$6,000 per month in benefits on a guaranteed-issue basis — without evidence of insurability or individual health inquiry. Child elected \$5,000 per month and Unum confirmed coverage effective December 1, 2003. (J.A. 422, 469). For the next eighteen years, she continued working and paid premiums on a policy Unum issued without determining her health condition — a product the actuarial community recognized is specifically designed to accept people actively at work with disabilities and to expect a sizable number of immediate claims. See Dawn E. Helwig, *Long-Term-Care Underwriting*, Session 55PD, Record of the Society of Actuaries, Vol. 25, No. 2 (June 1999) (J.A. 1017); Jeremy Pincus, *Voluntary Long-Term Care Insurance: Best Practices for Increasing Employee Participation*, EBRI Issue Brief No. 221 (Employee Benefit Research Institute, May 2000) (J.A. 993). The record contains evidence that Child sought and received assurances during enrollment that her

preexisting quadriplegia and ADL limitations would not disqualify her from guaranteed-issue coverage. (J.A. 763-66; J.A. 834-38).

When Child filed a claim in 2021, Unum conducted a systematic postclaim investigation. Before contacting Child, it received attending-physician statements from Dr. Annie Kontos and from Diane Young, ARNP, certifying assistance needed years prior to the effective date of coverage. (J.A. 487). Unum made three attempts to reach Child by telephone and, on January 27, 2022, conducted a structured telephone interview eliciting onset dates for each covered ADL. (J.A. 498). Unum's claim file shows that only after Child filed her claim did it begin to examine whether her ADL losses already existed on the 2003 effective date of coverage. (J.A. 496). Unum itself later described that claim-time examination as a 'thorough review' of the claim. (J.A. 1128). Unum's own claim manual contains a formal protocol — titled *Existing ADL or Cognitive Loss on the EDOC Analysis* — directing claim handlers to gather medical documentation and conduct a three-step health-status determination specifically for cases where 'coverage is offered under a guaranteed issue offer, and the claimant's functional status on the EDOC is not known.' (J.A. 535; J.A. 878-884). After eighteen years of collecting premiums, Unum denied benefits — concluding for the first time that Child's health and functional status on the December 1, 2003 effective date of coverage precluded benefits.

Unum's corporate representative Stephen Turner, a former underwriter, acknowledged that in

a guaranteed-issue scenario, Unum knows there will be people who might be wheelchair-bound but otherwise fully employable — people like Child. (J.A. 900). Turner further acknowledged that under this contract, Unum “would not and could not ask” any person who enrolled under guaranteed issue anything about their medical condition. (J.A. 891-93). Turner acknowledged that offering guaranteed issue was a business decision. (J.A. 903). When shown Unum’s own internal glossary — defining guaranteed issue as “coverage offered to a group without requiring evidence of insurability” — Turner conceded that guaranteed issue means guaranteed coverage. (J.A. 897-98).

Unum’s hired expert Debra Conner testified that Unum prices guaranteed-issue coverage actuarially — using incidence rates, age, and census data — without knowing each enrollee’s individual health condition, and that Unum did not elicit medical history from guaranteed-issue applicants. (J.A. 956-58). Conner confirmed that Unum offered and marketed guaranteed issue specifically to capture a larger percentage of employees, collect more premiums, and spread the risk across a greater pool of participants. (J.A. 951-52). Conner further conceded that offering guaranteed issue was a deliberate business decision, (J.A. 965), and that under guaranteed issue Unum “waived the right to underwrite that individual.” (J.A. 959).

B. The NAIC Two-Track Regulatory Framework

The NAIC Long-Term Care Insurance Model Regulation (#641) establishes the two underwriting tracks that together define when and how a long-term care insurer may determine an applicant's health condition. Section 11(A) of the Model Regulation provides: "All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant." Iowa adopted that language verbatim, and all surveyed jurisdictions have adopted the NAIC guaranteed-issue/postclaims-underwriting framework in substantially similar form. *See* Appendix D. The industry distinction the regulation encodes is well established: "Unlike employer-based group coverage, which is guaranteed to all eligible employees regardless of health, individual insurance policies are not guaranteed and are medically underwritten." Gary Schuman, *Post-Claim Underwriting: A Life & Health Insurer's Right to Investigate or Bad Faith?*, 45 Tort Trial & Ins. Prac. L.J. 697, 697 (2010). The NAIC Model Regulation codifies that distinction into a uniform regulatory framework.

For individually underwritten policies, Section 11(A) requires health questions at application. For guaranteed-issue policies, Section 11(A) expressly omits them. With guaranteed-issue, the insurer deliberately foregoes individual health inquiry, prices the group risk actuarially, and accepts all enrollees without regard to individual health conditions. The

guaranteed-issue exemption is not a gap in the regulation. It is a deliberate structural provision designed to facilitate group guaranteed issue coverage.

The prohibition against postclaims underwriting completes the framework. It prevents an insurer from delaying until claim time the health determination the regulation requires at issuance for individually underwritten policies and deliberately omits for guaranteed-issue policies. Iowa Admin. Code r. 191-39.6(2)(b) reinforces the coverage guarantee: a preexisting condition ‘need not be covered until the waiting period expires’, mandating coverage once the period expires. Iowa Code § 514G.7(3)(b) establishes the six-month waiting period. Iowa enacted that statute without a carve-out for group policies. In 2008, the legislature added an express group exemption, confirming it knows how to create exceptions when it intends to. 2008 Iowa Acts ch. 1175, § 6.

The group carve-out addresses whether the six-month preexisting-condition limitation applies to specified group coverage; it does not authorize postclaims underwriting. Appendix D confirms the distinction: jurisdictions vary in their treatment of group coverage under the six-month limitation, while consistently pairing guaranteed-issue coverage with the prohibition against postclaims underwriting. That the GI/PCU architecture remains constant regardless of whether a jurisdiction has adopted a group carve-out demonstrates that the two provisions are independent — and that no version of the NAIC

framework authorizes the post-claim health determination Unum conducted.

Nearly every American jurisdiction regulating long-term care insurance has adopted the NAIC framework, and the NAIC's Spring 2024 compilation documents widespread adoption of the postclaims underwriting prohibition. NAIC, *Long-Term Care Insurance Regulation Provisions* (Spring 2024). Appendix D demonstrates that every surveyed jurisdiction pairs the guaranteed-issue exemption with the prohibition against postclaims underwriting — reflecting the nationwide regulatory design in which the two provisions operate as complementary and essential components of the same framework. When a State adopts that framework, it is not writing on a blank slate — it is joining a coordinated national regulatory scheme. The question presented is, therefore, not peculiar to Iowa. It concerns whether a federal court sitting in diversity may alter an established regulatory framework by substituting a judge-made doctrine the State has never recognized in its statutes or decisions.

C. Proceedings Below

Iowa Code § 514G.7(3)(b) and its implementing regulation, Iowa Admin. Code r. 191-39.6(2)(b), establish a comprehensive and time-limited framework. The statute permits exclusion of a preexisting-condition loss only if 'the loss or confinement begins within six months following the effective date of coverage' — and only for that six-month period, after which the regulation mandates coverage. Neither provision authorizes a permanent

bar. Child argued below that a loss predating the effective date never begins 'within six months following' it and therefore falls outside the statute's exclusion clause and, read together with the implementing regulation, does not authorize the permanent exclusion the panel recognized. Iowa Admin. Code r. 191-39.8, titled 'Prohibition Against Postclaims Underwriting,' directly answers whether Unum had the right to conduct a post-claim health investigation. The panel answered that question in the affirmative without engaging the regulation's plain text or applying its governing standard — relying instead on a moral-hazard rationale.

The district court granted summary judgment to Unum. The Eighth Circuit affirmed. The panel acknowledged that the policy was 'guaranteed issue, meaning that preexisting conditions were no barrier to coverage.' 174 F.4th at 1103. The panel nonetheless interpreted Iowa Code § 514G.7(3)(a) as providing that '[i]n other words, identifying preexisting conditions requires looking back six months, but coverage is prospective from the "effective date" onward.' 174 F.4th at 1106. The panel quoted Iowa Code § 514G.7(3)(b) as prohibiting insurers from 'exclud[ing] coverage for a loss or confinement which is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person,' 174 F.4th at 1105, yet concluded from that text that Child 'misreads the statute' — that § 514G.7(3)(b) 'does not require [insurers] to cover losses that arise before the effective date of coverage' because doing so 'would create a moral hazard by allowing individuals to buy insurance and receive benefits right away for past

losses,' and would transform long-term care insurance from a product covering 'risk[s] of future events' to one covering 'known losses, contrary to how it is supposed to work.' 174 F.4th at 1105. The panel reached that result without engaging Iowa Admin. Code r. 191-39.8's text or the regulatory framework it establishes and from which it was derived.

The panel dismissed the postclaims underwriting argument in a single sentence: "Nor is there any evidence of post-claim underwriting to 'avoid liability,' like looking through her medical history after the fact. Child provided all the information Unum needed to deny the claim." 174 F.4th at 1105. In so finding, the panel did not properly engage or apply Iowa Admin. Code r. 191-39.8. That conclusion cannot be squared with the record or the plain reading of the applicable regulation and its derivation from the national framework. Unum's own appeals reviewer confirmed that Unum issued coverage without asking a single question about Child's medical condition, collected premiums for eighteen years, and then went back to the effective date of coverage to evaluate her health status at claim time. (J.A. 869-70). The panel applied a standard that allowed it to look past the record evidence and authorize the health-status investigation Iowa's regulatory framework prohibits.

The Eighth Circuit denied panel rehearing and rehearing en banc by order dated June 17, 2026. Judge Kelly did not participate. No judge dissented or wrote separately.

REASONS FOR GRANTING THE WRIT

I. The Eighth Circuit Displaced Iowa's Regulatory Choice in Violation of *Erie*.

Erie R.R. Co. v. Tompkins, 304 U.S. 64, 78 (1938), requires federal courts sitting in diversity to apply state law. That command is violated when a federal court substitutes a generalized common-law doctrine the State's courts have never adopted for the regulatory choices the State has enacted. *See Semtek Int'l Inc. v. Lockheed Martin Corp.*, 531 U.S. 497, 508–09 (2001); *Lehman Bros. v. Schein*, 416 U.S. 386, 390–91 (1974). This is the core concern that animated *Erie* itself: federal courts may not rely on generalized common-law principles to “control a conflicting law of a state” or to brush aside “the law of a state in conflict with their views.” 304 U.S. at 78–79 (quoting *Field, J.*).

The panel's conclusion that covering known losses is contrary to ‘how [long-term care insurance] is supposed to work,’ 174 F.4th at 1105, illustrates the *Erie* error precisely. That conclusion does not derive from Iowa's statutory text, Iowa's regulatory framework, or any Iowa court decision. It derives from the panel's own view of how insurance products should operate — which is what Justice Field condemned as ‘often little less than what the judge advancing the doctrine thinks at the time should be the general law on a particular subject.’ 304 U.S. at 78–79 (quoting *Field, J.*). In this case, the Iowa Legislature has spoken: Iowa Admin. Code r. 191-39.8 prohibits using the claims process to perform the health determination the insurer omitted at issuance.

Erie required the panel to apply that law. It applied the known-loss doctrine instead.

The deeper problem is structural. By making the known-loss doctrine available as an independent basis for denying guaranteed-issue claims, the panel did not merely misapply Iowa Admin. Code r. 191-39.8 — it bypassed the regulation entirely. An insurer invoking the known-loss doctrine need not justify its claim-time investigation under Iowa’s postclaims underwriting prohibition. The doctrine supplies an independent basis for denial that operates outside the regulation’s scope: because insurance is not “supposed” to cover “known losses”, the insurer may investigate, identify a pre-existing loss, and deny the claim — without ever engaging the question of whether that investigation was conducted at the right time and circumstance under Iowa law. Iowa Admin. Code r. 191-39.8 is not misapplied. It is rendered irrelevant. That is the *Erie* violation in its most fundamental form: a judge-made doctrine displacing an enacted state regulatory prohibition not by interpreting it differently, but by making it unnecessary to consult, apply, and enforce.

Instead of engaging Iowa's enacted regulatory framework, the panel relied on *Ritrama, Inc. v. HDI-Gerling Am. Ins. Co.*, 796 F.3d 962, 968 (8th Cir. 2015), a case involving an individual insured under a general liability policy in which the court cited the general principle “that insurance policies are meant to cover risks of future events — not known losses” — a premise that applies only to individual underwriting and has no application to guaranteed-issue group insurance designed to accept enrollees

regardless of their health condition. But no Iowa appellate court has adopted or applied the judge-made known-loss doctrine — a doctrine Chapter 514G and the NAIC model provisions it implements do not contain — and no reported decision of any court has applied it to guaranteed-issue group coverage. The Eighth Circuit applied a doctrine premised on individual health inquiry and concealment — neither of which exists in the guaranteed-issue context — to produce three specific *Erie* errors.

The panel's moral hazard rationale that permitting recovery would 'allow individuals to buy insurance and receive benefits right away for past losses' — is directly refuted by the record and by Iowa's regulatory framework. An insurer that knowingly accepts wheelchair-bound enrollees, prices the group risk actuarially, and collects eighteen years of premiums cannot claim through the known-loss doctrine that it was deceived into covering an unknown risk. And Iowa Admin. Code r. 191-39.8 confirms that the regulatory framework was specifically designed to accept that risk — which is precisely why it prohibits the post-claim determination Unum conducted. (J.A. 897-903; J.A. 956-58).

That reasoning produces three specific *Erie* errors.

First, the panel's statutory reading conflicts with Iowa's text and regulatory framework. Iowa requires courts to 'determine legislative intent from the words chosen by the legislature, not what it should or might have said,' and prohibits any

interpreting body from, 'under the guise of construction, extend[ing], enlarg[ing], or otherwise chang[ing] the meaning of a statute.' *Postell v. American Family Mutual Insurance Co.*, 823 N.W.2d 35, 49 (Iowa 2012). Iowa Code § 514G.7(3)(b), which the panel itself quoted, 174 F.4th at 1105, permits exclusion of a preexisting-condition loss only if it begins within six months following the effective date, and only for that period, after which Iowa Admin. Code r. 191-39.6(2)(b) mandates coverage. A loss predating the effective date entirely never begins 'within six months following' it and falls outside the exclusion clause altogether. The panel's purely prospective reading converts that time-limited framework into a permanent bar the legislature did not enact. The panel failed to consider and apply this Iowa authority.

The panel's reading also produces a result the statute and regulations foreclose: a guaranteed-issue enrollee whose preexisting condition causes a loss within six months after coverage issues is fully protected after the waiting period; a guaranteed-issue enrollee whose condition was significant enough at issuance that the loss had already manifested receives no protection at all and is permanently barred from coverage, while the insurer retains the premiums paid for that coverage.

Second, the panel applied the judge-made known-loss doctrine to guaranteed-issue group coverage, a context in which no reported court has applied it and that the doctrine's own rationale forecloses. The doctrine presupposes individual underwriting, health inquiry at application, and the

possibility of concealment by the insured. Iowa Admin. Code r. 191-39.8 deliberately eliminates that process for guaranteed-issue coverage. In the individual-underwriting context, the doctrine operates coherently because an insurer that investigates health at application could reject coverage for an existing loss if disclosed; concealment creates the inequity the doctrine prevents. In the guaranteed-issue context, that premise disappears. The insurer deliberately asks no health questions, prices the group risk actuarially, knowingly accepts claim-eligible enrollees, and issues coverage without regard to individual health status. There is no concealment, no deception, and no underwriting decision that the insured prevented the insurer from making. When an insurer asks no information about a matter, 'it is a fair assumption that it regards the matter as immaterial.' *Uslife Credit Life Ins. Co. v. McAfee*, 630 P.2d 450, 453 (Wash. Ct. App. 1981) (quoting 43 Am. Jur. 2d Insurance § 730, at 717 (1969)). Consistent with that principle, courts describe the known-loss doctrine as preventing fraud by an individual insured who conceals an existing or imminent loss from an insurer making an underwriting decision. *United Capitol Ins. Co. v. Hoodco, Inc.*, 974 S.W.2d 572, 575 (Mo. Ct. App. 1998). Guaranteed-issue coverage is an actuarially priced product designed to accept all group enrollees regardless of health condition. Immediate claims from a percentage of enrollees are expected, priced into the premium, and are not an abuse of the insurance relationship. The panel cited no decision applying the known-loss doctrine to guaranteed-issue coverage, and Petitioner has identified none. Instead, it relied

on *Ritrama*, 796 F.3d at 968, involving individually underwritten liability insurance, for the general proposition that insurance covers only future unknown risks — a premise that fits individual underwriting but not guaranteed-issue group insurance deliberately designed to accept enrollees regardless of their health condition.

Third, the panel dismissed Iowa Admin. Code r. 191-39.8 (titled “Prohibition Against Postclaims Underwriting”) in a single sentence without engaging its text, its title, or the established definition of the prohibited practice and its derivation from uniform National model statutory language. The panel asked whether there was evidence of “looking through medical history after the fact.” 174 F.4th at 1105. That is not the regulatory standard. The regulation prohibits using the claims process to perform the omitted underwriting determination. Under Iowa’s prohibition, the applicant’s health condition must either be ascertained at issuance or, in the case of guaranteed-issue coverage, deliberately not ascertained at all. The insurer may not defer that underwriting determination until after a claim is filed. Having applied the wrong legal standard, the panel found no evidence of the standard it did not apply.

Postclaims underwriting has been defined as “the practice of conducting no investigation until a claim is submitted, then scrutinizing prior medical history to avoid liability.” *St. Joseph’s Hosp. & Med. Ctr. v. Reserve Life Ins. Co.*, 742 P.2d 808, 815 & n.3 (Ariz.1987) (quoting W. Shernoff, S. Gage & H. Levine, *Insurance Bad Faith Litigation* § 5.22[2]

(1984)). The Iowa Supreme Court recognized this prohibited practice more than three decades ago, affirming punitive damages against an insurer that used claim-time investigation to rescind nursing home policies after claims were made. *Nassen v. National States Ins. Co.*, 494 N.W.2d 231, 234-35 (Iowa 1992). To use the claims process to conduct the omitted underwriting determination is precisely what courts have identified as this prohibited practice — “the 20-20 vision of hindsight to seek out prior health problems in order to try and defeat the claim.” *Uslife Credit Life Ins. Co. v. McAfee*, 630 P.2d 450, 455 (Wash. Ct. App. 1981). Applying the panel's standard rather than Iowa's would compound that error: it would be “to build a trap for all purchasers of life and health insurance” and “precedent allowing any life or health insurer so inclined, whenever a claim is presented, to use the 20-20 vision of hindsight to seek out prior health problems in order to try and defeat the claim.” *Id.*

Unum's claim file documents that practice: physician certifications obtained before contacting Child, three telephone attempts, a structured ADL interview eliciting onset dates, and a 'thorough review' that produced the denial — all consistent with Unum's claim manual protocol titled *Existing ADL or Cognitive Loss on the EDOC Analysis* — directing claim handlers to gather medical documentation and conduct a three-step health-status determination specifically for cases where ‘coverage is offered under a guaranteed issue offer, and the claimant's functional status on the EDOC is not known.’ (J.A. 535; J.A. 878-884). Yet the panel held, “Child provided all the information Unum needed to deny

the claim.” 174 F.4th at 1105. Exactly — information Unum obtained only after deliberately choosing not to obtain it at issuance. The panel’s failure to engage Iowa Admin. Code r. 191-39.8 is not a factual error. It is an *Erie* error: a federal court deciding a question of Iowa regulatory law without engaging the regulation that answers it.

This error produces precisely that result: allowing the substantive rule governing an Iowa insured’s claim to turn on whether the dispute was heard in federal court presents the forum-shopping and inequitable-administration concerns *Erie* was designed to prevent. See *Semtek Int’l Inc. v. Lockheed Martin Corp.*, 531 U.S. 497, 508-09 (2001). Such displacement creates the ‘dual system of enforcement of state-created rights’ this Court warned against. Cf. *Salve Regina Coll. v. Russell*, 499 U.S. 225, 234 (1991) — a system in which the substantive rule applied to a guaranteed-issue long-term care claim depends on whether the insured happens to be in federal or state court.

II. The Question Is National, Not Iowa-Specific.

The question presented arises under a regulatory framework adopted nationwide — and the Eighth Circuit’s decision threatens the actuarial foundation of that framework in every jurisdiction that has adopted it. Guaranteed-issue long-term care coverage is an established insurance product built on a specific actuarial architecture: the insurer knowingly accepts that a percentage of enrollees will be claim eligible on day one and prices the policy

accordingly. (J.A. 765). The actuarial community confirmed this in 1999, at an industry conference on long-term care insurance underwriting hosted by the Society of Actuaries: “With true guaranteed issue, your goal is to accept anybody, even if they’re actively at work with a disability... you’re going to get a sizable number of immediate claims with guaranteed issue.” (J.A. 1017). The Employee Benefit Research Institute confirmed in 2000 that guaranteed issue “has a direct effect on participation in terms of encouraging enrollment among those who have (or perceive that they have) health conditions that might disqualify them for coverage through an individually purchased policy.” (J.A. 993). The NAIC Model Regulation codifies this actuarial reality in its two-track framework. Every surveyed jurisdiction regulating long-term care insurance has adopted the NAIC postclaims underwriting prohibition — a point the NAIC’s Spring 2024 compilation confirms. *NAIC, Long-Term Care Insurance Regulation Provisions* (Spring 2024). Appendix D demonstrates that every surveyed jurisdiction pairs the guaranteed-issue exemption with the prohibition against postclaims underwriting — reflecting the nationwide regulatory design in which the two provisions operate as complementary and essential components of the same framework. If a federal court may invoke the known-loss doctrine to deny expected claims that are actuarially priced into guaranteed-issue group coverage, the doctrine does not prevent fraud — it eliminates the coverage the regulatory framework was built to provide, in every state that has adopted the NAIC statutory model. That is the national importance of the question presented.

The six-month preexisting-condition limitation reinforces the national scope. All 52 surveyed jurisdictions — the 50 States, the District of Columbia, and Puerto Rico — have enacted materially similar six-month preexisting-condition limitations. *See* Appendix D. The jurisdictions vary as to whether group coverage is expressly exempted from that limitation; Iowa's governing 2003 statute contained no such carve-out. Iowa did not add a group carve-out until 2008, confirming the legislature knew how to create one when it wished. 2008 Iowa Acts ch. 1175, § 6.

When a federal court applies this doctrine to a product specifically designed to operate without individual health inquiry, the court does not merely misapply it — it collapses the regulatory distinction between the two tracks that every surveyed jurisdiction has adopted, rendering the guaranteed-issue exemption meaningless in federal court.

The perverse practical consequence is confirmed by Unum's own claims manual. For individually underwritten enrollees approved above the guaranteed-issue threshold, Unum evaluated health status at issuance and waived the preexisting-condition exclusion upon approval — locking coverage in from day one. (J.A. 442). For guaranteed-issue enrollees, the same manual directs a formal three-step health-status determination at claim time, expressly acknowledging that 'the claimant's functional status on the EDOC is not known' — not because the claimant concealed it, but because Unum deliberately chose not to ask. (J.A. 878-884). Guaranteed-issue enrollees who pay the same

premiums therefore have no certainty of coverage during the entire period they pay them; they learn only at claim time whether coverage ever existed. By permitting the known-loss doctrine to supply the legal basis for that claim-time determination, the Eighth Circuit converted a fraud-prevention principle into a mechanism that enables the precise practice Iowa Admin. Code r. 191-39.8 was enacted to prohibit. That is the inversion of the two-track regulatory framework Iowa and every surveyed jurisdiction enacted.

The practical consequences of the decision below extend beyond the Eighth Circuit. As the only federal appellate decision addressing the known-loss doctrine in the guaranteed-issue long-term care insurance context, the opinion will be cited as persuasive authority in federal courts across the country and in state court litigation under the same NAIC-model framework. The decision permits every guaranteed-issue long-term care insurer to sell coverage without individual health inquiry, collect premiums for years or decades, and then — when a claim is filed — conduct the health-status investigation deliberately omitted at issuance and permanently deny benefits on that basis. That is the claim-time underwriting practice the NAIC regulatory framework was designed to prohibit.

The decision below does not merely resolve one Iowa insured's claim under Iowa law; it establishes federal court methodology for displacing a uniform national regulatory framework that every surveyed jurisdiction has adopted. Because the NAIC models are designed to promote uniformity, divergent federal

interpretations undermine the uniformity those models were intended to achieve. That is the national importance of the question presented.

III. The Decision Below Produces a Result No Court Has Sanctioned.

The panel cited no decision applying the judge-made known-loss doctrine to a guaranteed-issue group policy, and Petitioner has identified none. A doctrine no Iowa appellate court has adopted or applied — and that no reported decision has applied to guaranteed-issue group coverage — cannot displace the State's enacted regulatory framework. No fraud-prevention doctrine should sanction this result: the insurer retains eighteen years of premiums, while the insured—a quadriplegic woman who sought assurances she was covered and was told she was—receives nothing. Petitioner has identified no reported decision permitting an insurer to invoke the known-loss doctrine in this guaranteed-issue setting after deliberately foregoing health inquiry and collecting premiums for years.

There is no basis for a federal court to predict that the Iowa Supreme Court would adopt, contrary to its own statutory and regulatory framework, the judge-made known-loss doctrine for the first time in a form that permits an insurer to perform at claim time the health determination it chose not to make at issuance, strips coverage from the population Iowa's guaranteed-issue framework was designed to protect, and creates a windfall for an insurer that deliberately chose the guaranteed-issue track.

IV. At a Minimum, the Eighth Circuit Should Have Certified the Determinative Iowa-Law Question.

If the Court is not prepared to resolve the *Erie* question at this stage, it should grant, vacate, and remand for the Eighth Circuit to certify the determinative Iowa-law question to the Iowa Supreme Court. Petitioner requested certification in the alternative in her petition for rehearing en banc. The Eighth Circuit denied rehearing without addressing that request.

Iowa Code § 684A.1 authorizes the Iowa Supreme Court to answer questions of law certified by a federal court of appeals when those questions may be determinative of the cause and there is no controlling Iowa precedent. Iowa R. App. P. 6.1101. Two independent grounds support certification.

First, no Iowa court has held that Iowa's statutory and regulatory framework allows a guaranteed-issue insurer to conduct at claim time the health inquiry it omitted at issuance and then use the resulting determination to deny benefits. Nor has any Iowa court construed § 514G.7(3)(b) in the guaranteed-issue context, construed Iowa Admin. Code r. 191-39.8 at all, or adopted the known-loss doctrine the panel invoked to permit that result. Certification is particularly appropriate in view of "the novelty of the question and the great unsettlement" of Iowa law. *Lehman Bros.*, 416 U.S. at 391. Both conditions are present in their strongest form: the panel permitted a claim-time health determination that no Iowa court has authorized,

under a common-law doctrine no Iowa court has adopted, notwithstanding an enacted regulatory framework that expressly governs health inquiry in guaranteed-issue coverage.

This Court has vacated and remanded for certification in analogous circumstances. In *McKesson v. Doe*, 592 U.S. 1 (2020) (per curiam), the Fifth Circuit adopted a novel theory of state tort liability that the State’s highest court had never addressed. This Court held that the court of appeals “should not have ventured into so uncertain an area of tort law ... without first seeking guidance on potentially controlling Louisiana law from the Louisiana Supreme Court.” *Id.* at 5. The Fifth Circuit certified on remand. The Eighth Circuit ventured no less far here, resolving unsettled questions of Iowa insurance law and invoking a common-law doctrine Iowa’s courts have never adopted to permit a claim-time health determination no Iowa court has authorized. *See also Clay v. Sun Ins. Off. Ltd.*, 363 U.S. 207, 212 (1960) (vacating and remanding for certification where court of appeals could not “make a confident guess how the [state] Supreme Court would construe the statute”—an insurance case); *Arizonans for Official English v. Arizona*, 520 U.S. 43, 79 (1997) (“[s]peculation by a federal court about the meaning of a state statute in the absence of prior state court adjudication is particularly gratuitous when ... the state courts stand willing to address questions of state law on certification”).

Second, the Iowa Supreme Court’s resolution will carry persuasive weight in every jurisdiction that has adopted the same NAIC-model two-track

framework. Because those models are designed to promote uniformity, an authoritative state-court interpretation of the guaranteed-issue exemption and postclaims-underwriting prohibition will serve the national interest in uniform treatment of the framework—not just Iowa’s interest in controlling its own law.

Nor can the decision below be defended on the ground that the Eighth Circuit sits over Iowa and is therefore steeped in Iowa law. This Court rejected the analogous reasoning in *Salve Regina*, holding that the argument that federal judges are better arbiters of unsettled state law because of their exposure to the courts of the State in which they sit rests on “overbroad generalizations” and is foreclosed by *Erie*. See 499 U.S. at 238. If familiarity confers no special competence, genuine unsettlement calls for certification, not prediction. Certification supplies what prediction cannot: an authoritative answer from the only court empowered to give one.

The controlling questions for certification are:

(1) Whether Iowa Code § 514G.7(3)(b) (2003) and Iowa Admin. Code r. 191-39.8 bar a guaranteed-issue group long-term care insurer that issued coverage without ascertaining the enrollee's health condition at issuance from performing that omitted health-condition determination after a claim is filed and denying benefits on that basis; and

(2) Whether, under Iowa law, the common-law known-loss doctrine may be applied to permanently deny benefits under a guaranteed-issue group long-

term care policy governed by Iowa Code chapter 514G and Iowa Admin. Code chapter 191-39.

CONCLUSION

The decision below permits a federal court sitting in diversity to alter not merely Iowa insurance law, but a uniform national regulatory framework that Iowa and every surveyed jurisdiction have enacted. The petition for a writ of certiorari should be granted.

In the alternative, Petitioner respectfully requests that the Court grant, vacate, and remand to the Eighth Circuit with instructions to certify the controlling question of Iowa law to the Iowa Supreme Court.

Respectfully submitted,

STEVEN M. DUNN

Counsel of Record

STEVEN M. DUNN, P.A.

11900 Biscayne Boulevard,
Suite 600

Miami, FL 33181

(305) 868-1400

sdunn@smdunnlaw.com

BRUCE H. STOLTZE

STOLTZE & STOLTZE, PLC

300 Walnut Street,

Suite 260

Des Moines, IA 50309

(515) 244-1473

bruce.stoltze@stoltzelaw.com

Counsel for Petitioner

APPENDIX

APPENDIX TABLE OF CONTENTS

Appendix A: Eighth Circuit Panel Opinion, 174 F.4th 1101 (8th Cir. 2026), May 11, 2026	App. 1
Appendix B: District Court Memorandum Opinion and Order, 735 F. Supp. 3d 1061 (N.D. Iowa 2024), May 31, 2024	App. 13
Appendix C: Order Denying Petition for Panel Rehearing and Rehearing En Banc, June 17, 2026	App. 44
Appendix D: State Statutory and Regulatory Provisions based on the NAIC LTCI Model Act and Regulations	App. 45

App. 1

APPENDIX A

United States Court of Appeals
For the Eighth Circuit

No. 24-2347

Denise J. Child
Plaintiff - Appellant

v.

Unum Life Insurance Company of America
Defendant - Appellee

Appeal from United States District Court
for the Northern District of Iowa - Eastern

Submitted: November 18, 2025
Filed: May 11, 2026

Before BENTON, GRASZ, and STRAS, Circuit
Judges.

STRAS, Circuit Judge.

Does a long-term-care insurance policy in Iowa cover
losses that occurred before it went into effect?
Although Denise Child thinks so, the district court¹
disagreed. So do we.

¹ The Honorable Leonard T. Strand, United States District Judge
for the Northern District of Iowa.

App. 2

I.

Over 40 years ago, Child lost the use of her arms and legs after a car accident. She has needed substantial help with basic activities like bathing, dressing, and eating ever since. Despite her limitations, she worked as a speech therapist at an Iowa education agency for over three decades.

Midway through her time there, the agency began offering group long-term-care insurance. The policy, issued by Unum Life Insurance Company of America, covered nursing-home, assisted-living, and home-care expenses. *See Collins v. Metro. Life Ins. Co.*, 117 F.4th 1010, 1015–16 (8th Cir. 2024) (describing long-term-care insurance). It was “guaranteed issue,” meaning that preexisting conditions were no barrier to coverage. *See, e.g., Crowne Invs., Inc. v. Bryant*, 638 So. 2d 873, 875 (Ala. 1994) (explaining that a “guaranteed[-]issue” policy is one offered “regardless of health history”).

Before enrolling, Child had questions about how the policy worked. She consulted specialists within her own agency, who told her that Unum *would* issue the insurance if she chose monthly benefits at or below the \$6,000 mark. If she opted for more, however, she would need to answer questions about her medical history. She went with the guaranteed-issue option.

But one provision, what the parties call the “existing-loss provision,” still worried her. It carved out “loss[es] of [an ability to perform a daily living activity]” that already existed on the “effective date of coverage.” Among the activities listed were “bathing,” “dressing,” “toileting,” “transferring,” “continence,” and “eating,” none of which she could do without help. Although

App. 3

Unum denies she ever called about the carveout, it is undisputed that, if she did, the full extent of her condition never came up. Based on the limited information she shared, the representative reportedly told her that the provision would not affect her right to future benefits.

With her questions answered, she enrolled by completing a benefit-election form.

When she saw the existing-loss provision in her Certificate of Insurance, she again became concerned. She contacted one of the specialists from before, who assured her that preexisting conditions would not stand in the way of benefits. She also allegedly called Unum, which gave her the same advice. But like the first time, her inability to perform the listed daily activities did not come up. Based on these conversations, she decided to keep paying the premiums.

She did so for nearly 20 years, until continuing to work became too difficult. At that point, she gave notice that she was resigning and filed “a Long Term Care claim” raising her “bathing, dressing, toileting, transferring, continence, eating (cutting food), and . . . mobility” needs. The problem for her, at least in Unum’s eyes, was that those limitations had existed on the day she enrolled, which brought the existing-loss provision into play. On that basis, Unum denied the claim.

Upset about the denial and convinced that Unum had misled her decades before, she sued for breach of contract, fraudulent misrepresentation, and bad faith in state court. After removing the case to federal court, the insurer moved for summary judgment. Over

App. 4

a cross-motion from Child, the district court sided with Unum and dismissed the case.

II.

We review the grant of summary judgment de novo. *See Cincinnati Ins. Co. v. Rymer Cos.*, 170 F.4th 1159, 1162 (8th Cir. 2026). It is proper when there is “no genuine issue of material fact” and “the evidence, viewed in a light most favorable to the nonmoving party, shows . . . the [party seeking it] is entitled to judgment as a matter of law.” *Id.* (alteration in original) (citation omitted).

Like most insurance disputes, summary judgment here depends on the terms of the policy. Everyone agrees that Iowa law applies, so “the intent of the parties at the time the policy was sold . . . control[s].” *Just v. Farmers Auto. Ins. Ass’n*, 877 N.W.2d 467, 471 (Iowa 2016) (citation omitted). Intent depends on “what the policy itself says.” *Id.* (citation omitted); *see Boelman v. Grinnell Mut. Reinsurance Co.*, 826 N.W.2d 494, 501 (Iowa 2013) (“The plain meaning of the insurance contract generally prevails.”). A breach occurred if Unum unjustifiably broke its promise to pay benefits. *See Molo Oil Co. v. River City Ford Truck Sales, Inc.*, 578 N.W.2d 222, 224 (Iowa 1998).

A.

Under the “plain terms” of the policy, Unum held up its end of the bargain. *Smithway Motor Xpress, Inc. v. Liberty Mut. Ins. Co.*, 484 N.W.2d 192, 195 (Iowa 1992). As the benefit-information page made clear, the timing of losses mattered.

“[E]xisting loss[es],” defined as those present on the “effective date of coverage,” were “only . . . eligible for coverage” if she “recover[ed] from” them. The benefit-election form echoed the timing requirement in even clearer terms. It said that the “loss of Activities of Daily Living . . . *must* occur after your effective date of coverage under this Long Term Care plan in order to be covered.” (Emphasis added); *see Christensen v. Qwest Pension Plan*, 462 F.3d 913, 916–17 (8th Cir.2006) (considering a warning in a benefit-election form when evaluating a breach- of-fiduciary-duty claim against plan administrators).

No one disputes that Child’s “effective date of coverage” was December 1, 2003. The disagreement is about its significance. Although Child believes her loss of function, which had occurred over two decades before, was just a preexisting condition, the policy took a different view. It made clear that she needed to “recover” from “existing loss[es]” before she could get benefits for them. She did not provide “acceptable proof” that she had, so while any new losses of daily activities from her preexisting condition would presumably have been covered, the policy’s plain terms made clear that existing losses on the “effective date of coverage” would not be.

B.

Unless, of course, coverage came from someplace else. One possibility is a statute, which “form[s] a part of the policy . . . as if [it were] actually written in the insurance contract.” *Dave Ostrem Imports, Inc. v. Globe Am. Cas./GRE Ins. Grp.*, 586 N.W.2d 366, 368 (Iowa 1998). When a conflict arises between “a policy

provision” and “a statutory requirement, . . . the statute controls.” *Lee v. Grinnell Mut. Reinsurance Co.*, 646 N.W.2d 403, 406 (Iowa 2002).

Iowa had a law in place when Child enrolled that limited the way long-term- care insurance policies could deal with preexisting conditions. *See Barnett v. Durant Cmty. Sch. Dist.*, 249 N.W.2d 626, 627 (Iowa 1977) (looking to statutes “existing at the time [the] plaintiffs entered their . . . contracts”). It prohibited them from “*exclud[ing] coverage for a loss or confinement which is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person.*” Iowa Code § 514G.7(3)(b) (2003) (emphases added). Child reads this provision as *requiring* Unum to cover her losses because her inability to perform daily activities began before the effective date of coverage, not within the six months “following” it. *Id.*

She misreads the statute. It prevents insurers from denying coverage for losses from preexisting conditions occurring *beyond* a six-month waiting period, exactly like Child’s policy does. It does not require them to cover losses that arise *before* the effective date of coverage.² If it did, it would create a

² Nor did the absence of coverage for pre-effective-date losses need to “appear as a separate paragraph.” Iowa Admin. Code § 191-39.7(4) (2003) (imposing that requirement for “limitations with respect to preexisting conditions”). The lack of coverage was due to the timing of the *loss*, not its relationship to a preexisting *condition*. Compare *Webster’s Third New International Dictionary* 1338 (2002) (defining a “loss” as “a person or thing or an amount that is lost”), with *id.* at 473 (defining a “condition” as “a mode or state of being”).

App. 7

moral hazard by allowing individuals to buy insurance and receive benefits right away for past losses.

Her interpretation would transform long-term-care insurance from a product that protects against the “risk[] of future events” to one covering “known losses,” contrary to how it is supposed to work. *Ritrama, Inc. v. HDI-Gerling Am. Ins. Co.*, 796 F.3d 962, 968 (8th Cir. 2015); see 7 Jordan R. Plitt et al., *Couch on Insurance* § 102:7 (3d ed. 2025 update) (stating that the rule “[i]mplicit in the concept of insurance is that the loss . . . must occur during the policy period for the insured to recover[, which] obviously excludes losses that occur before the policy is issued”). Nothing in the statute requires such a nonsensical result.³ See *In re Det. of Geltz*, 840 N.W.2d 273, 275 (Iowa 2013) (stating that Iowa courts give statutes a “sensible and logical construction” (citation omitted)).

The statutory provision right before, which defines “preexisting condition,” all but confirms our interpretation. See *Christensen v. Iowa Dist. Ct. for Story Cnty.*, 21 N.W.3d 529, 533 (Iowa 2025) (“We read statutes as a whole, . . . in harmony with surrounding

³ The same goes for Iowa Administrative Code § 191-39.6(2) (2003). Although it said that long-term-care policies could not “limit[] or exclude[] coverage by type of illness, treatment, medical condition or accident,” Child’s policy does not do so. *Id.* Any of those events can cause an inability to perform daily tasks but the resulting limitations, which determine coverage, do not fall within the list. And even if they did, the policy does not single out a specific “type of illness, treatment, medical condition or accident,” like one resulting from a car crash or affecting only an insured’s arms or legs. *Id.* (emphasis added).

App. 8

provisions.” (citation omitted)). “Preexisting condition[s]” include “symptoms which would cause an ordinarily prudent person to seek” or “receive[] . . . health care services within six months *preceding* the effective date of coverage.” Iowa Code § 514G.7(3)(a) (2003) (emphasis added); *accord Webster’s Third, supra*, at 1787 (defining “preexist” as “to exist earlier” or “to exist before”).

In other words, identifying preexisting conditions requires looking back six months, but coverage is prospective from the “effective date” onward. Iowa Code § 514G.7(3)(a) (2003).

C.

The reasonable-expectations doctrine also requires a glance backwards, but only to “the underlying negotiations or the inferences arising from the circumstances of when the parties entered the policy.” *Boelman*, 826 N.W.2d at 506; *see Vos v. Farm Bureau Life Ins. Co.*, 667 N.W.2d 36, 50 (Iowa 2003) (explaining that the doctrine is a “narrow” one (emphasis and citation omitted)). As a “prerequisite,” “circumstances attributable to the insurer [must] foster[] coverage expectations or . . . the policy is such that an ordinary layperson would misunderstand its coverage.” *Boelman*, 826 N.W.2d at 506 (citation omitted). According to Child, the calls to Unum and the specialists within her own agency were “circumstances” that led her to reasonably believe that the policy covered her then-existing limitations.

Id.

It is hard to see how any belief on her part could have been reasonable given the “plain terms” of the policy. *Smithway Motor Xpress*, 484 N.W.2d at 195. Child admits she “absolutely” reviewed it, including the provision that expressly carved out coverage for “existing loss[es] of [Activities of Daily Living].” Not to mention that the benefit-election form included an even clearer statement about when those losses had to occur: “*after* [her] effective date of coverage.” (Emphasis added).

Given the “clarity of” these provisions, a “reasonable person could not have understood coverage would exist.” *Farm Bureau Life Ins. Co. v. Chubb Custom Ins. Co.*, 780 N.W.2d 735, 743–44 (Iowa 2010) (declining to apply the “reasonable expectations” doctrine).

Selecting the guaranteed-issue policy, which had lower monthly benefits, should not have changed those expectations. No one would think that eliminating coverage for pre-effective-date *losses* “(1) [was] bizarre or oppressive, (2) eviscerate[d] terms explicitly agreed to, or (3) eliminate[d] the dominant purpose of the transaction.” *Boelman*, 826 N.W.2d at 506 (citation omitted) (listing the situations when the doctrine applies). To the contrary, the background presumption, supported by the disclaimers she saw, is that the policy only covered losses occurring after its effective date, once she began paying premiums. *Cf. id.* at 505 (stating that the reasonable-expectations doctrine “does not expand coverage on a purely equitable basis”); *Nat’l Sur. Corp. v. Westlake Invs., LLC*, 880 N.W.2d 724, 740 (Iowa 2016) (“[W]e will not strain to interpret an insurance policy to impose liability on an insurer”). It is how insurance

works. *See Couch on Insurance* § 102:7; *see also United States v. Simpson*, 538 F.3d 459, 463 (6th Cir. 2008) (“Insurance coverage, by its very nature, is forward-looking . . .”).

Regardless, her alleged communications with Unum do not bear the weight she places on them. Although her memory was “fuzzy,” she never described the full extent of her condition or the limitations she already had. The omission may have been inadvertent, but under a reasonably-prudent-person standard, it does not matter.

See Am. Fam. Ins. Co. v. Corrigan, 697 N.W.2d 108, 118 (Iowa 2005) (explaining that the measuring stick is what a “reasonable person in the insured’s position” would have done). A person cannot reasonably rely on an answer given in the absence of material facts. *See Vos*, 667 N.W.2d at 50 (describing the “reliance interest” on which the reasonable-expectations “doctrine is founded” (emphasis omitted)); *see also Boelman*, 826 N.W.2d at 506 (stating that the reasonable- expectations doctrine applies when the insured “prove[s] circumstances *attributable to the insurer* that fostered coverage expectations” (emphasis added) (citation omitted)).

Nor could she reasonably rely on the answers given by the specialists she consulted. *See Clemens Graf Droste Zu Vischering v. Kading*, 368 N.W.2d 702, 711 (Iowa 1985) (“[A]n actual agency must exist before [the] principal may be held liable.” (citation omitted)). The policy itself disclaimed an agency relationship with anyone acting on behalf of her employer: “For all purposes of this Policy, the [employer] acts on its own behalf or as the employees’ agent. *Under no circumstances will the [employer] be deemed Unum’s*

agent.” (Emphasis added); see *Boelman*, 826 N.W.2d at 506 (explaining that “[o]nly representations made *by the insurer* at the time of policy negotiation and issuance are relevant” (emphasis added)). And even if the specialists had been agents, the policy goes on to say that “[n]o other person, *including an agent*, [could] change [it] or waive any part of it.” (Emphasis added). For multiple reasons, in other words, the reasonable-expectations doctrine does not apply.

III.

A few loose ends remain. One is Child’s fraudulent-misrepresentation claim. See *Smidt v. Porter*, 695 N.W.2d 9, 22 (Iowa 2005) (laying out the elements).

Underlying it is the alleged advice she received from Unum. The problem, however, is the same as before: any inaccuracy was the result of the incomplete information provided by Child, not any intentional deception by Unum. See *id.* (specifying that “intent to deceive” is an element).

Her bad-faith claim ends up in the same place, except the reason is that Unum had a “reasonable basis” for denying coverage under the existing-loss provision.

Bellville v. Farm Bureau Mut. Ins. Co., 702 N.W.2d 468, 473 (Iowa 2005) (holding that having one is a defense to a bad-faith claim). Once it did, the lack of an investigation no longer mattered. See *McIlravy v. N. River Ins. Co.*, 653 N.W.2d 323, 333 (Iowa 2002) (noting that a “flawed investigation” *may* give rise to an inference of bad faith, but not if the insurer “had a reasonable basis for denial”). Nor is there any evidence of post-claim underwriting to “avoid

liability,” like looking through her medical history after the fact. *St. Joseph’s Hosp. & Med. Ctr. v. Reserve Life Ins. Co.*, 742 P.2d 808, 815 n.3 (Ariz. 1987) (citation omitted). Child provided all the information Unum needed to deny the claim.

IV.

We accordingly affirm the judgment of the district court.

APPENDIX B

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

DENISE J. CHILD,

Plaintiff,

No. C22-2071-LTS-MAR

vs.

UNUM LIFE INSURANCE COMPANY OF
AMERICA,

Defendant.

**MEMORANDUM
OPINION AND ORDER**

I. INTRODUCTION

This case is before me on cross-motions for summary judgment. Defendant Unum Life Insurance Company of America (Unum) has filed a motion (Doc. 37) for summary judgment as to all counts, to which plaintiff Denise Child (Child) has filed a resistance (Doc. 46) and Unum has filed a reply (Doc. 49). Child has filed a motion (Doc. 38)¹ for summary judgment on the limited issues of coverage of benefits and wrongful

¹ Child filed her brief in support of her motion at Doc. 42.

post claim underwriting under her breach of contract claim, to which Unum has filed a resistance (Doc. 45) and Child has filed a reply (Doc. 48). Oral argument is not necessary. See Local Rule 7(c).

II. PROCEDURAL HISTORY

On November 4, 2022, Child commenced an action against Unum in the Iowa District Court for Black Hawk County. Doc. 2. On November 29, 2022, Unum removed the case to this court based on diversity jurisdiction under 28 U.S.C. § 1332. See Doc.

1. Child asserts the following claims: breach of contract (Count I), bad faith (Count II), 1 and fraudulent misrepresentation (Count III). Trial is scheduled to begin August 5, 2024.

III. SUMMARY JUDGMENT STANDARDS

Any party may move for summary judgment regarding all or any part of the claims asserted in a case. Fed. R. Civ. P. 56(a). Summary judgment is appropriate when “the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue of 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).

A material fact is one that “might affect the outcome of the suit under the governing law.” *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). Thus,

“the substantive law will identify which facts are material.” *Id.* Facts that are “critical” under the substantive law are material, while facts that are “irrelevant or unnecessary” are not. *Id.*

An issue of material fact is genuine if it has a real basis in the record, *Hartnagel v. Norman*, 953 F.2d 394, 395 (8th Cir. 1992) (citing *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586–87 (1986)), or when “a reasonable jury could return a verdict for the nonmoving party’ on the question.” *Woods v. DaimlerChrysler Corp.*, 409 F.3d 984, 990 (8th Cir. 2005) (quoting *Anderson*, 477 U.S. at 248). Evidence that only provides “some metaphysical doubt as to the material facts,” *Matsushita*, 475 U.S. at 586, or evidence that is “merely colorable” or “not significantly probative,” *Anderson*, 477 U.S. at 249–50, does not make an issue of material fact genuine.

As such, a genuine issue of material fact requires “sufficient evidence supporting the claimed factual dispute” so as to “require a jury or judge to resolve the parties’ differing versions of the truth at trial.” *Anderson*, 477 U.S. at 248–49. The party moving for entry of summary judgment bears “the initial responsibility of informing the court of the basis for its motion and identifying those portions of the record which show a lack of a genuine issue.” *Hartnagel*, 953 F.2d at 395 (citing *Celotex*, 477 U.S. at 323). Once the moving party has met this burden, the nonmoving party must go beyond the pleadings and by depositions, affidavits, or otherwise, designate specific facts showing that there is a genuine issue for trial. *Mosley v. City of Northwoods*, 415 F.3d 908, 910 (8th Cir.

2005). The nonmovant must show an alleged issue of fact is genuine and material as it relates to the substantive law. If a party fails to make a sufficient showing of an essential element of a claim or defense with respect to which that party has the burden of proof, then the opposing party is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 322.

In determining if a genuine issue of material fact is present, I must view the evidence in the light most favorable to the nonmoving party. *Matsushita*, 475 U.S. at 587–88. Further, I must give the nonmoving party the benefit of all reasonable inferences that can be drawn from the facts. *Id.* However, “because we view the facts in the light most favorable to the nonmoving party, we do not weigh the evidence or attempt to determine the credibility of the witnesses.” *KammueLLer v. Loomis, Fargo & Co.*, 383 F.3d 779, 784 (8th Cir. 2004). Instead, “the court’s function is to determine whether a dispute about a material fact is genuine.” *Quick v. Donaldson Co., Inc.*, 90 F.3d 1372, 1376–77 (8th Cir. 1996). On cross motions for summary judgment, the “court must rule on each party’s motion on an individual and separate basis, determining, for each side, whether a judgment may be entered in accordance with the Rule 56 standard.” 10A Charles Alan Wright, Arthur R. Miller & Mary Kay Kane, *Federal Practice and Procedure* § 2720 (3d ed. 1998).

IV. RELEVANT FACTS²

The following facts are undisputed unless otherwise noted. In 1980, Child was involved in a car accident that left her paralyzed with quadriplegia. Doc. 46-1 at 1. As such, she is confined to a wheelchair and requires substantial assistance with activities of daily living (ADLs) such as bathing, dressing, toileting, transferring, continence, eating and ambulating/mobility. *Id.* at 1-2. She has never recovered from her loss of ADLs. *Id.* at 2.

In 2003, Child's employer, Area Education Agency 267 (AEA 267) offered its employees enrollment in a long-term care (LTC) plan (the Policy) through Unum. *Id.* at 2. The Policy was sold under guaranteed issue although the parties dispute what this means. Unum states that according to the terms of LTC coverage secured by AEA 267, if an individual elected to enroll for LTC benefits greater than \$6,000 per month or for an unlimited duration, the individual was required to complete an application, undergo medical underwriting and provide evidence of insurability. *Id.* at 6. However, if an individual elected to enroll for LTC benefits less than or equal to \$6,000 per month, the individual was not required to complete an application or provide evidence of insurability but simply had to elect the level of coverage and duration by completing the Benefit Election Form. *Id.* The

² This section is limited to facts related to Unum's motion for summary judgment.

Benefit Election Form contained a statement immediately above the individual's signature line that required the individual to acknowledge that the individual had read and understood that loss of ADLs or Severe Cognitive Impairment must occur after the effective date of coverage. *Id.* at 8. The Commissioner of Insurance for the State of Iowa approved this policy form (TQGLTC95) on January 29, 1997.³ *Id.* at 11.

Child interprets guaranteed issue as meaning guaranteed coverage. Doc. 49-1 at 4. Unum states that while coverage under the Policy was guaranteed for individuals who enrolled for LTC benefits less than or equal to \$6,000 per month, the individual would still have to meet the requirements of the Policy to obtain benefits. *Id.* at 4-5.

The parties dispute the role that AEA 267 played in explaining the Policy's coverages and exclusions to employees, including Child. Child asserts that Unum designated AEA 267 as plan administrator, plan fiduciary and enrollment agent for the Policy. Doc. 46-1 at 13. Unum notes that the part of the Policy that Child relies on, identifying AEA 267 as the Plan Administrator, is entitled "ERISA – Additional Summary Plan Description Information." Doc. 49-1 at 13. Because the Employee Retirement Income Security Act of 1974 (ERISA) does not apply to the Policy, as AEA 267 is a governmental entity and the plan a governmental plan, see 29 U.S.C. § 1003(b)(1),

³ Child notes there is no evidence that other documents were approved, including the Benefit Election Form and, in any event, argues this "stamp of approval" is meaningless and has no force or effect based on the arguments she is raising. Doc. 46-1 at 11.

Unum contends the ERISA provisions are not applicable. *Id.*

With regard to whether AEA 267 could act as an agent for Unum, Unum acknowledges that AEA 267 explained coverages and exclusions to its employees but disputes that it was an agent. Doc. 46-1 at 3-4. The parties agree that the Policy states:

“For all purposes of this Policy, the Policyholder acts on its own behalf or as the employees’ agent. Under no circumstances will the Policyholder be deemed Unum’s agent.” *Id.* at 13.

Unum states that the role of the plan administrator was to: (1) provide employees with an enrollment kit on or prior to their eligibility date, (2) ensure employees return the completed forms by the due date and (3) review the Benefit Election Form to ensure (a) it was signed and dated, (b) the benefit choices were clearly identified, (c) the employee’s address is correct, (d) the employee’s date of birth was included, (e) the employee’s social security number was included, and (f) the employee’s date of hire was included. Doc. 49-1 at 13. The enrollment kit included an Outline of Coverage, Plan Highlights/Schedule of Benefits, Rate Sheets, and a Benefit Election Form. Doc. 46-1 at 5-6. The Outline of Coverage included the following Existing Loss provision:

If you have an existing loss of ADLs or Severe Cognitive Impairment on your effective date of coverage, that loss or impairment will only be eligible for coverage if you recover from that loss or impairment. We must receive acceptable proof of your ADL or cognitive recovery, such as a Physician’s statement or an assessment.

Id. at 6. Child contends this provision is misplaced because Iowa law requires any condition or limitation to benefit eligibility to be in a separate heading in the Outline of Coverage. Id. at 5-6. This language is not contained within the preexisting condition exclusion or within the “Delay of Coverage” or “Limitation on Benefits” sections of the Policy. Id. at 14. Rather, it is under a section entitled “When You are Eligible for a Monthly Benefit.” Doc. 49-1 at 12.

In 2003, Child enrolled for coverage under the Policy by completing a Benefit Election Form. Child enrolled for LTC benefits at the monthly level of \$5,000 and a facility benefit duration of six years. Doc. 46-1 at 6. As such, she was not required to complete an application, provide evidence of insurability or go through medical underwriting. Id. at 6-7. Child understood that although coverage under the Policy was guaranteed, she would still have to meet the requirements of the Policy to obtain benefits.⁴ Id.

Part of the parties’ disagreement concerning whether Child is entitled to LTC benefits involves her communications with individuals at AEA 267 in

⁴ Child clarifies that she agrees only to the extent there were specifically delineated provisions in the Policy such as Who May Apply, When Coverage Becomes Effective, When Coverage is Delayed and Exclusions and Limitations. Doc. 46-1 at 7. She argues that none of these bar her claim. Additionally, she notes benefit eligibility under the Policy requires a need for assistance with two or more ADLs, an assessment performed by a LHP, a plan of care and a certification of chronic illness. Id. She acknowledges these conditions apply to her as well.

charge of administering the plan. Child noticed the following language in the Benefit Election Form:

By signing below you signify that you have read and understand that loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after your effective date of coverage under this Long Term Care plan in order to be covered and that certain limitations and exclusions apply to your coverage. This information is contained in your kit.

Id. at 8. Child states her employer assured her that her preexisting condition would not be a bar to benefits. Doc. 49-1 at 6-7. Specifically, Unum notes that Child spoke with Ralph Bartelt, Head of the Human Resource Department of AEA 267. Child testified that Bartelt told her: “That’s right, Denise. This is good. This is going to work for you” and “This will be a good thing for you.” Id. at 7. In a declaration, Bartelt does not confirm that he had any direct conversations with Child. Id. Betty Beauregard, an accounting specialist with AEA 267, also encouraged Child to enroll in the policy. Doc.

46-1 at 4. Unum notes that Beauregard does not recall any specifics from these conversations. Doc. 49-1 at 7.

Child asserts that she also contacted Unum through a telephone number on the enrollment form about this issue and received the same assurances that her preexisting condition would not exclude her from benefit coverage because the LTC policy and certificate were being issued as guaranteed issue.⁵⁵

⁵ Unum disputes that Child made any calls to Unum but states that it included Child’s allegations for purposes of its motion for summary judgment, arguing that even if true, they do not create

Doc. 46-1 at 8-10. Child states she made one call prior to enrolling in the Policy and a second call after signing the Benefit Election Form and within the 30-day window to withdraw enrollment under the Certificate of Insurance. *Id.* at 8, 14. Unum notes that Child testified her recollection of one or perhaps two calls was “fuzzy.” *Id.* at 9. Child asserts she recalls the pertinent parts of the first call but does not recall every detail. *Id.* Child testified her recollection of the first call was as follows:

What I told them was that I had a health condition that required – that required daily cares, daily caregivers already, and I said I’m guarantee issue and I’m staying under the amount required for having to go through underwriting, so I don’t have to answer any medical questions, but I already have caregiving needs, and does this statement apply to me since I am guarantee issue? And the answer was: “no, ma’am, it does not.” *Id.* at 10. Child did not recall disclosing her use of a wheelchair in either call. *Id.* at 10, 7 . Child testified she recalls the following conversation about “preexisting conditions” during her second call:

I asked them if those statements – From what – From what I recall, I asked them something about: “Do preexisting conditions or health conditions matter when it comes to benefits in the future?”

And she said that it was guarantee issue “and your benefits will not – or your benefits will not be affected by anything.” And she actually said – she said

a material dispute of fact on any of Child’s causes of action. See Doc. 37-2 at 5, n. 2.

something about, which I didn't – it didn't really matter to me, she said something about: "Once you have had 60 days or two years behind you, none of that would matter anyway." Id. at 16.

Child paid her monthly premiums on the policy and filed a claim for LTC benefits in 2021. In the claim form, Child acknowledged she needed assistance with her ADLs of bathing, dressing, toileting, transferring, continence, eating and ambulating/mobility beginning in 1982.⁶ Id. at 17. In a phone call with a Benefits Specialist assigned to the claim, Child stated she had required hands-on assistance with her ADLs of bathing, dressing, toileting, transferring and continence since 1980 and occasionally needed assistance with eating. Id. at 18. Child confirmed her ADL needs had not changed since 1980. Id.

Unum denied Child's claim based on an "existing loss of ADLs" on her effective date of coverage. Id. at 18-20. It did not contact AEA to determine what representations were made to Child. Doc. 49-1 at 12. Child asserts that the Benefits Specialist told her that her existing loss of ADLs was a preexisting condition and Child asserts that Unum denied Child's claim due to her preexisting physical and medical condition. Id. at 18- 20.

Child appealed and in a letter dated April 1, 2022, Unum stated that Child "confirmed she has needed ADL assistance for bathing, dressing, toileting,

⁶ Child testified that the year on her claim form was incorrect and that she has needed assistance with her ADLs since February 6, 1980. Doc. 46-1 at 17.

transferring, continence, and occasionally eating” since 1980 and also “confirmed she has never had any periods of ADL recovery and has required the same level of assistance since the 1980s.” Id. at 21. The letter quoted the “existing loss of ADLs” provision in the Policy and Benefit Election Form and confirmed that the pre-existing condition exclusion did not apply to the decision on the claim.⁷ Id. It affirmed the denial of her claim.

V. DISCUSSION

A. Unum’s Motion for Summary Judgment

Unum seeks summary judgment on each of Child’s claims: breach of contract (Count I), first party bad faith (Count II) and fraudulent misrepresentation (Count III). I will address each in turn.

1. Count I – Breach of Contract

Unum argues it is entitled to summary judgment on Child’s breach of contract claim because: (1) the Policy

⁷ 7 Child notes the letter (1) failed to address or respond to her assertion that the Existing Loss provision was an improper reliance upon a preexisting condition to deny her claim, (2) failed to properly investigate Child’s claim that at the time of issuance of the LTC policy, Child had been assured by Unum and her employer that guaranteed issuance of coverage meant her preexisting condition before her effective date of coverage would not stop her from obtaining benefits and (3) failed to address or respond to the assertion of wrongful post claim underwriting used to deny benefits to Child. Doc. 46-1 at 21.

clearly and unambiguously states that any existing loss of ADLs prior to the effective date of coverage is not covered under the Policy unless the insured recovers from that loss and (2) Child suffered a loss of her ADLs (the same loss she claims under the Policy) long before her effective date of coverage and never recovered from that loss. Child argues the Policy conflicts with Iowa statutes and the prohibition of post claim underwriting. Specifically, Child cites Iowa Code § 514G.6⁸ and Iowa Admin. Code §§ 191-39.7 and 191-39.32-39.

“Generally, interpretation of an insurance policy is a question of law.” *Just v. Farmers Auto Ins. Ass’n*, 877 N.W.2d 467, 471 (Iowa 2016). To prevail on a breach of contract claim under Iowa law,⁹ a plaintiff must prove:

(1) the existence of a contract; (2) the terms and conditions of the contract; (3) that [plaintiff] has performed all the terms and conditions required under the contract; (4) the defendant's breach of the contract in some particular way; and (5) that plaintiff has suffered damages as a result of the breach.

Molo Oil Co. v. River City Ford Truck Sales, Inc., 578 N.W.2d 222, 224 (Iowa 1998) (citing *Iowa-Illinois Gas & Elec. Co. v. Black & Veatch*, 497 N.W.2d 821, 825

⁸ As Child notes, the statutes she relies on are from the 2003 Iowa Code, which was in effect when the Policy was purchased. These sections have since been repealed.

⁹ Neither party contends that the law of any other state applies in this diversity action.

(Iowa 1993)). A party breaches a contract when, without legal excuse, the party fails to perform any promise that forms a whole or a part of the contract. *Id.* (citing *Magnusson Agency v. Public Entity Nat'l Co. Midwest*, 560 N.W.2d 20, 27 (Iowa 1997)).

Because “insurance policies are contracts between the insurer and insured, [they] must be interpreted like other contracts, the objects being to ascertain the intent of the parties.” *Talen v. Employers Mut. Cas. Co.*, 703 N.W.2d 395, 407 (Iowa 2005). “If the language of the policy is unambiguous, . . . that intent is determined by what the policy itself says.” *Monroe County v. International Ins. Co.*, 609 N.W.2d 522, 525 (Iowa 2000). “An ambiguity exists when, after application of our relevant rules of interpretation, a genuine uncertainty results as to which of two or more meanings is proper.” *Am. Fam. Mut. Ins. Co. v. Petersen*, 679 N.W.2d 571, 576 (Iowa 2004), amended on denial of reh’g (May 6, 2004).

The breach Child alleges is based not on the terms of the Policy itself, but on an allegation that the Policy fails to comply with Iowa statutes in effect at the time, which are inherently part of the Policy.¹⁰ See *Lee v.*

¹⁰ As Unum notes, Child’s petition does not allege that the Policy violated any Iowa statute and the statute she cites does not create a private cause of action. See Doc. 49 at 4, n.5 (citing *Seeman v. Liberty Mut. Ins. Co.*, 322 N.W.2d 35, (Iowa 1982)). Child’s factual allegations concern the way the Policy was presented as guaranteed issue during open enrollment as well as particular language in the Policy itself, all of which Child characterizes as a “trap” that Unum used to induce Child to pay full premiums and then allowed Unum to engage in post claim underwriting to deny benefits. See Doc. 2 at 15-17. Child

Grinnell Mut. Reinsurance Co., 646 N.W.2d 403, 406 (Iowa 2002) (explaining that a statute that authorizes a contract of insurance “forms a basic part of the policy and is treated as if it had actually been written into the policy” (quoting *Tri-State Ins. Co. v. De Gooyer*, 379 N.W.2d 16, 17 (Iowa 1985))). When there is a conflict between a policy provision and a statutory requirement, “the policy provision is ineffective and the statute controls.” *Id.* Specifically, Child argues that Unum’s intent was to use the Existing Loss provision to undermine the intent of the controlling statutes, which she argues is to protect insureds from the exclusion of existing losses where underwriting has been waived and to prohibit post claim underwriting to achieve a claim denial.¹¹ Doc. 46-3 at 9. She cites Iowa Admin. Code § 191-39.7, which states “[i]f a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitation shall appear as a separate paragraph of the policy or certificate and shall be labeled as “Preexisting Condition Limitations.” Additionally, she cites Iowa Code §

acknowledges that her claim is not a “bona fide good faith insurance contract dispute” but that Unum’s conduct in issuing this policy on guaranteed issue and then denying Child’s claim based on an existing loss of ADLs on the effective date of coverage conflicts with Iowa insurance law and policy.

¹¹ Child makes other broad assertions to suggest Unum had a nefarious intent based on its marketing of LTC policies to seniors and the large number of LTC policies it has issued. I find these allegations largely irrelevant to the issue at hand.

514G.7, which provides the following regarding Preexisting Conditions:

a. A long-term care insurance policy or certificate shall not use a definition of preexisting conditions which is more restrictive than the following: “Preexisting condition” means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or a condition for which medical advice or treatment was recommended or received from a provider of health care services within six months preceding the effective date of coverage of an insured person.

b. A long-term care insurance policy shall not exclude coverage for a loss or confinement which is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person.

c. The definition of “preexisting condition” does not prohibit either of the following:

(1) An insurer from using an application form designed to elicit the complete health history of an applicant.

(2) An insurer from underwriting in accordance with that insurer’s established underwriting standards based on the answers on an application conforming with subparagraph (1).

Iowa Code § 514G.7 (2003). Child interprets this statute to mean that when an insurer solicits an application for LTC insurance and does not require or elicit the complete medical history of the applicant, the insurer cannot exclude a loss or confinement that existed on the date of coverage because doing so would

require the insurer to ask medical questions, which it waived via guaranteed issue. *Id.* She asserts that failure to disclose that the Existing Loss provision would apply to guaranteed issue applicants violates the statutory disclosure requirements regarding preexisting conditions.

Unum disagrees that any of the statutes or regulations cited by Child apply here, noting that they require only that a policy “shall not exclude coverage for a loss or confinement which is the result of a preexisting condition unless the loss or confinement [from the pre-existing condition] begins within six months following the effective date of coverage.” Iowa Code § 514G.7(3) (2003) (emphasis added by Unum). It explains that Child’s loss was not the result of a preexisting condition because she did not have symptoms before the effective date of coverage that had not yet resulted in a loss and her loss was not the result of a preexisting condition that began within six months after the effective date of coverage. Therefore, Unum argues this statute does not apply to Child’s situation. Doc. 49 at 4. With regard to the placement of the Existing Loss provision in the Policy and Iowa Admin. Code § 191-39.7, Unum argues that it is not the same as a preexisting condition, which is a separate provision in the Policy and was not the basis on which Unum denied Child’s claim. Doc. 49 at 3.

I agree with Unum that Child is conflating preexisting condition and existing loss.

They are not synonymous. Section 514G.7(3) provides that if a loss occurs as a result of a preexisting condition at least six months after the effective date of coverage, the insurer cannot exclude coverage. The statute says nothing about covering losses that exist

at or before the effective date of coverage. Nor does it require coverage for an existing loss in the absence of medical underwriting.

The fact that Unum issued the Policy without inquiring into Child's medical condition does not prohibit Unum from denying coverage for a loss that existed at the time of the effective date of coverage. This does not amount to post claim underwriting because Unum did not inquire into Child's medical history after Child filed her claim.

Rather, Child disclosed the date of her loss of ADLs in association with her claim, which was long before her effective date of coverage. Unum had disclosed that coverage would not be provided for existing losses by including the disclaimer above the signature line in the Benefit Enrollment Form and in the Policy itself. As Unum notes, the regulations Child cites that prohibit post claim underwriting specifically state: "[a]ll applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant." Iowa Admin. Code 191-39.8(514G) (2003) (emphasis added). Because the Policy was issued under guaranteed issue, Unum was not required to perform medical underwriting and it did not perform post claim underwriting by asking the date of the loss. Unum did not deny Child's claim based on a preexisting condition, but on an existing loss. Thus, the Policy does not conflict with the regulations or statutes Child relies on. As Unum notes, Child's argument is antithetical to the concept of insurance, which is to protect against risks of future losses, not known ones. Child's breach of contract

claim based on Iowa statutes and regulations fails as a matter of law.

Child's other argument is based on the reasonable expectations doctrine. This doctrine "is a recognition that insurance policies are sold on the basis of the coverage they promise." *Boelman v. Grinnell Mut. Reinsurance Co.*, 826 N.W.2d 494, 505 (Iowa 2013) (quoting *Clark-Peterson Co. v. Indep. Ins. Assocs., Ltd.*, 492 N.W.2d 675, 679 (Iowa 1992)). The doctrine requires that an exclusion "(1) is bizarre or oppressive, (2) eviscerates terms explicitly agreed to, or (3) eliminates the dominant purpose of the transaction." *Id.* at 506. "Evidence of reasonable expectations comes from the underlying negotiations or the inferences arising from the circumstances of when the parties entered the policy." *Id.* "Only representations made by the insurer at the time of policy negotiation and issuance are relevant." *Id.* (citing *Vos v. Farm Bureau Life Ins. Co.*, 667 N.W.2d 36, 50 (Iowa 2003)).

Child contends she is entitled to benefits under this doctrine because, despite the Policy language, AEA 267 assured Child that the Existing Loss provision did not apply to her as someone who was enrolling under guaranteed issue. Child asserts that employees of AEA 267 made these assurances as agents of Unum. Under the Restatement (Third) of Agency:

Agency is the fiduciary relationship that arises when one person (a "principal") manifests assent to another person (an "agent") that the agent shall act on the principal's behalf and subject to the principal's control, and the agent manifests assent or otherwise consents to act.

Restatement (Third) of Agency § 101, at 17 (2006). “Whether a party serves as another’s agent is ordinarily a question of fact.” *Vroegh v. Iowa Dept. of Corrections*, 972 N.W.2d 686, 707 (Iowa 2022) (citing *Peak v. Adams*, 799 N.W.2d 535, 546 (Iowa 2011)).

However, there must be substantial evidence to support the existence of an agency.

Walnut Hills Farms, Inc. v. Farmers Co-op Co. of Creston, 244 N.W.2d 778, 780 (Iowa). “A mere scintilla is not enough.” *Id.* (citing *Martin v. Jaekel*, 188 N.W.2d 331, 333-34 (Iowa 1971)).

Under Iowa law, “[t]he party asserting an agency relationship must prove it exists by a preponderance of the evidence.” *Frontier Leasing Corp. v. Links Engineering, LLC*, 781 N.W.2d 772, 776 (Iowa 2010). “Actual authority exi[s]ts if the principal has either expressly or by implication granted the agent the authority to act on the principal’s behalf.” *Soultz Farms, Inc. v. Schafer*, 797 N.W.2d 92, 102 (Iowa 2011) (citing *Grismore v. Consol. Prods. Co.*, 5 N.W.2d 646, 651 (1942)). Actual authority can be express (where there is direct evidence the principal granted authority to the agent) or implied (where circumstantial evidence proves the agent’s authority). *Id.* “Apparent authority is authority the principal has knowingly permitted or held the agent out as possessing.” *Id.* Apparent authority is decided based on the principal’s communications to the third party, meaning it “must be determined by what the principal does, rather than by any acts of the agent.” *Id.* (cleaned up).

Child argues that AEA 267 could make representations on behalf of Unum because Unum

appointed AEA 267 as plan administrator, fiduciary and enrollment agent. Unum argues that none of these roles created an agency relationship. The Policy states: “Area Education Agency 267 is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties.”¹² Doc. 38-2 at 71. Those duties, as described in Unum’s Plan Administrator Guide include: (1) provide employees with an enrollment kit on or prior to their eligibility date, (2) ensure employees return the completed forms by the due date and (3) review the Benefit Election Form to ensure (a) it was signed and dated, (b) the benefit choices were clearly identified, (c) the employee’s address is correct, (d) the employee’s date of birth was included, (e) the employee’s social security number was included, and (f) the employee’s date of hire was included. Doc. 49-1 at 13 (citing Doc. 38-3 at 184). The Policy also states, in two separate places: “For all purposes of this Policy, the Policyholder acts on its own behalf or as the employees’ agent. Under no circumstances, will the Policyholder be deemed to be Unum’s agent.” *Id.* at 35, 69.

The majority view on this issue is that an employer is not the agent of an insurance company that has issued a group policy, but an agent for the employees. See

¹² As Unum notes, this statement is under a section titled “ERISA Additional Summary Plan Description Information.” Doc. 38-2 at 71. Because AEA 267 is a governmental entity, ERISA does not apply. See 29 U.S.C. § 1003(b)(1) (providing the provisions of the subchapter shall not apply to any employee benefit plan if such plan is a governmental plan).

Boseman v. Conn. Gen. Life Ins. Co., 301 U.S. 196, 204-05 (1937) (“When procuring the policy, obtaining applications of employees, taking payroll deduction orders, reporting changes in the insured group, paying premiums and generally in doing whatever may serve to obtain and keep the insurance in force, employers act not as agents of the insurer but for their employees or for themselves.”); *Hayes v. Lincoln Gen. Ins. Co.*, 899 F.2d 684, 686 (7th Cir. 1990) (“According to Indiana law, when an employer acts as a middle man between an insurance company and its employees, the employer is the agent of the employees, not the insurance carrier.”); *Lamb v. Conn. Gen. Life Ins.*, 509 F. Supp. 560, 560 n.2 (D.N.J. 1980) (“The majority rule is that the group policyholder acts for itself and on behalf of the members of the group; it is not the agent of the insurance carrier. New Jersey adheres to the majority rule.”); *Hanaieff v. Equitable Life Assur.*

Soc. of U.S., 92 A.2d 202, 204 (Penn. 1952) (“while it is true that there is a diversity of opinion among the several jurisdictions as to whether, in the case of such group insurance policies, the employer occupies the role of agent of the employees or of the insurer, in our own State, as in the Supreme Court of the United States, this question has been definitely resolved against plaintiff’s contention”); *Pepkowski v. Life of Indiana Ins. Co.*, 535 N.E.2d 1164, 1167 (Ind. 1989) (fact that employer provided application form and benefits booklet, assisted plaintiff in completing the form and mailed it to insurer, was not contacted by any other insurance agent regarding her coverage and insurer accepted application was insufficient to show genuine issue for trial as to whether employer had authority to bind insurer); *Hendrix v. Republic Nat. Life Ins. Co.*, 606 S.W.2d 601, 603 (Ark. Ct. App. 1980)

(“We hold that because Arkansas law contemplates that a group insurance policy is a contract between the employer and the insurer and not a contract between the employee and insurer, the employer is not to be regarded as the agent of the insurer for the purpose of collecting insurance premiums from the employee.”); 1A Couch on Ins. § 8.13, n. 10 (citing cases applying majority rule).

Child cites one Iowa case addressing this issue, which recognizes that the issue is fact dependent and that “no hard and fast rule should be adopted as to whether agency principles always apply.” *Davis v. Ottumwa Young Men’s Christian Ass’n*, 438 N.W.2d 10, 16 (Iowa 1989). The Court stated:

The general rule appears to be that ‘neither an employer nor the employer’s agent is an agent of an insurance company, or clothed with any power to waive any of the conditions of a group policy of insurance covering the employees of such employer.’ 44 Am.Jur.2d Insurance § 1851, at 844 (1982) (footnote omitted). However, ‘it has been stated broadly that an employer as the administrator of an employees’ group insurance policy is the agent of the insurer, to whom any omission of duty by the employer in its administration of the policy should be attributable.’ Id. at 845 (footnote omitted).

Id. at 16. Here, the issue concerns conditions of the Policy and not its administration – such as providing applications, collecting premiums or any of the specific tasks assigned to plan administrator as described in the Plan Administrator Guide for AEA 267. Doc.

38-3 at 187. Child has come forward with no other evidence from which a reasonable jury could conclude AEA 267 was acting as Unum's agent. As such, Child cannot sustain her breach of contract or reasonable expectations claim on a theory that AEA 267 was acting as Unum's agent in making representations to Child regarding the terms and conditions of the Policy.

With regard to any representations by Unum, Child does not appear to rely on any representations made during her calls to Unum. Unum spent two pages of its brief discussing why these calls did not give Child a reasonable expectation that her existing ADL loss would be covered. See Doc. 37-1 at 12-14. In response, Child makes no argument that there is a fact issue as to whether any such calls created a reasonable expectation. Indeed, all she says on the matter is "whether the jury believes Ms. Child called Unum is a red herring because the AEA properly advised the Plaintiff that her preexisting condition would not bar a claim for benefits under the policy." See Doc. 46- 3 at 14-16. As such, I consider Child to have waived any argument that the reasonable expectations doctrine should apply based on representations by Unum during her alleged calls. See, e.g., *Satcher v. Univ. of Arkansas at Pine Bluff Bd. of Trs.*, 558 F.3d 731, 735 (8th Cir. 2009) ("failure to oppose a basis for summary judgment constitutes waiver of that argument."). Child has not demonstrated a genuine issue of material fact on the reasonable expectations doctrine.

In sum, the claim denial was consistent with the Policy and with the Iowa statutes and regulations that apply to LTC policies. Nor has Child demonstrated a genuine issue of material fact on the reasonable

expectations doctrine based on representations from either AEA 267 or Unum. Child's breach of contract claim fails as a matter of law.

2. Count II – Bad Faith

Unum argues that Child's bad faith claim fails as a matter of law because her claim under the Policy is at least fairly debatable and there is no evidence that Unum knew or had reason to know its denial was without reasonable basis. Like Child's breach of contract claim, Unum asserts that the Policy language is clear and unambiguous and that its decision on Child's claim was consistent with such language as well as any Iowa statutes that applied to LTC policies at the time. Child argues that Iowa statutes prohibit (1) the exclusion of losses that exist on the effective date of coverage and (2) post claim underwriting where underwriting is either insufficient or altogether waived. She also argues that Unum failed to investigate the representations made by the AEA to Child, despite instructions in its claim manual.

To prevail on a first party bad faith insurance claim pursuant to Iowa law, a plaintiff must show "(1) that the insurer had no reasonable basis for denying benefits under the policy and, (2) the insurer knew, or had reason to know, that its denial was without basis." *Thorton v. American Interstate Insurance Company*, 897 N.W.2d 445, 461-62 (Iowa 2017) (quoting *United Fire & Cas. Co. v. Shelly Funeral Home, Inc.*, 642 N.W.2d 648, 657 (Iowa 2002)). The first element is objective and the second element is subjective. *Bellville v. Farm Bureau Mut. Ins. Co.*, 702 N.W.2d 468, 473 (Iowa 2005).

With regard to the first element, “[a] reasonable basis exists for denial of policy benefits if the insured's claim is fairly debatable either on a matter of fact or law.” Bellville, 702 N.W.2d at 473. This issue may be decided as a matter of law. *Id.* A claim is “fairly debatable when it is open to dispute on any logical basis Stated another way, if reasonable minds can differ on the coverage-determining facts or law, then the claim is fairly debatable.” Bellville, 702 N.W.2d at 473. Because the first element’s focus is on whether there was a debatable issue, it is not dispositive if the insurer’s position was ultimately incorrect. *Id.* Instead, the dispositive question is whether a fairly debatable claim existed. *Id.* When “an objectively reasonable basis for denial of a claim actually exists, the insurer cannot be held liable for bad faith as a matter of law.” *Id.* at 474 (emphasis in original). Courts do not weigh the evidence an insurance company considered; they determine simply whether evidence existed to justify the company’s denial of the policyholder’s claim. *Id.*

Even if a policyholder shows that the insurance company lacked an objective reasonable basis to deny the claim, bad faith liability attaches only if the insurance company “knew or should have known that the basis for denying its insured’s claim was unreasonable.” *Id.* “An insurer's negligent or sub-par investigation or evaluation of a claim is relevant to the fact finder's determination of whether the insurer should have known its denial lacked a reasonable basis.” *Id.* However, an improper investigation alone “is not sufficient cause for recovery if the insurer in fact has an objectively reasonable basis for denying the claim.” *Id.* (cleaned up).

Because Child's breach of contract claim fails as a matter of law, her claim of bad faith also fails, as there is no genuine issue of material fact concerning whether Unum had a reasonable basis for denying Child's claim. Indeed, Unum's decision was consistent with the terms of the Policy and with the Iowa statutes and regulations governing LTC policies. Likewise, there is also no evidence that Unum knew or had reason to know its decision was without reasonable basis. Because there are no facts supporting that AEA 267 had authority to act as Unum's agent outside of its administration duties, Unum's failure to contact AEA 267 in investigating the claim is of no consequence. Unum is entitled to summary judgment on Child's bad faith claim.

3. Count III – Fraudulent Misrepresentation

Unum argues it is entitled to summary judgment on Child's claim of fraudulent misrepresentation based on alleged conversations with her employer and Unum representatives regarding her eligibility for coverage. It argues that Unum cannot be bound by any representations made by Child's employer and that Child's description of any representation from Unum's customer care representatives fails to rise to the level of a misrepresentation. Finally, it argues there is no evidence that Child justifiably relied on any representations of coverage or evidence of scienter or intent to deceive.

Child cites the following actions as evidence of fraud: (1) Unum induced AEA employees to purchase policies by offering guaranteed issue coverage and representing that preexisting losses were not excluded under the policy; (2) Unum delivered policies and confirmed coverage; (3) Unum charged and

accepted premium payments; (4) Unum purposely concealed its intention to post claim underwrite the guaranteed issue group; (5) Unum knowingly violated Iowa law by excluding preexisting losses and (6) Unum kept the money it collected for coverage it says never existed. See Doc. 46-3 at 20-21. Under Iowa law:

To establish a claim for fraudulent misrepresentation, [a plaintiff] has the burden of proving each of the following elements: “(1) representation, (2) falsity, (3) materiality, (4) scienter, (5) intent to deceive, (6) reliance, and (7) resulting injury and damage.” These elements must be established by “a preponderance of clear, satisfactory, and convincing proof.” *Van Sickle Constr. Co. v. Wachovia Commercial Mortg., Inc.*, 783 N.W.2d 684, 687 (Iowa 2010) (quoting *Lloyd v. Drake Univ.*, 686 N.W.2d 225, 233 (Iowa 2004)). A claim of fraudulent nondisclosure is analyzed under a similar framework, with the nondisclosure of a material fact serving as the “representation” element. See *Anderson v. Boeke*, 491 N.W.2d 182, 188 (Iowa 1992) (a representation “need not be an affirmative misstatement,” as fraud “can also arise from the failure to disclose material facts”); *Schaller Telephone Co. v. Golden Sky Systems, Inc.*, 298 F.3d 736, 740 (8th Cir. 2002) (noting that “Iowa law recognizes a cause of action for fraudulent misrepresentation based on nondisclosure of material facts”).

Child’s main argument in support of this claim is that Unum failed to disclose that “‘coverage’ was never intended to be vested until after a claim was made and then through post claim underwriting determine whether the insured had an ‘existing’ loss of ADLs on

the effective date of coverage.”¹³ Doc. 46-3 at 21. It is undisputed that the “Existing Loss” provision was in the Benefit Enrollment Form and that Child saw it. See Doc. 46- 1 at 8, 14. As such, Child’s claim of fraudulent misrepresentation based on a failure by Unum to disclose material facts is not supported by the evidence. Also, as discussed above, a denial based on the Existing Loss provision is not the same as excluding a preexisting condition. Applying the Existing Loss provision does not amount to post claim

¹³ To the extent Child also relies on alleged representations by Unum and AEA 267 employees that under guaranteed issue the Existing Loss provision did not apply to her, that claim fails as a matter of law. With regard to representations by her employer, these statements cannot bind Unum for the reasons stated above. See *supra* Section V(A)(1). With regard to representations by Unum, Child’s resistance does not address these representations, except for a conclusory statement that “it is undisputed that the Plaintiff relied on the representations of Unum and the AEA that under guaranteed issue, her preexisting condition would not bar her claim for benefits.” Doc. 46-3 at 22. To the extent she has not waived this argument, see *Satcher*, 558 F.3d at 735, she nevertheless has failed to demonstrate a genuine issue of material fact on at least the elements of scienter and intent to deceive. See *Van Sickle Const. Co.*, 783 N.W.2d at 688 (“Scienter and intent to deceive may be shown when the speaker has actual knowledge of the falsity of his representations or speaks in reckless disregard of whether those representations are true or false.”); *Hlubek v. Pelecky*, 701 N.W.2d 93, 96 (Iowa 2005) (“Speculation is not sufficient to generate a genuine issue of fact.”). Notably, a representation that a “preexisting condition” would not bar a claim would not be false under the Policy language.

underwriting, nor does it violate the Iowa statutes or regulations cited by Child concerning LTC policies. Unum is entitled to summary judgment on Child's fraudulent misrepresentation claim.

4. Punitive Damages

Because Child's claims of bad faith and fraudulent misrepresentation fail as a matter of law, so too does her claim for punitive damages. See *Higgins v. Blue Cross of Western Iowa and South Dakota*, 319 N.W.2d 232, 235 (Iowa 1982) ("Punitive damages may not be recovered for a mere breach of contract; it is only when the breach also constitutes an independent tort, or other illegal or wrongful act, that punitive damages become a possibility.").

B. Child's Motion for Partial Summary Judgment

Because Unum is entitled to summary judgment on each of Child's claims, Child's motion for summary judgment on the limited issues of coverage and wrongful post-claim underwriting must be denied.

VI. CONCLUSION

For the reasons stated herein: 1. Unum's motion (Doc. 37) for summary judgment is granted in its entirety.

2. Child's motion (Doc. 38) for partial summary judgment is denied.

3. This action is hereby dismissed and judgment shall enter in favor of Unum against Child.

4. The trial of this case, currently scheduled to begin August 5, 2024, is hereby canceled.

5. The Clerk of Court shall close this case.

IT IS SO ORDERED this 31st day of May, 2024.

Leonard T. Strand

United States District Judge

APPENDIX C

**UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT**

No. 24-2347

Denise J. Child

Appellant

v.

Unum Life Insurance Company of America

Appellee

Appeal from U.S. District Court for the Northern
District of Iowa - Eastern
(6:22-cv-02071-LTS)

ORDER

The petition for rehearing en banc is denied. The
petition for rehearing by the panel is
also denied.

Judge Kelly did not participate in the consideration
or decision of this matter.

June 17, 2026

Order Entered at the Direction of the Court:
Clerk, U.S. Court of Appeals, Eighth Circuit.

/s/ Susan E. Bindler

Appellate Case: 24-2347 Page: 1 Date Filed:
06/17/2026 Entry ID: 5652140

App. 45

APPENDIX D

**STATE STATUTORY AND REGULATORY
PROVISIONS BASED ON THE NAIC LTCI
MODEL ACT AND REGULATIONS**

Jurisdiction	GI Exception to Health Inquiry (NAIC Model Reg. § 11(A))	Postclaims Underwriting Prohibition Citation	Six-Month Preexisting Condition Limitation (NAIC Model Act § 6C(2))	Group Carve-Out
Iowa	<i>Iowa Admin. Code r. 191-39.8</i>	Same Section	<i>Iowa Code § 514G.7(3)(b)</i>	NO
Alaska	<i>Alaska Admin. Code tit. 3, § 28.558</i>	Same Section	<i>Alaska Stat. § 21.53.030</i>	NO
Connecticut	<i>Conn. Agencies Regs. § 38a-501-14</i>	Same Section	<i>Conn. Agencies Regs. § 38a-528-4</i>	NO

Jurisdiction	GI Exception to Health Inquiry (NAIC Model Reg. § 11(A))	Postclaims Underwriting Prohibition Citation	Six-Month Preexisting Condition Limitation (NAIC Model Act § 6C(2))	Group Carve-Out
Georgia	<i>Ga. Comp. R. & Regs. r. 120-2-16-.11</i>	Same Section	<i>Ga. Comp. R. & Code Ann. § 33-42-6(2)</i>	NO
Kansas	<i>Kan. Admin. Regs. § 40-4-37l</i>	Same Section	<i>Kan. Admin. Regs. § 40-4-37h</i>	NO
Maine	<i>Me. Rev. Stat. ch. § 425, § 11</i>	Same Section	<i>Me. Rev. Stat. tit. 24-A, § 5075</i>	NO

Jurisdiction	GI Exception to Health Inquiry (NAIC Model Reg. § 11(A))	Postclaims Underwriting Prohibition Citation	Six-Month Preexisting Condition Limitation (NAIC Model Act § 6C(2))	Group Carve-Out
Maryland	<i>Md. Code Regs. 31.14.01.09</i>	Same Section	<i>Md. Code Regs. 31.14.01.04</i>	NO
Minnesota	<i>Minn. Stat. § 62S.21</i>	Same Section	<i>Minn. Stat. § 62S.05</i>	YES
Montana	<i>Mont. Admin. R. 6.6.3106</i>	Same Section	<i>Mont. Code Ann. 33-22-1108</i>	NO
New Hampshire	<i>N.H. Code Admin. R. Ins. 3601.10</i>	Same Section	<i>N.H. Rev. Stat. Ann. 415-D:5</i>	NO

Jurisdiction	GI Exception to Health Inquiry (NAIC Model Reg. § 11(A))	Postclaims Underwriting Prohibition Citation	Six-Month Preexisting Condition Limitation (NAIC Model Act § 6C(2))	Group Carve-Out
New Jersey	<i>N.J. Admin. Code § 11:4-34.9</i>	Different Section	<i>N.J. Stat. Ann. § 17B:27E-6</i>	NO
New Mexico	<i>N.M. Admin. Code § 13.10.15.22</i>	Same Section	<i>N.M. Admin. Code § 13.10.15.22</i>	NO
New York	<i>N.Y. Comp. Codes R. & Regs. tit. 11, § 52.25</i>	Same Section	<i>N.Y. Comp. Codes R. & Regs. tit. 11, § 52.25</i>	NO

Jurisdiction	GI Exception to Health Inquiry (NAIC Model Reg. § 11(A))	Postclaims Underwriting Prohibition Citation	Six-Month Preexisting Condition Limitation (NAIC Model Act § 6C(2))	Group Carve-Out
Ohio	<i>Ohio Admin. Code § 3901-4-01(K)</i>	Same Section	<i>Ohio Rev. Code Ann. 3923.44</i>	NO
Oklahoma	<i>Okla. Admin. Code § 365:10-5-44.1</i>	Same Section	<i>Okla. Stat. Ann. tit. 36, 4426</i>	NO
Oregon	<i>Or. Admin. R. 836-052-0576</i>	Same Section	<i>Or. Rev. Stat. Ann. 743.655</i>	YES
Pennsylvania	<i>31 Pa. Code § 89a.110</i>	Same Section	<i>40 Pa. Stat. Ann. 991.1105</i>	NO

Jurisdiction	GI Exception to Health Inquiry (NAIC Model Reg. § 11(A))	Postclaims Underwriting Prohibition Citation	Six-Month Preexisting Condition Limitation (NAIC Model Act § 6C(2))	Group Carve-Out
Puerto Rico	<i>P.R. Laws Ann. tit. 26, § 3905</i>	Same Section	<i>P.R. Laws Ann. tit. 26, § 10256</i>	NO
Rhode Island	<i>R.I. Code R. § 230-RICR-20-35-1.11</i>	Same Section	<i>R.I. Gen. Laws § 27-34.2-6</i>	NO
Texas	<i>28 Tex. Admin. Code § 3.3823</i>	Same Section	<i>28 Tex. Admin. Code § 3.3824</i>	NO
Utah	<i>Utah Admin. Code R590-148-12</i>	Same Section	<i>Utah Code Ann. 31A-22-1406</i>	NO

Jurisdiction	GI Exception to Health Inquiry (NAIC Model Reg. § 11(A))	Postclaims Underwriting Prohibition Citation	Six-Month Preexisting Condition Limitation (NAIC Model Act § 6C(2))	Group Carve-Out
Vermont	<i>Vt. Code R. 4-5-16:11</i>	Same Section	<i>Vt. Stat. Ann. tit. 8, 8086</i>	NO
Virginia	<i>14 Va. Admin. Code § 5-200-80</i>	Same Section	<i>14 Va. Admin. Code § 5-200-80</i>	NO
Wyoming	<i>Wyo. Code R. § 26-36-108</i>	Same Section	<i>Wyo. Stat. Ann. 26-38-105</i>	NO
Alabama	<i>Ala. Admin. Code r. 482-1-091-.09</i>	Same Section	<i>Ala. Code 27-19-105</i>	YES

Jurisdiction	GI Exception to Health Inquiry (NAIC Model Reg. § 11(A))	Postclaims Underwriting Prohibition Citation	Six-Month Preexisting Condition Limitation (NAIC Model Act § 6C(2))	Group Carve-Out
Arizona	<i>Ariz. Admin. Code § R20-6-1011</i>	Same Section	<i>Ariz. Rev. Stat. Ann. 20-1691.03</i>	NO
Arkansas	<i>Ark. Admin. Code § 054.00.13-11</i>	Same Section	<i>Ark. Code Ann. § 23-97-308</i>	YES
California	<i>Cal. Ins. Code § 10232.3(a)</i>	Same Section	<i>Cal. Ins. Code § 10232.4</i>	YES
Colorado	<i>Colo. Code Regs. 4-4-1, § 11</i>	Same Section	<i>Colo. Rev. Stat. § 10-19-108</i>	YES

Jurisdiction	GI Exception to Health Inquiry (NAIC Model Reg. § 11(A))	Postclaims Underwriting Prohibition Citation	Six-Month Preexisting Condition Limitation (NAIC Model Act § 6C(2))	Group Carve-Out
Delaware	<i>Del. Code Ann. tit. 18, § 7105</i>	Same Section	<i>Del. Code Ann. tit. 18, § 7105</i>	YES
D.C.	<i>D.C. Mun. Regs. tit. 26, § 2620</i>	Same Section	<i>D.C. Code § 31-3605</i>	YES
Florida	<i>Fla. Admin. Code r. § 690-157.109</i>	Same Section	<i>Fla. Stat. § 627.9407</i>	YES
Hawaii	<i>Haw. Rev. Stat. § 431:10H-218</i>	Same Section	<i>Haw. Rev. Stat. § 431:10H-108</i>	YES

Jurisdiction	GI Exception to Health Inquiry (NAIC Model Reg. § 11(A))	Postclaims Underwriting Prohibition Citation	Six-Month Preexisting Condition Limitation (NAIC Model Act § 6C(2))	Group Carve-Out
Idaho	<i>Idaho Admin. Code r. § 18.04.11.015</i>	Same Section	<i>Idaho Code § 41-4605</i>	YES
Illinois	<i>50 Ill. Admin. Code § 2012.65</i>	Same Section	<i>215 Ill. Comp. Stat. Ann. 5/351A-5</i>	YES
Indiana	<i>Ind. Admin. Code tit. 760, r. § 2-5-1</i>	Same Section	<i>Ind. Code § 27-8-12-10.5</i>	YES

Jurisdiction	GI Exception to Health Inquiry (NAIC Model Reg. § 11(A))	Postclaims Underwriting Prohibition Citation	Six-Month Preexisting Condition Limitation (NAIC Model Act § 6C(2))	Group Carve-Out
Kentucky	<i>Ky. Admin. Regs. tit. 806, § 17:081, § 8</i>	Same Section	<i>Ky. Rev. Stat. Ann. § 304.14-615</i>	YES
Louisiana	<i>La. Admin. Code tit. 37, § XIII:1921</i>	Same Section	<i>La. Rev. Stat. Ann. § 22:1186</i>	YES
Massachusetts	<i>211 Mass. Code Regs. 65.11</i>	Same Section	<i>Mass. Gen. Laws Ann. ch. 176U, § 3</i>	YES

Jurisdiction	GI Exception to Health Inquiry (NAIC Model Reg. § 11(A))	Postclaims Underwriting Prohibition Citation	Six-Month Preexisting Condition Limitation (NAIC Model Act § 6C(2))	Group Carve-Out
Michigan	<i>Mich. Comp. Laws Ann. § 500.3921</i>	Same Section	<i>Mich. Comp. Laws Ann. § 500.3911</i>	YES
Mississippi	<i>19 Miss. Code R. Pt. 3, R. 8.09</i>	Same Section	<i>19 Miss. Code R. Pt. 3, R. 8.06</i>	YES
Missouri	<i>Mo. Code Regs. Ann. tit. 20, § 400-4.100:9</i>	Same Section	<i>Mo. Ann. Stat. 376.1109</i>	YES

Jurisdiction	GI Exception to Health Inquiry (NAIC Model Reg. § 11(A))	Postclaims Underwriting Prohibition Citation	Six-Month Preexisting Condition Limitation (NAIC Model Act § 6C(2))	Group Carve-Out
Nebraska	<i>Neb. Admin. Code § 46-009</i>	Same Section	<i>Neb. Rev. Stat. § 44-4513</i>	YES
Nevada	<i>Nev. Admin. Code § 687B.067</i>	Same Section	<i>Nev. Admin. Code § 687B.111</i>	YES
North Carolina	<i>N.C. Admin. Code tit. 11, r. § 12.1007</i>	Same Section	<i>N.C. Gen. Stat. § 58-55-30</i>	YES
North Dakota	<i>N.D. Admin. Code § 45-06-05.1-09</i>	Same Section	<i>N.D. Cent. Code Ann. 26.1-45-06</i>	YES

Jurisdiction	GI Exception to Health Inquiry (NAIC Model Reg. § 11(A))	Postclaims Underwriting Prohibition Citation	Six-Month Preexisting Condition Limitation (NAIC Model Act § 6C(2))	Group Carve-Out
South Carolina	<i>S.C. Code Ann. Regs. § 69-44, § 11</i>	Same Section	<i>S.C. Code Ann. § 38-72-60</i>	YES
South Dakota	<i>S.D. Admin. R. 20:06:21:40</i>	Same Section	<i>S.D. Codified Laws 58-17B-6</i>	YES
Tennessee	<i>Tenn. Comp. R. & Regs. 0780-01-61-.11</i>	Same Section	<i>Tenn. Code Ann. § 56-42-105</i>	YES

Jurisdiction	GI Exception to Health Inquiry (NAIC Model Reg. § 11(A))	Postclaims Underwriting Prohibition Citation	Six-Month Preexisting Condition Limitation (NAIC Model Act § 6C(2))	Group Carve-Out
Washington	<i>Wash. Admin. Code 284-83-045</i>	Same Section	<i>Wash. Rev. Code Ann. § 48.83.040</i>	YES
West Virginia	<i>W. Va. Code R. § 114-32-9</i>	Same Section	<i>W. Va. Code § 33-15A-6</i>	YES
Wisconsin	<i>Wis. Admin. Code § Ins 3.46(10)(f)</i> <i>(“except those that are guaranteed issue”)</i>	<i>Same Section</i>	<i>Wis. Stat. Ann. § 632.76</i>	YES