UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

DUANE BUCK and ANN BUCK, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

AMERICAN GENERAL LIFE INSURANCE COMPANY,

Defendant.

Civil No. 17-13278 (NLH/KMW)

OPINION

APPEARANCES:

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HILLMAN, District Judge

This case is a putative class action alleging the breach of a universal life insurance policy. Presently before the Court is Defendant American General Life Insurance's Motion to Dismiss Plaintiffs' First Amended Complaint and Motion to Strike Class Allegations. For the reasons expressed herein, Defendant's Motion to Dismiss will be denied, in part, and granted, in part. Defendant's Motion to Strike Class Allegations will be denied without prejudice.

BACKGROUND

We take our brief recitation of the facts from Plaintiffs' first amended complaint. In 1984, Plaintiffs Duane and Ann Buck (collectively, "Plaintiffs") purchased a universal life insurance policy (the "Policy") on the life of Duane Buck with his wife, Ann Buck, as an additional insured. The Policy was issued by The Old Line Life Insurance Company of America, a company later acquired by Defendant American General Life Insurance Company ("Defendant" or "AGLIC").

Before discussing the specifics of the Policy and the dispute which later arose under it, it is important to establish the basic principles of a universal life insurance policy. Universal life insurance is a form of permanent life insurance, also known as flexible premium or adjustable life insurance.

This refers to the fact that a policy is for a term of years with a set periodic premium, but the premium, benefits, and beneficiaries may all be modified during the term of years.

This type of insurance is meant to give a policyholder coverage for her entire lifetime, while allowing her to vary premium payments, adjust death benefits, and build a cash value while young to offset the higher premiums charged later in life. In other words, as Plaintiffs explain, this type of policy has three elements: (1) the premium, payable periodically, (2) the death benefit, payable to the beneficiary upon death of the insured, and (3) the cash surrender value, the value the policyholder receives if the policy is surrendered prior to death. The cash value built up in the policy receives preferred tax treatment and may be used to pay the cost of insurance in place of a premium, to borrow money against the policy, or merely saved to build cash value.

These types of policies are governed, in part, by the Internal Revenue Code. This provides an outer limit for the amount of cash value that may accrue within a policy while still qualifying for preferred tax treatment. See I.R.C. § 7702, et seq. If the cash value exceeds this outer limit, a policy may lose preferred tax treatment as "life insurance." Besides this penalty, it is unclear from the parties briefing whether there are any other consequences to the owner or insurer. Both

parties note that the actual calculations to determine the premium amount to pay to keep this preferred tax treatment and build cash value are too complicated to explain and, in any event, those calculations are irrelevant to this case.

Initially, the Policy provided a $70,000 death benefit for Duane Buck, a $25,000 rider for Ann Buck, and three $5,000 riders, one for each of the couple's children. The Policy guaranteed an interest rate of 4.5%, compounded yearly, for all premiums paid in excess of cost. The Policy also granted Plaintiffs the right to effectuate a partial or total surrender of the Policy at certain points with certain predetermined fees. AGLIC also provided "Annual Reports" which show the policy's current death benefit, current cash value, total amount of premiums paid, total accumulated growth, and total charges assessed. As the name suggests, the Policy promised that these Annual Reports would be sent – at least - on a yearly basis.

At some point thereafter, Plaintiffs increased Duane Buck's death benefit to $100,000 and Ann Buck's death benefit to $50,000. In 2008, Plaintiffs requested that AGLIC reduce the death benefit for both Duane and Ann Buck to $25,000 and that it eliminate the $15,000 in riders the couple had maintained for their children. AGLIC complied.

In connection with the 2008 decrease in death benefit, AGLIC provided the Bucks with a "Supplemental Illustration" (the

"Illustration") dated September 29, 2008. The Illustration provides policyholders with projections to help them decide how desired changes to their policy may affect the ability of their investment to grow while maintaining preferred tax status.[1] Plaintiffs allege the Illustrations provided by AGLIC determined the amount of yearly or monthly premiums they paid. The Bucks paid the premium as described in the Illustration.

On January 7, 2016, AGLIC sent Plaintiffs a letter which claimed the Policy had been funded to its limit and was at risk of losing its preferred tax status. Plaintiffs allege that the reason the Policy was at risk of losing its preferred tax status was because Defendant used faulty compliance procedures and software which failed to adequately predict the amount of premiums required to keep the Policy tax compliant throughout its life. Defendant, in this letter, claimed that it was a combination of the decrease in death benefits and premium amount which led to this compliance issue.

AGLIC presented the Bucks with three options that would allow the Policy to maintain its tax status: (1) increasing the death benefit (which would have required additional underwriting), (2) surrendering the Policy, or (3) maintaining

[1] According to AGLIC, the Illustration is (1) not a part of the policy, (2) did not purport to provide tax advice, and (3) did not address whether or how tax regulations could affect premium payments. This will be addressed in more detail infra.

the Policy, allowing annual refunds, and ceasing premium payments until the cash value of the Policy was exhausted. AGLIC, in the letter, reserved the right to completely surrender the Policy if Plaintiffs did not choose one of the three listed options.

Plaintiffs chose none of these options. Each option presented Plaintiffs with either a loss of the Policy, increased premiums, or loss of the benefit of the 4.5% interest rate being applied to their future premium payments (as they would be prohibited from making any further premium payments until a later date). AGLIC continued to send letters over the following year, reiterating the options available and that it reserved the right to unilaterally surrender the policy if no option was chosen.

On January 13, 2017, AGLIC sent a letter stating (1) the Policy remained non-compliant, (2) a check would be sent in the amount of $3,260 representing the amount the Policy was overfunded, and (3) the cash value of the Policy would be used to pay premiums until it had been exhausted, at which time Plaintiffs could resume paying premiums.

Finally, on December 11, 2017 AGLIC sent a letter stating Plaintiffs "may pay enough into the policy each year as necessary to maintain . . . coverage without building up any excess policy value." Plaintiffs allege this prohibits them

from gaining the benefit of the 4.5% interest rate and building any cash value within the Policy. In effect, Plaintiffs allege, the Policy has been transformed into a year-to-year term policy.

On December 19, 2017 Plaintiffs filed a complaint in this Court, which included class action allegations. Plaintiffs present two claims for relief: breach of contract and rescission. Defendant filed its Motion to Dismiss and Motion to Strike Class Allegations on March 5, 2018. It has been fully briefed and is ripe for adjudication.

DISCUSSION

A. Subject Matter Jurisdiction

This Court has jurisdiction over this action under the Class Action Fairness Act of 2005. See 28 U.S.C. § 1332(d) (granting United States district courts jurisdiction over putative class claims, which, in aggregate, exceed $5,000,000 and include one putative class member who is diverse from defendants). Plaintiffs are individual citizens of New Jersey and AGLIC is a citizen of Texas having been incorporated there and maintaining its principal place of business in that state.

As for amount in controversy, the First Amended Class Action Complaint is unfortunately vague and internally inconsistent - or at least redundant. First, while it alleges AGLIC has approximately 100,000 individual life insurance policies in force in New Jersey, it fails to distinguish between

universal life policies – at issue here – and other forms of life insurance. Second, in one sentence the First Amended Class Action Complaint alleges AGLIC received "over $100 million in premiums annually" and then in the next sentence alleges AGLIC received over $600 million in premiums "in 2016 alone" both numbers attributed to its New Jersey life insurance customers. [Doc. No. 8 at para. 6.]

Despite the lack of clarity and specificity, it seems plausible at this stage of the proceedings that a large enough percentage of AGLIC life insurance customers are universal life customers and given the large dollar volume of premiums for all life insurance policies in force - whichever alleged number is more accurate – that the putative class damages exceed the statutory minimum.

B. Standard for Motion to Dismiss

When considering a motion to dismiss a complaint for failure to state a claim upon which relief can be granted pursuant to Federal Rule of Civil Procedure 12(b)(6), a court must accept all well-pleaded allegations in the complaint as true and view them in the light most favorable to the plaintiff. Evancho v. Fisher, 423 F.3d 347, 351 (3d Cir. 2005). It is well settled that a pleading is sufficient if it contains "a short and plain statement of the claim showing that the pleader is entitled to relief." FED. R. CIV. P. 8(a)(2).

"While a complaint attacked by a Rule 12(b)(6) motion to dismiss does not need detailed factual allegations, a plaintiff's obligation to provide the 'grounds' of his 'entitle[ment] to relief' requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do . . . ." Bell Atl. Corp. v. Twombly, 550 U.S. 544, 555 (2007) (alteration in original) (citations omitted) (first citing Conley v. Gibson, 355 U.S. 41, 47 (1957); Sanjuan v. Am. Bd. of Psychiatry & Neurology, Inc., 40 F.3d 247, 251 (7th Cir. 1994); and then citing Papasan v. Allain, 478 U.S. 265, 286 (1986)).

> To determine the sufficiency of a complaint, a court must take three steps. First, the court must "tak[e] note of the elements a plaintiff must plead to state a claim." Second, the court should identify allegations that, "because they are no more than conclusions, are not entitled to the assumption of truth." Third, "whe[n] there are well-pleaded factual allegations, a court should assume their veracity and then determine whether they plausibly give rise to an entitlement for relief."

Malleus v. George, 641 F.3d 560, 563 (3d Cir. 2011) (alterations in original) (citations omitted) (quoting Ashcroft v. Iqbal, 556 U.S. 662, 664, 675, 679 (2009)). A court may "generally consider only the allegations contained in the complaint, exhibits attached to the complaint and matters of public record." Schmidt v. Skolas, 770 F.3d 241, 249 (3d Cir. 2014)

(citing Pension Benefit Guar. Corp. v. White Consol. Indus., Inc., 998 F.2d 1192, 1196 (3d Cir. 1993)).

A district court, in weighing a motion to dismiss, asks "not whether a plaintiff will ultimately prevail but whether the claimant is entitled to offer evidence to support the claim." Twombly, 550 U.S. at 563 n.8 (quoting Scheuer v. Rhoades, 416 U.S. 232, 236 (1974)); see also Iqbal, 556 U.S. at 684 ("Our decision in Twombly expounded the pleading standard for 'all civil actions' . . . ."); Fowler v. UPMC Shadyside, 578 F.3d 203, 210 (3d Cir. 2009) ("Iqbal . . . provides the final nail in the coffin for the 'no set of facts' standard that applied to federal complaints before Twombly."). "A motion to dismiss should be granted if the plaintiff is unable to plead 'enough facts to state a claim to relief that is plausible on its face.'" Malleus, 641 F.3d at 563 (quoting Twombly, 550 U.S. at 570).

C. Motion to Dismiss

Defendant moves to dismiss the breach of contract and rescission claims pleaded in the amended complaint. Defendant generally argues that the breaches complained of are not breaches of any contractual terms.[2] First, Defendant asserts

[2] Although Defendant makes this all-encompassing claim, it does not work through Plaintiffs' complaint showing how each and every breach complained of is not based on a provision within the Policy. Accordingly, this Court will only consider the

there is no breach because the Illustration complained of was not a part of the contract and cannot be the basis for a breach claim. Second, Defendant asserts there is no breach because Defendant did not unilaterally effectuate a surrender, it merely refunded excess premiums. The proof, Defendant asserts, is the fact that the death benefit was not reduced correspondingly. Third, Defendant argues there can be no rescission claim in the absence of a substantive breach of contract claim. Thus, if the breach of contract claim is dismissed the rescission claim must be dismissed as well.[3]

Plaintiffs counter with a few arguments. First, Plaintiffs assert that a breach of either the Annual Reports or the Illustration requirement is a breach of the Policy. Second, Plaintiffs argue the alleged surrender constituted a breach, because whether it is labeled a surrender or refund, Defendant had no right to issue it. Plaintiffs assert that even if the so-called surrender was a premium refund, Defendant had no right to unilaterally effectuate the refund. Third, Plaintiffs assert it is a breach of contract for an insurance company to refuse to

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specific arguments made by Defendant in its motion and will not engage in a wholesale search of the complaint and Policy.

[3] This Court will not address Defendant's argument concerning misrepresentation and negligent misrepresentation. Claims for either have not been brought by Plaintiffs, so those arguments are irrelevant at this time.

accept a premium.

In order to properly plead a breach of contract claim, Plaintiffs must show "(1) the existence of a valid contract between the parties; (2) failure of the defendant to perform its obligations under the contract; and (3) a causal relationship between the breach and the plaintiff's alleged damages." Motamed v. Chubb Corp., 15-cv-7262, 2016 U.S. Dist. LEXIS 33301, at *11-12 (D.N.J. Mar. 15, 2016) (citing Sheet Metal Workers Int'l Ass'n Local Union No. 27, AFL-CIO v. E.P. Donnelly, Inc., 737 F.3d 879, 900 (3d Cir. 2013)). Defendant does not dispute that a valid contract exists or that, in the event a breach has been sufficiently pleaded, there is a causal relationship between the breach and the damages. The Court will deem these admitted solely for purposes of the present analysis.

a. Illustrations and Annual Report

First, Defendant argues the Illustrations and Annual Reports provided by AGLIC are not a part of the contract and therefore cannot serve as the basis for a breach of contract claim. Defendant cites the Policy's language, which states "THE CONTRACT" consists of the "[P]olicy, including any riders and endorsements, the original application and any supplemental applications." Because the Annual Reports and Illustrations are not listed as a part of "THE CONTRACT," Defendant argues, they cannot be the basis for the breach.

Defendant misunderstands Plaintiffs' theory of breach here. It is not that either the Annual Report or Illustration are a part of the Policy, it is that the Policy makes specific promises regarding these two items. Defendant sums this up succinctly in its reply brief, stating that the Policy "required only that AGLIC provide annual reports and requested illustrations containing certain required information . . . ." While Plaintiffs do not argue, in their complaint or brief in opposition, that AGLIC failed to provide these documents, they do argue that misrepresentations or omissions in either could give rise to a breach. In essence, the Annual Reports or the Illustration received by Plaintiffs did not contain the required information. This Court examines the Policy provision for each document in turn.

Under the heading "ANNUAL REPORT" the Policy states that AGLIC "will send a report to the owner at least once each year" which contains information on the "policy's current specified amount, cash value and debt, partial surrenders, premiums paid and charges made since the last report, and any other data required by the state in which this policy is delivered." AGLIC is correct that this does not incorporate the Annual Reports into the Policy, but it does create an obligation under which AGLIC must provide a report with the specified information yearly.

A breach of this provision could occur under two sets of circumstances. First, if the Annual Report is not sent or sent without the information promised, then AGLIC could have breached the Policy. This is not alleged to be the case here. Second, if the Annual Report is sent containing misrepresentations or omissions as to the information the Policy promises it would include, then that may also amount to a breach. This is what is alleged here in Plaintiffs' complaint. Defendant has not presented to this Court any case law which would require this Court to dismiss this theory of breach (or the similar theory discussed immediately below).[4] While the Court does not decide at this stage whether this does constitute a breach, drawing all reasonable inferences in favor of Plaintiffs, this Court finds Plaintiffs may move forward with a theory of breach on the basis of the Annual Report.

[4] Defendant does argue that Plaintiffs "fail to explain (likely because the argument is untenable) how any alleged inaccuracies in the annual reports and requested illustrations could give rise to a breach of contract claim. Neither type of document contains promises capable of being breached." This does not persuade this Court that these theories of breach must be dismissed, as it misstates both the burden and the theory of breach. While there may be case law stating an inaccuracy in a document that one party was contractually obligated to produce to another cannot serve as the basis for a breach claim, Defendant has not brought that case law before this Court. Moreover, Defendant misstates Plaintiffs' argument. It is not that the Annual Report or Illustration contains a promise capable of being breached, it is that they allegedly contain misrepresentations or omissions, which is a breach of the alleged promise contained in the Policy.

Under the heading of "ILLUSTRATION OF FUTURE BENEFITS AND VALUES," the Policy states:

> Upon the owner's written request and payment of the service fee then in effect, we will provide an illustration of future death benefits and cash values. The illustration will be based on necessary assumptions specified by us and/or the owner. This includes assumptions as to specified amount, coverage options and future premium payments.

For the purposes of this analysis, the Court considers this a conditional promise, dependent upon whether AGLIC receives (1) a written request and (2) payment of the service fee. It appears there is no dispute that Plaintiffs satisfied the conditions precedent and that Defendant sent the Illustration.

The same two possibilities for breach exist as were explained with the Annual Reports. Again, while the Court does not decide at this stage whether this does, in fact, constitute a breach, drawing all reasonable inferences in favor of Plaintiffs, this Court finds Plaintiffs may move forward with a theory of breach of contract on the basis of the Illustration. Thus, this Court will deny Defendant's Motion to Dismiss on this theory of breach.[5]

b. AGLIC's Unilateral Partial Surrender

Defendant asserts that it had the right under the Policy to

[5] Plaintiffs do not contend that the changes made to the Policy in 2008 constitute a modification that would somehow add the Annual Reports or Illustration into the Policy, so this ancillary argument by Defendant is irrelevant.

unilaterally return excess premiums to Plaintiffs. At this early stage in the proceedings, we must make all reasonable inferences in favor of Plaintiffs. Plaintiffs have presented two, reasonable explanations for the contractual underpinning of the $3,260 check sent by AGLIC to Plaintiffs. Plaintiffs argue it was either a premium refund or a partial surrender. Under either definition, Plaintiffs contend, the return of funds was a breach as AGLIC was without power to effectuate it.

Under one view, in AGLIC's own words from its January 13, 2017 letter, this check was "a refund of the amount overfunded." This is further evidenced by the check itself, which noted the payment was a "DEFRA violation refund." If this was in fact a refund, then there has been no breach by Defendant. Under the clear terms of the Policy, AGLIC reserved the right to "refund any part of a premium that exceeds the premium guidelines applicable to this policy under the Internal Revenue Code of 1954." Neither party disputes that this Policy was non-compliant and Plaintiffs do not allege that the $3,260 returned to them was done so for any other reason than to keep the Policy compliant.

But, AGLIC's many letters create ambiguity. In AGLIC's first letter on January 7, 2016, it states if Plaintiffs choose none of the three options, AGLIC "reserve[s] the right to exercise the automatic option, i.e. surrender the policy . . .

." As Plaintiffs never responded to the Defendant's January 7, 2016 letter, the Court must infer at this stage that AGLIC exercised "the automatic option." This is further evidenced by AGLIC's January 17, 2017 letter enclosing what it described as a "partial surrender check." In that letter, AGLIC stated it had "completed [Plaintiffs] request for a partial surrender" of the Policy.

According to the contract "[t]he owner may, by written request, make a partial surrender of this policy. The partial surrender may take effect on any monthly date while the insured is alive and before the maturity date." This is the only portion of the contract that concerns partial surrender.

Defendant asserts this language allows it to effectuate a unilateral partial surrender. But, this language is silent as to whether Defendant may effectuate, unilaterally, a partial surrender of the Policy. The Court cannot rewrite the Policy and Defendant has presented no law that would read this right into the Policy where it has not been explicitly granted.

Defendant also argues there is circumstantial evidence showing this was not a partial surrender of the Policy. Defendant states whenever a partial surrender occurs, the death benefit must also be correspondingly reduced. Since there was no reduction in death benefit, this could not be a partial surrender. The Policy does not state exactly what Defendant

argues. Instead, the Policy states: "After any partial surrender the specified amount may not be less than $25,000 unless a lower amount is specified by our then current company rules." This raises the reasonable possibility that a partial surrender could have occurred without a corresponding reduction in death benefit. At this early stage, the Court must draw this reasonable inference in favor of Plaintiffs. Therefore, Plaintiffs may not continue to pursue a breach of contract claim under the "refund" theory, but may do so under the "partial surrender" theory.

c. Refusal to Accept Planned Premiums

Defendant argues it did not breach the Policy, as a matter of law, because it refused to accept premium payments from Plaintiffs. Defendant essentially asserts that there is no part of the Policy that requires it to accept premiums in this manner. Plaintiffs argue they were obligated to pay the monthly premium and Defendant was obligated to accept it, both under the Policy and as a matter of law.

Before turning to the law, this Court must first determine whether there is a Policy provision requiring the payment of a premium. One factor complicates the analysis. Because the Policy is a universal life policy, it allows the Plaintiff to pay the cost of insurance through the cash value of the Policy as well as through monthly premiums – or any combination

thereof. In practice, that means Plaintiffs need not pay a premium as long as there is enough cash value in the Policy to cover the cost of insurance. Unlike most insurance policies, the payment of a premium is not a condition of insurance – only coverage of the cost of insurance is a condition of maintaining coverage.

The ability to pay the cost of insurance in this manner is implicit, rather than explicit in the contract. Under the section entitled "CONTINUATION OF INSURANCE," the Policy states "[i]f premium payments cease, insurance under this policy and benefits under any rider will continue as provided, subject to the Grace Period provision." The "Grace Period" is a 61-day period that starts on "a monthly date on which the surrender value is not large enough to cover the next monthly deduction." Combining the two sections, it is implied that the Policy will continue as long as the surrender value is greater than the next monthly deduction even in the absence of premium payments. In other words, it appears that payment of a monthly premium is not a condition of insurance, just the existence of cash value in excess of the cost of insurance.

Plaintiffs, therefore, are not arguing there was a breach of the Policy because the Policy was cancelled even though they paid the premium requested. The Policy is still in effect. The argument is more nuanced. Specifically, Plaintiffs argue that

Defendant is obligated to accept a premium paid directly from Plaintiffs – regardless of whether the premium is needed to cover the cost of insurance or whether the premium may rob the Policy of its preferred tax status.

As discussed above, "THE CONTRACT" includes the Policy and "any riders and endorsements, the original application, and any supplemental applications . . . ." And, the Policy, through an endorsement, does state the Plaintiffs would pay "$ 124.00" "monthly" in a "Planned Premium." Because of the unique nature of a universal life policy (discussed supra), however, a premium payment is not a condition of insurance – just a surrender value that is in excess of the cost of insurance.

Neither is there an explicit provision of the Policy that this Court can find – or that the parties have pointed out – that states the Defendant is obligated to accept the premium. But, this is not dispositive of the issue. In a contract for provision of goods, there is no provision stating the buyer must accept conforming goods from the seller. It is implied and may be so implied here. See, e.g., Michaelsen v. Sec. Mut. Life Ins. Co., 154 F. 356, 356-57 (3d Cir. 1907) ("[T]he obligation of the insured to pay yearly premiums on his policy implies a corresponding obligation on the insurer to receive such premiums yearly, so long as the policy remains in force . . . and an unjust refusal to accept such premiums constitutes a breach of

contract.”).

At this stage, this Court does not decide this issue, but it cannot dismiss this theory of breach as a matter of law. While Defendant is correct that Plaintiffs’ case law does not address the special case of the universal life insurance policy, it has not brought forth any case law, assuming the facts in Plaintiffs’ case as true, that require dismissal. This Court will allow the Plaintiffs to proceed under this theory of breach.

d. Rescission

Defendant’s argument for dismissing Plaintiffs’ rescission claim depends exclusively on its argument for dismissing Plaintiffs’ breach of contract claim. In other words, the rescission claim can be dismissed only if no breach of contract claim survives Defendant’s Motion to Dismiss. Because this Court will not dismiss the breach of contract claim, it will not dismiss the rescission claim.

D. Standard for Motion to Strike Class Allegations

Defendant also moves to strike Plaintiffs’ class allegations from the complaint under Federal Rules of Civil Procedure 12(f), 23(c)(1)(A), and 23(d)(1)(D). Plaintiffs resist Defendant’s motion, arguing a decision on class allegations is premature and unwarranted.

This Court recognizes, as Defendant has ably argued, that

"[a]t an early practicable time after a person sues or is sued as a class representative, the court must determine by order whether to certify the action as a class action." FED. R. CIV. P. 23(c)(1)(A). But, "[a]s a practical matter, the court's [decision] usually should be predicated on more information than the complaint itself affords . . . [and] courts frequently have ruled that discovery relating to the issue whether a class action is appropriate needs to be undertaken before deciding whether to allow the action to proceed on a class basis." Oravsky v. Encompass Ins. Co., 804 F. Supp. 2d 228, 240-41 (D.N.J. 2011) (citing 5C Wright, Miller & Kane, Federal Practice & Procedure Civil 3d § 1785.3 (explaining that the practice employed in the overwhelming majority of class actions is to resolve class certification only after an appropriate period of discovery)).

Thus, "dismissal of class certification allegations should be ordered only 'in those rare cases where the complaint itself demonstrates that the requirements for maintaining a class action cannot be met.'" S. Broward Hosp. Dist. v. MedQuist, Inc., 516 F. Supp. 2d 370, 401 (D.N.J. 2007) (quoting Clark v. McDonald's Corp., 213 F.R.D. 198, 205 n.3 (D.N.J. 2003)). This Court also notes that "the better course is to deny [a motion to strike class allegations] because 'the shape and form of a class action evolves only through the process of

discovery.'" Id. at 401-02 (quoting Conley v. Gibson, 355 U.S. 41, 45-46 (1957)).

E. Motion to Strike Class Allegations

Defendant argues on two grounds that this Court should strike all nationwide class allegations. Defendant does not dispute that Plaintiffs have satisfied the requirements of Federal Rule of Civil Procedure 23(a) in their complaint, but instead focus on: (1) whether Plaintiffs have satisfied the predominance requirement of 23(b)(3) and (2) whether the putative class action presents manageability issues which may make collective adjudication unwise and impracticable.

Plaintiffs argue that a decision on the class allegations is premature as no discovery has yet been completed. In addition, Plaintiffs assert that they may pursue certification under 23(b)(2), instead of 23(b)(3). This could moot Defendant's argument concerning predominance and superiority. Finally, Plaintiffs distinguish many of the cases cited by Defendant from the present situation.

First, this Court will address Defendant's predominance argument. Predominance is only shown where "questions of law or fact common to class members predominate over any questions affecting only individual members." FED. R. CIV. P. 23(b)(3). Defendant asserts the putative class is comprised of individuals who received an illustration or annual report detailing the

premium payments to be made and a letter like one Plaintiffs received, which they assert was a form letter. To sustain the breach of contract claim, Defendant asserts, Plaintiffs must show this Court that these class members relied on an illustration or annual report in making premium payments, were issued a letter like the one Plaintiffs received as a result of their reliance, and AGLIC no longer accepted their premium payments. Defendant argues there can be no predominance here because individual inquiry is required into whether each owner of a universal life insurance policy actually relied upon the illustration and annual report in making premium payments.

Defendant's argument misses the mark. Plaintiffs do not bring a case alleging liability for fraudulent misrepresentation (or another similar cause of action). Instead, Plaintiffs bring a breach of contract claim. Reliance is not a required element of breach of contract. Plaintiffs may only have to prove there were omissions or misrepresentations in the annual reports or illustrations. This could be proven by showing the software program that calculated permissible premium amounts was somehow incorrectly programmed. This, obviously, would not require individualized proof and could be a fact common to all class members. Whether or not Plaintiffs pursue this theory or another seems to be entirely dependent on the discovery which they receive.

It is not this Court's place to predict what evidence may be found and which theory (or theories) Plaintiffs may pursue. This is exactly why motions to strike class allegations filed prior to discovery are disfavored. This Court refuses to rest its opinion on the conjecture and assumptions presented by Defendant. Accordingly, this Court will deny Defendant's Motion to Strike Class Allegations, without prejudice, on predominance grounds.

Second, this Court will address Defendant's manageability argument. Manageability refers to the Federal Rule of Civil Procedure 23(b)(3) superiority requirement, which states that "a class action [must be] superior to other available methods for fairly and efficiently adjudicating the controversy." Defendant argues this case does not meet the manageability requirement because it is a putative nationwide class action asserting claims that arise under each state's common law. Defendants assert that statutes of limitations, claim accrual, and parol evidence likely all differ state-to-state and would require this Court to apply fifty different standards.

Defendant's argument is well-taken. This case could present many different standards. It also may not, considering Plaintiffs' assertion that almost every state follows fairly standard elements for a breach of contract claim. Regardless of what may happen, the fact that it only may happen shows these

arguments are premature. This Court cannot decide whether to allow class allegations to move forward on the basis of Defendant's conjecture of what may arise. Accordingly, this Court will deny Defendant's Motion to Strike Class Allegations, without prejudice, on manageability grounds.

To be sure, Defendant has presented arguments that may well prove persuasive. This Court does not yet decide whether those arguments are meritorious. Thus, while Defendant's Motion to Strike Class Allegations will be denied, it will be denied without prejudice. Defendant is free to raise these same grounds in later filings, whether it be another motion to strike or in response to Plaintiffs' motion for class certification.

F. Leave to Amend

Plaintiffs request in their brief in opposition that they be given the opportunity to amend their complaint if either of Defendant's motions were granted in whole or in part. Federal Rule of Civil Procedure 15(a) requires this Court to "freely give leave when justice so requires." Although leave to amend should be freely given, it need not be given in cases where amendment would be futile. See Grayson v. Mayview State Hosp., 293 F.3d 103, 108 (3d Cir. 2002). Here, this Court has only foreclosed Plaintiffs from pursuing a breach of contract claim under the theory that a unilateral refund by AGLIC may have amounted to breach. Considering this ruling, amendment would be

futile, as the clear text of the Policy shows this would not be a breach. Therefore, this Court will deny Plaintiffs' request for leave to amend.

CONCLUSION

For the reasons set forth in this Opinion, this Court will deny, in part, and grant, in part, Defendant's motion to dismiss. This Court will also deny Defendant's motion to strike class allegations, without prejudice.

An appropriate Order will be entered.

Date: October 31, 2018
At Camden, New Jersey

s/ Noel L. Hillman
NOEL L. HILLMAN, U.S.D.J.