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Bernard Rothman

Paul Nassar

Andrew Schepard

Maurice A. Deane School of Law at Hofstra University

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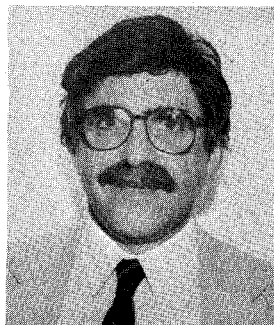
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BERNARD ROTHMAN*
PAUL NASSAR**
ANDREW SCHEPARD***
New York City

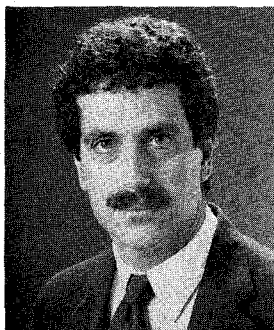
AIDS and New York Matrimonial Law



Bernard Rothman



Paul Nassar



Andrew Shepard

The largest number of people in the United States infected with the AIDS virus live in New York State.¹ Some number of these New Yorkers are married, parents and involved in a disintegrating relationship with their spouse. Accordingly, AIDS-related problems will be a centerpiece of their divorces. Indeed, cases involving AIDS are beginning to be reported in the state's trial courts.²

Our thesis is that the Bar and Bench should aim, as far as possible, to treat an AIDS-related divorce identically to any other divorce involving a spouse with a progressive, inevitably fatal disease.³ This goal serves the important policies of confidentiality and non-discrimination that are at the core of public health strategy to contain the spread of the AIDS virus. It also promotes vitally needed cooperation between spouses in preparing the family unit for the simultaneous tragedies of death and divorce.

First, this article briefly outlines basic medical facts about AIDS. We then suggest the approach courts and lawyers should take in cases involving AIDS-related divorce issues including grounds, economics, child

* Partner, Finklestein Bruckman Wohl Most & Rothman (New York City); Fellow, American Academy of Matrimonial Lawyers; Member, Executive Committee, and Chairman, Special Committee on AIDS and Matrimonial Law Family Law Section, New York State Bar Association; guest Lecturer in Family Law, Benjamin Cardozo Law School, Albert Einstein College of Medicine, New York State and American Bar Association CLE Programs.

** M.D. 1968. Diplomate of the American Board of Neurology & Psychiatry; Fellow, American Psychiatric Association; Assistant Professor Clinical Psychiatry, College of Physicians & Surgeons, Columbia University.

*** Associate Professor and Director of Clinical Programs, Hofstra Law School. J.D. Harvard Law School, 1972; Of Counsel to William S. Beslow, Esq. (New York City). Former Consultant New York State Law Revision Commission on Child Custody. Author of numerous articles on Family Law.

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¹ The scientific name for the virus that causes AIDS as well as other diseases, is the Human Immunodeficiency Virus ("HIV"). This virus has previously had other names, including human T-lymphotropic virus type III (HTLV-III), lymphadenopathy associated virus (LAV) or AIDS-related virus. HIV is the designation for the virus recently approved by an international committee of scientists for purposes of promoting uniformity. NEW YORK STATE DEPARTMENT OF HEALTH, ACQUIRED IMMUNE DEFICIENCY SYNDROME: 100 QUESTIONS AND ANSWERS ABOUT AIDS 1 (1987) [hereinafter cited as AIDS QUESTIONS

custody and involuntary blood tests. Finally, we make broader recommendations for how divorce counsel and courts can help families undergoing an AIDS-related divorce cope with their devastating problems.

Basic Medical Facts About AIDS

A. Definition and Symptoms.

Acquired Immunodeficiency Syndrome ("AIDS") is not a single disease but a spectrum of conditions resulting from infection with the Human Immunodeficiency Virus ("HIV virus"). The HIV virus attacks the body's immune system, making it less able to combat disease.

The HIV virus causes a range of manifestations in exposed people. The nature of the manifestations, not infection with the virus, determine whether the infected person has AIDS.⁴

1. Seropositivity and blood testing.

A seropositive person is someone whose immune system produces detectable antibodies (substances produced in the blood to fight disease organisms) to the HIV virus.

Seroconversion is that point in time when antibodies first become detectable by a blood test, resulting in the individual becoming "seropositive."

A seropositive blood test does not show that a person has AIDS, or any other disease caused by HIV infection, or will develop one in the future. It shows only that he has been exposed to the HIV virus and presumably is infected.⁵ At the time of seroconversion the infected person may exhibit a short-term flu-like illness, or may show no symptoms at all ("asymptomatic").

The time between exposure to the HIV virus and a seropositive antibody test is usually two months, but can range up to twelve months.⁶ The blood test produces a small percentage of false positive (and

negative) results.⁷ Health authorities believe that seropositive people should consider themselves capable of transmitting the HIV virus to others through sexual activity, needle sharing, or pregnancy, and should take appropriate precautions.

2. HIV infected.

This category contains most seroconverted people. They are infected but show no visible symptoms. Although the immune system of an HIV infected person has not yet been seriously damaged, abnormalities in laboratory blood tests begin to appear. HIV infected people may, however, remain asymptomatic for many years. How many of them may eventually develop ARC or AIDS will be discussed subsequently.

3. ARC (AIDS Related Complex).

This somewhat elastic category includes HIV infected people with a range of clinical symptoms and conditions that show evidence of their infection. It does not include, however, people with the "opportunistic diseases" included within the Center for Disease Control's definition of AIDS.⁸

4. AIDS.

Patients with AIDS: (a) test seropositive for the HIV virus; (b) show changes in laboratory tests of their immune system; (c) show symptoms of "opportunistic infections" or other serious diseases that indicate underlying cellular immunodeficiency, and (d) have no other explanation for their conditions.⁹

AND ANSWERS]. In this article the terms "HIV virus" and "AIDS virus" will be used interchangeably. For discussion of incidence of AIDS in New York, see *infra* notes 12-15 and accompanying text.

² See *Anne D. v. Raymond D.*, 528 N.Y.S.2d 775 (Sup. Ct. 1988) (denying AIDS test of defendant spouse in divorce action based on claim she had committed adultery); *Doe v. Roe*, 526 N.Y.S.2d 718 (Sup. Ct. 1988) (AIDS test request denied in custody dispute with in-laws); *Jane W. v. "John" W.*, 137 Misc.2d 24, 519 N.Y.S.2d 603 (Sup. Ct. 1987) (visitation granted to AIDS-positive parent).

³ A similar policy of non-discrimination in employment was recently recommended by the Citizens Commission on AIDS for New York City and Northern New Jersey. The Commission was co-chaired by John Jacobs, chief executive officer of the National Urban League and John Zucotti, a former Deputy Mayor of New York City. Its diverse membership drew on some of the most talented people in New York. The Commission's "Bill of Rights" consisting of pledges of non-discrimination were adopted by a number of the nation's leading employers (e.g. IBM, ITT, Chemical Bank and Johnson & Johnson) with over 1.5 million employees. *N.Y. Times*, Feb. 18, 1988 at B11, col. 1-4.

⁴ We have drawn on the HIV disease classification system of a recent Committee Report of the Association of the Bar of the City of New York, which in turn adapted its classification system from a National Institute of Justice Report. Joint Subcommittee on AIDS in the Criminal Justice System of the Committee on Corrections and Committee on Criminal Justice Operations and Budget, *AIDS and the Criminal Justice System: A Preliminary Report and Recommendations*, 42 REC. A.B. CITY N.Y. 901, 902 (1987). The classification system is consistent with the Centers for Disease Control's definition of AIDS.

⁵ AIDS QUESTIONS AND ANSWERS, *supra* note 1, at 8.

⁶ Fisher, *AIDS Update*, 35 HENRY FORD HOSP. MED. J. 5, 7 (1987) [hereinafter cited as *AIDS Update*].

⁷ Meyer & Pauker, *Screening for HIV: Can We Afford the False Positive Rate?*, 317 NEW ENG. J. MED. 238 (1987).

⁸ *AIDS and the Criminal Justice System*, *supra* note 4, at 903. For a discussion of the elasticity of the definition of ARC, see *AIDS Update*, *supra* note 6, at 11 (arguing that ARC has no generally agreed on medical definition and that the term should be reserved for "those with severe symptoms, prodromal infections or severe immune deficiency as manifested by T-helper counts under 200/mm").

⁹ The symptoms of underlying HIV infection that define AIDS fall into five categories:

1. fever or diarrhea lasting longer than one month, involuntary weight loss of 10% or more, or a combination of these;

2. Central Nervous System disorders like dementia (loss or impairment of mental functions), or diseases of the Peripheral Nervous System like polyneuropathy (changes of sensation in hands and feet such as shooting pains or a feeling of pins and needles);

3. "opportunistic infections" which usually do not occur in people whose immune system functions normally. These otherwise rare infections include *Pneumocystis carinii*, (a severe lung infection) and toxoplasmosis (an infectious agent causing brain, lung and other tissue damage);

4. relatively rare cancers like Kaposi's sarcoma (a malignant form of skin cancer) and various tumors of the lymph tissues;

5. other conditions related to the HIV infection or defects in immunity like chronic lymphoid intestinal pneumonitis (which causes chronic diarrhea).

From thirty to forty percent of AIDS patients show symptoms of brain disease or damage to the spinal cord. Psychotic episodes may appear and motor and coordination changes are seen quite frequently, occasionally as the earliest presenting problem.¹⁰ Not all the symptoms, however, are the result of the HIV virus infection of the brain or nerve tissues; some are related to the opportunistic infections that define AIDS. Also, certain drugs used to treat these opportunistic infections may affect mental functioning, causing hallucinations or changes in personality.

B. Incidence.

How large the base of the HIV infection pyramid really is - that is, how many people are actually infected - can only be estimated.¹¹ The "conversation rate" from asymptomatic infection to clinical symptoms is the subject of intensive study and informed speculation.¹²

In 1987 the American Medical Association reported that the number of HIV infected people in the United States "may number 1.5 million, approximately 35,000 of whom have been reported to suffer from AIDS and more than 20,000 of whom are dead."¹³ Recently, federal public health officials have revised their estimates upward and predict that at least 450,000 Americans will be diagnosed as having AIDS by the end of 1993 and as many as 100,000 new cases will be reported in that year alone.¹⁴ As of July, 1988 more than 14,000 New York City residents have been diagnosed as having AIDS.¹⁵

C. Prognosis and treatment

There is no cure for AIDS and no vaccine that will stop the spread of the HIV virus. Only a single drug, AZT, has been licensed to treat infection with the HIV virus itself, although other drugs are available to treat the opportunistic infections that help define AIDS.

AZT prolongs life in some patients, but is highly toxic. Another group of AIDS-related drugs is under experimental study. The Food and Drug Administration recently projected, however, that these experiments were unlikely to yield more than one or two new useful drugs before 1991.¹⁶

About fifty-eight percent of all patients diagnosed as having AIDS have died. The death rate increases to more than seventy percent two years after diagnosis; some people, however, are still alive after seven years. "In New York City, AIDS is the leading cause of death among men 25 to 44 years old and women 25 to 34. . . . Of the persons in whom AIDS was diagnosed before 1983, 87 percent are dead."¹⁷

D. Transmission

Current research establishes that HIV infection is primarily transmitted through heterosexual or homosexual sexual acts. It can also be transmitted via blood through transfusions, the sharing of contaminated needles or from pregnant mothers to their fetuses.¹⁸

Unlike the viruses that cause most transmissible diseases—cold, flu, measles, etc. - the HIV virus is not transmitted through sneezing, coughing, eating or drinking from common utensils, or merely being around an infected person.¹⁹ An ongoing study at Montefiore Hospital in New York, one of many confirming that the HIV virus is not transmitted through "casual contact", is described in a recent article:

"These AIDS patients [the ones involved in the study] are mostly poor, Hispanic, intravenous drug abusers living in very crowded conditions in New York City—certainly not an optimal situation

Without Clinical Evidence of Immunodeficiency, 144AM J. PSYCHIATRY 1342 (1987).

¹¹ American Medical Association Board of Trustees, *Prevention and Control of Acquired Immunodeficiency Syndrome: An Interim Report*, 258 J. A.M.A. 2097, 2012 (1987)[hereinafter cited as *AMA AIDS Report*].

¹² *Id.* The speculative nature of estimates of the total number of HIV infected people is illustrated by New York City's recent "downward" modification of the number of HIV infected residents. In 1983 the City estimated the number to be 400,000, or about 1 in 18 residents. Health officials recently revised the number to 250,000 based on a "reduction" of the estimated population of homosexual men. *N.Y. Times*, July 20, 1988 at A1, col. 1. See also *N.Y. Times* July 22, 1988 at B4, col. 2 for an article describing the difficulties of making accurate estimates of the scope of HIV infection.

¹³ *AMA AIDS Report*, *supra*, note 11, at 2097.

¹⁴ The figures are not formally published, but have been reported in the newspapers. *N.Y. Times*, July 14, 1988 at B9 col. 4. Recently, researchers at the Centers For Disease Control issued a report projecting that ninety-nine percent of HIV infected people will eventually contact ARC or AIDS. This projection is based on a mathematical model drawn from a sample of gay men in San Francisco. Not all medical experts agree with this figure but, as stated by New York City Health Commissioner Dr. Steven Joseph: "The 99 percent projection reinforces all our pessimism both for individuals and the drain on resources. I don't know anyone in the field who does not agree that the overwhelming percentage of infected people will have serious if not severe symptomatology, in the high 80's, 90's - as close to universal as you can get in medicine." *Id.*

¹⁵ *N.Y. Times*, July 20, 1988, at A1, col. 1. See generally, Weinberg & Murray, *Coping With AIDS, The Special Problems of New York City*, 317 NEW ENG. J. MED 1469, 1470 (1987).

¹⁶ *N.Y. Times*, July 14, 1988, at B9, col. 1-3.

¹⁷ Weinberg & Murray, *supra* note 15, at 1470.

¹⁸ *AIDS Update*, *supra* note 6, at 7-8.

¹⁹ See *AMA AIDS Report*, *supra* note 11, at 258 J. A.M.A. 2100 ("The transmission of the AIDS virus does not occur through casual contacts"); Fischl, Dickinson, Scott, Klimas, Fletcher & Parks, *Evaluation of Heterosexual Partners, Children, and Household Contacts of Adults with AIDS*, 257 J. A.M.A. 640, 644 (1987)(detailed study of households and families with an adult AIDS patient shows that HIV virus "is not spread through close contact other than intimate sexual or blood exposures"). Courts that have allowed HIV infected children to attend school with their peers have made identical findings. See *Ray v. School Dist.*, 666 F. Supp. 1524, 1530-31 (M.D. Fla. 1987); *Thomas v. Atascadero Unified School Dist.*, 662 F. Supp. 376, 380 (C.D. Cal. 1986); *District 27 Community School Bd. v. Board of Educ.*, 130 Misc.2d 398, 403-08, 502 N.Y.S.2d 325, 330-32 (Sup. Ct. 1986).

Centers for Disease Control: *Revision of the Case Definition of Acquired Immunodeficiency Syndrome for National Reporting -United States*, 36 MORBIDITY & MORTALITY WEEKLY REP. 15 (1987).

¹⁰ Beckett, Summergard & Mansreck *Symptomatic HIV Infection of the CNS in a Patient*

regarding household hygiene. A total of 199 of these household contacts have been studied. Ninety percent of these contacts had shared the bathroom and kitchen. 50% had drunk from the same glass or eaten from the same dish before it had been washed. 30% to 40% had slept in the same bed (mostly children sleeping with their parents) and bathed with the patient. 10% to 15% used items that might draw blood such as razors, toothbrushes, or nail clippers. 83% kissed on the cheek and 17% kissed on the lips. That none of these 199 nonsexual household members is seropositive is strong evidence against close personal contact short of sexual relations transmitting HIV.²⁰

Matrimonial Law and AIDS

A. Grounds for divorce.

New York is a fault divorce state which also permits divorce by mutual consent. Fault need not be established if the parties separate for a year or more pursuant to a written separation agreement.²¹ Absent such agreement, to obtain a judgement of separation leading to divorce,²² or a divorce, a spouse must establish "marital fault."²³

Because the HIV virus is sexually transmitted or transmitted through the sharing of contaminated needles by drug addicts, it is easy to create arguments that the infected spouse is "at fault" for the divorce. Vital public policy to control the spread of AIDS, however, outweighs permitting a spouse to use evidence of HIV infection as proof of marital fault in a divorce action. Public health strategy seeks to limit the spread of the HIV virus by encouraging voluntary testing, disclosure of infection to sexual partners, and abstinence from high risk behavior. This strategy is implemented by assuring AIDS victims of confidentiality and non-discrimination.²⁴

A further policy aim is to encourage a divorcing family with an AIDS parent/spouse to work together. The spouses and their children face the monumental tasks of coping with the emotional and financial implications of simultaneous death and divorce.

Retrospective fault recrimination destroys whatever modicum of cooperation might otherwise be possible.²⁵ Strong indications that the courts disfavor fault based arguments in AIDS cases will encourage lawyers to temper the level of acrimony.²⁶

1. Adultery.

Adultery, one of the grounds of marital fault, is "the commission of an act of sexual or deviate sexual intercourse, voluntarily performed by the defendant, with a person other than the plaintiff after the marriage of plaintiff and defendant."²⁷

Assume that the plaintiff in a divorce action has a seronegative and the defendant a seropositive test for the HIV virus. Plaintiff seeks to introduce the defendant's test results into evidence, arguing that it is proof of adultery. The court might believe that the blood test alone (assuming its accuracy)²⁸ does not conclusively establish that the defendant has committed adultery, since it is possible that the virus was transmitted through needle sharing or blood transfusion. Nor does a seropositive blood test establish the time of transmission and any act of sexual intercourse that may be related to it. However, since the most common transmission method is through sexual intercourse, counsel might argue that seropositivity has some probative value on the adultery claim.

We believe, however, that whatever probative value the blood test result may have, is far outweighed by its prejudicial effect on both public health strategy and on the parties future.

Admission of the blood test result into evidence will create a fear that the infected spouse will be publicly revealed to be HIV positive and make it less likely that high risk groups will cooperate with voluntary testing.²⁹ There is a high risk of discrimination if employers, coworkers and friends know of a positive test result. Moreover, there is also a high risk that the estranged

²⁰ *AIDS Update*, *supra* note 6, at 8.

²¹ N.Y. DOM. REL. LAW § 170(5)-(6) (McKinney 1988)

²² N.Y. DOM. REL. LAW § 200 (McKinney 1988)

²³ N.Y. DOM. REL. LAW § 170(1)-(6) (McKinney 1988)

²⁴ E.g., *Draft Report of the Chairman of the President's Commission on the Human Immunodeficiency Virus Epidemic*, excerpts reprinted in the *N.Y. Times*, June 3, 1988 at 30, col. 4 [hereinafter cited as *President's AIDS Commission Report*]; *AMA AIDS Report*, *supra* note 11, at 2101-02; NEW YORK STATE DEPT OF HEALTH, A PHYSICIAN'S GUIDE TO AIDS: ISSUES IN THE MEDICAL OFFICE 5 (1988). New York has enacted landmark legislation, effective February 1, 1989, regulating confidentiality of HIV testing. The bill's statement of legislative intent states: "The legislature recognizes that maximum confidentiality protection for information related to human immune deficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) is an essential public health measure" N.Y. SEN. B 9265A, § 1 (July 15, 1988) (signed by Governor Cuomo Sept. 1, 1988).

²⁵ See *McMahan v. McMahan*, 100 A.D.2d 826, 827, 474 N.Y.S.2d 974, 974-75 (1st Dep't 1984)(explaining reasons for rule disallowing pre-trial discovery on marital fault):

"[I]n most instances, other than to exacerbate an already frequently acrimonious relationship, no purpose would be served in allowing discovery of the various charge and countercharge of misconduct which an estranged husband and wife engage in hurling at each other. Whatever possibility there might exist for the couple involved in this litigation to be able to deal courteously with each other in the future, if only for the sake of their children would be rendered even more unlikely by further exploration into specific acts of wrongdoing."

²⁶ See Mnookin & Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L. J. 950 (1979)(discussing the impact of substantive and procedural rules on negotiation of divorce settlements).

²⁷ N.Y. DOM. REL. LAW § 170(4)(McKinney 1988)

²⁸ See *supra* at note 7 and accompanying text.

²⁹ E.g., *President's AIDS Commission Report*, *supra* note 24; *AMA AIDS Report*, *supra* note 11, at 2098; *Conference Health Experts Rule Out Mandatory Testing*, 2 AIDS POL'Y & LAW No. 4 (March 11, 1987)(reporting consensus results of national conference convened by federal public health officials). See *South Florida Blood Service, Inc. v. Rasmussen*, 467 So. 2d 798, 802 (Fla. Dist. Ct. App., 1985)(denying disclosure of names of blood bank donors to plaintiff who alleged the transmission of the HIV virus through a blood transfusion)("AIDS is the modern day equivalent of leprosy. AIDS, or a mere suspicion of AIDS, can lead to discrimination in employment, education, housing and even medical treatment").

spouse or counsel will abusively misuse the information.

A divorcing party, furthermore, is entitled to a jury trial on marital fault.³⁰ HIV infection is sometimes confused with moral retribution for homosexuality, "deviate" sexual practices and drug addiction. Evidence that a divorce defendant is seropositive might induce a jury to "convict" him of adultery even though he acquired the virus "innocently" through needle sharing or blood transfusion.

Finally, admission of the blood test results will only exacerbate the deteriorating relationship between estranged spouses, making planning for the future on a cooperative basis almost impossible.

The plaintiff should be required to prove adultery by more traditional means (e.g. hiring a private detective) which are less likely to offend the emerging public policy of non-discrimination against AIDS carriers.

2. Cruel and inhuman treatment.

"Cruel and inhuman treatment" of the plaintiff by the defendant is also marital fault. The statute defines the term as "conduct of the defendant...[that] so endangers the physical or mental well-being of the plaintiff as renders it unsafe or improper to cohabit with the defendant."³¹

Again, assume that the defendant has tested positive and the plaintiff negative, and the plaintiff offers the defendant's test results as proof of cruel and inhuman treatment.

The court should again reject the offer of proof. There is no danger that the defendant will transmit the HIV virus to the plaintiff through casual contact. It is not "unsafe or improper" to cohabit with an HIV infected person so long as the spouses abstain from high risk behavior.

The only circumstances we can conceive of that would justify receiving the evidence of the HIV positive test is when the plaintiff

establishes a *prima facie* case that the defendant intentionally or negligently transmitted the AIDS virus. Such conduct might be both a crime and tort.³² It could thus also be "cruel and inhuman treatment,"³³ and establish grounds for divorce.

The *prima facie* case requires a showing of more than a fear of possible infection.³⁴ To establish it the plaintiff must present a detailed medical affidavit confirming a seropositive HIV virus test and a personal affidavit that plaintiff engaged in no high risk behavior other than sexual relations with the "accused" spouse.

B. Economic issues.

Except for conduct that "shocks the conscience of the court," marital misconduct, such as adultery, is generally not relevant to property division at the time of divorce.³⁵ Our view is that the only conduct of an AIDS infected spouse that rises to the "shock the conscience" level is intentional or negligent transmission of the disease to family members through high risk behavior.³⁶

In the absence of such deliberate or negligent wrongdoing, AIDS should simply be treated as any other fatal, debilitating disease such as brain cancer. The problem,

³⁰ N.Y. DOM. REL. LAW § 173 (McKinney 1988)

³¹ N.Y. DOM. REL. LAW § 170 (1)(McKinney 1988)

³² In *Maraham v. Maraham*, 123 A.D.2d 165, 510 N.Y.S.2d 104 (1st Dep't 1986) the Appellate Division held that a wife can maintain a tort action against her husband for wrongful transmission of genital herpes on either fraud or negligence theories. In so holding the Court relied on N.Y. PUB. HEALTH LAW § 2307 (McKinney 1985) which provides:

"Any person who, knowing himself or herself to be infected with an infectious venereal disease, has sexual intercourse with another shall be guilty of a misdemeanor."

This statute has not yet been applied to transmission of the HIV virus. A strong argument can be made, however, that a person infected with the HIV virus who knowingly fails to warn their sexual partner has acted ir-

responsibly and should be subject to criminal and tort sanctions. See *AMA AIDS Report*, *supra* note 11, at 2103.

³³ "Cruel and inhuman treatment" is not necessarily limited to conduct which is either tortious or criminal, though doing so would give some clear definition to an otherwise amorphous concept. Judicial decisions attempt to distinguish between "serious misconduct" which qualifies and "mere incompatibility" which does not. *Brady v. Brady*, 64 N.Y.2d 339, 476 N.E.2d 290, 486 N.Y.S.2d 891 (1985); *Hessen v. Hessen*, 33 N.Y.2d 406, 308 N.E.2d 891, 353 N.Y.S.2d 421 (1974). The plaintiff must "generally show a course of conduct by the defendant spouse which is harmful to the physical or mental health of the plaintiff and makes cohabitation unsafe or improper." *Brady v. Brady*, 64 N.Y.2d 339, 343, 476 N.E.2d 290, 292, 486 N.Y.S.2d 891, 893 (1985). Intentional or negligent transmission of the HIV virus to an unknowing spouse would seem to qualify under this test. Indeed, there are some suggestions in the case law that the intent of the defendant in inflicting the "cruel and inhuman treatment" is not relevant. "[S]ection 170 of the Domestic Relations Law focuses exclusively upon the effect of the conduct complained of and makes no mention of its cause." *Pajak v. Pajak*, 56 N.Y.2d 394, 397, 437 N.E.2d 1138, 1139, 452 N.Y.S.2d 381, 382 (1982)(holding that mental illness is not an affirmative defense to a complaint of cruel and inhuman treatment)(emphasis added).

³⁴ A spouse's unsupported fear that her estranged spouse may have infected her with the HIV virus is not sufficient for a tort action. The plaintiff must allege that she has tested seropositive for the HIV virus and that it has in fact been deliberately or negligently transmitted to her by her estranged spouse. *Doe v. Doe*, 136 Misc.2d 1015, 519 N.Y.S.2d 595 (Sup. Ct. 1987).

³⁵ E.g., *O'Brien v. O'Brien*, 66 N.Y.2d 576, 589, 489 N.E.2d 712, 719, 498 N.Y.S.2d 743, 750 (1985); *Blickstein v. Blickstein*, 99 A.D.2d 287, 472 N.Y.S.2d 110 (2d Dep't 1984). The Appellate Divisions are divided as to whether marital fault can play a role in determining maintenance and the scope of its influence. Compare *Stevens v. Stevens*, 107 A.D.2d 987, 484 N.Y.S.2d 708 (3d Dep't 1985) and *Nolan v. Nolan*, 107 A.D.2d 190, 486 N.Y.S.2d 415 (3d Dep't 1985) with *Wilson v. Wilson*, 101 A.D.2d 536, 476 N.Y.S.2d 120 (1st Dep't 1984), *appeal denied*, 67 N.Y.2d 667, 476 N.E.2d 1006 487 N.Y.S.2d 1027 (1985) and *Maloney v. Maloney*, 114 A.D.2d 440, 494 N.Y.S.2d 356 (2d Dep't 1985)

³⁶ In *Blickstein v. Blickstein*, 99 A.D.2d 287, 472 N.Y.S.2d 110 (2d Dep't 1984), the seminal New York case defining the role of marital fault in equitable distribution, the Court referred to a New Jersey case, *D'Arc v. D'Arc*, 164 N.J. Super. 226, 395 A.2d 1270 (1978), *aff'd*, 175 N.J. Super. 598, 421 A.2d 602 (1980), *cert. denied*, 451 U.S. 971 (1981) as an example of the degree of marital misconduct that could influence equitable distribution. The husband in *D'Arc* had offered \$50,000 for the murder of his wife during the pendency of divorce proceedings.

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however, is that the courts do not have a consistent legislative framework or philosophy to guide them in addressing this problem.

The Equitable Distribution Law ("EDL") is a comprehensive, integrated approach to the problems of economic distributions at divorce, which consist of three components: property division, maintenance and child support. EDL requires the court to consider thirteen factors in distributing marital property. They include "the probable future financial circumstances of each party,"³⁷ "any award of maintenance,"³⁸ and, most significantly for present purposes, "the age and health of both parties."³⁹ The EDL also requires the court to consider similar factors in setting maintenance.⁴⁰ A shorter group of factors (specifically excluding parental misconduct) determines child support payments, including "where practical and relevant, the standard of living the child would have enjoyed had the marriage not been dissolved."⁴¹

Thus some, but not all, of the factors determining property distribution, maintenance, and child support require the court to consider the "needs" of the parents and the children. Others require consideration of their respective contributions to the marriage and raising of children. Still others mandate the court to maintain the pre-separation standard of living. The statute does not set a priority on any one factor but requires consideration of all. The breadth and interrelationship of the factors to be considered allows the courts great flexibility to make economic determinations on a case by case basis.

Assume a defendant with AIDS in a divorce action is a parent with two children, who cannot work any longer because of his disease. Assume further that he does not have medical insurance coverage⁴² or life insurance.⁴³ The family's total resources are, however, too great for the defendant to qualify for

Medicaid.⁴⁴ Finally, assume, as is likely, that the resources of the family are finite and all members of the family will be unable to maintain their standard of living after the divorce.

There are, in essence, three possible, but inconsistent, theories that could govern the division of the family's assets:

1. most family wealth could be distributed to the non-AIDS spouse and the children, since the AIDS spouse is likely to die. Making the AIDS spouse a virtual pauper will shift the considerable costs of his medical care⁴⁵ to society by making him eligible for Medicaid. An unequal distribution of wealth to the healthy spouse and the children can be viewed as compensation for the irreparable loss of a future income provider.

2. alternatively, it could be argued that a disproportionate share of the family wealth should be distributed to the AIDS spouse because he needs extra resources to cover his medical costs and to prevent the indignity of pauperization by disease.

3. finally, a court could divide the family wealth without regard to whether one spouse had AIDS, on the theory that the decree represents a distribution of property rights that vest at the time that the divorce action is filed. The special future health needs of the AIDS spouse could be taken into account in setting maintenance payments.⁴⁶

None of these approaches is fully satisfactory.

Approach one, pauperization of the AIDS spouse, recognizes that the family will be losing a breadwinner and that the costs of medical care are likely to deplete the family's assets. It is, however, an ethically questionable attempt to shift the burden of medical care from the family to the state. The authorities regulating eligibility for Medicaid are likely to view the divorce distribution as a sham, and challenge it. Furthermore, the proposed pauperization of the AIDS

spouse deprives him of property to which he is entitled.

Approach two, which distributes a larger share of the resources to the AIDS spouse, has

³⁷ N.Y. DOM. REL. LAW § 236 (B)(5)(d)(8) (McKinney 1986)

³⁸ N.Y. DOM. REL. LAW § 236 (B)(5)(d)(5) (McKinney 1986)

³⁹ N.Y. DOM. REL. LAW § 236 (B)(5)(d)(2) (McKinney 1986)

⁴⁰ N.Y. DOM. REL. LAW § 236 (B)(6)(1)-(11) (McKinney 1986)

⁴¹ N.Y. DOM. REL. LAW § 236 (B)(7)(3) (McKinney 1986)

⁴² Enforcement of a New York State Insurance Department regulation which prohibits HIV testing for health insurance applicants was recently enjoined. The State has declared its intention to appeal. The regulation does not address HIV testing for life insurance applicants. *Health Ins. Ass'n. v. Corcoran*, ___ N.Y.S. ___ (Sup Ct 1988).

⁴³ There is a substantial debate on the impact of AIDS on the life insurance industry. The industry estimates that by the mid-1990's AIDS related deaths could constitute 10% of the life insurance industry's total claims. AMERICAN COUNCIL OF LIFE INS., *AIDS and LIFE INSURANCE* 4 (1987). Life insurance companies routinely test for AIDS in connection with new individual (not group) applications for insurance. *Id.* at 19. See *supra* note 42.

⁴⁴ People diagnosed as having AIDS are presumed to be disabled under the Supplemental Security Income program and thus become eligible for Medicaid. SSI "provides benefits to disabled persons with low incomes and few or no assets. In 36 states (where 90% of the reported AIDS cases have occurred) those eligible for Supplemental Security Income are automatically eligible for Medicaid. . . . Patients with AIDS not qualifying for Supplemental Security Income may still become eligible for Medicaid as medically needy individuals. . . ." Roper, *From the Health Care Financing Administration*, 258 J. A.M.A. 3489 (1987). Nationally, about 40% of AIDS patients are served under Medicaid, with the proportion rising to 65-70% in New York City. *Id.*

⁴⁵ Estimates of hospital costs over the lifetime of a patient with AIDS range from \$24,517 to \$147,000. Iglehart, *Health Policy Report: Financing The Struggle Against AIDS*, 317 NEW ENG. J. MED. 180, 182 (1987). A recent study by a government economist, which includes the cost of AZT, an AIDS treatment drug, estimates lifetime treatment costs at \$69,000. *N.Y. Times*, May 25, 1988, at B17, col. 7.

⁴⁶ See *Antis v. Antis*, 108 A.D.2d 884, 889, 485 N.Y.S.2d 770, 771 (2d Dep't 1985) (trial court maintenance award to wife raised in light of her mental illness and disfigurement due to burns); *Rodgers v. Rodgers*, 98 A.D.2d 386, 389, 470 N.Y.S.2d 401, 404 (2d Dep't 1983)(increased maintenance award to wife in poor health to assist her in maintaining standard of living and to make health insurance payments).

support in a needs theory. However, it depletes resources available to the children for the benefit of the spouse who will die in the very near future.

Approach three seems to us, at least on the surface, to be the fairest. It neither punishes nor provides extra compensation for the spouse with AIDS. Any special needs of the AIDS spouse or the non-AIDS spouse and the children are recognized through maintenance or child support payments, which look to the future and can be modified. However, the neutrality approach leaves less resources available for the prospectively economically disadvantaged non-AIDS spouse and the children.

The difficulty of choosing between these competing approaches enhances the virtue of the flexibility provided to the courts by EDL. Decisions about which approach, or combination thereof, to apply should be made on a case by case basis. It is unlikely that any case will be as "pure" as our hypothetical.

The fundamental variables affecting AIDS related divorce economic decision-making are the balance between family and government responsibility in paying for the costs of medical care for AIDS patients and replacing their lost earning power. The longer an AIDS spouse can work, the less the economic impact of the divorce on the family unit. This reasoning emphasizes the importance of prohibitions against employment discrimination against AIDS carriers.⁴⁷

If possible, medical insurance coverage for both the AIDS infected spouse as well as the family should be preserved or obtained as part of a divorce settlement.⁴⁸ Such coverage will help to reduce financial difficulties that the family faces.

If hard economic choices have to be made, the needs of the children should be paramount. Therefore, while economic distributions should not punish an AIDS spouse, they should favor preserving a major

percentage of the family wealth for the children's benefit.

C. Child custody.

The traditional custody standard of "best interests of the child" should govern cases where one parent is seropositive.⁴⁹ The risk of casual transmission of the HIV virus from parent to child is extremely remote. It is not, therefore, a sufficient basis for denying visitation or otherwise severing a functioning parent-child relationship. An infected parent, however, who deliberately or negligently engages in high risk behavior with his child (child abuse involving sexual contact or sharing dirty needles) should be denied unsupervised and possibly all visitation with the child.

Otherwise, the parent with AIDS should be treated as any other parent to the extent that their physical and mental condition permits.⁵⁰ If, however, a parent's physical and mental capacities and judgement subsequently become impaired, the court should modify a custody decree to redefine parental rights and responsibilities appropriately.⁵¹

D. Involuntary Blood Tests.

Suppose in our hypothetical case the plaintiff moves for an involuntary HIV blood test of the defendant on the grounds that she suspects that the defendant has engaged in high risk sexual practices, or associates with high risk groups. The plaintiff argues that a seropositive HIV blood test will be relevant evidence in the divorce action.

CPLR § 3121, on its face, seems to authorize involuntary blood testing in matrimonial matters.⁵² Two lines of precedent, however, limit the apparently broad authorization of the statute. First, two of the four Appellate Divisions do not allow pre-trial disclosure on subjects related to marital fault.⁵³ Second, despite the statutory authorization for involuntary medical examina-

⁴⁷ AIDS infection is generally considered a "handicap" under federal, state and local law, making employment discrimination based thereon generally unlawful. See Parmet, *AIDS and The Limits of Discrimination Law*, 15 J.L. MED. & HEALTH CARE 61, 1987; Leonard, *AIDS and Employment Law Revisited*, 14 HOFSTRA L. REV. 11 (1985).

⁴⁸ Empire Blue Cross and Blue Shield (New York City) does no medical underwriting of its individual applicants for basic insurance coverage. Acceptance of individual new applicants is not contingent upon their medical history or present medical condition. Even major medical insurance is available from Empire Blue Cross & Blue Shield without medical underwriting once a year, during an open enrollment period. The individual contracts, however, exclude payment of benefits for pre-existing conditions during the first eleven months of coverage. Ehrlich, *Paying for AIDS Care - The Insurance Issues* (July 25, 1987) (unpublished address by Associate General Counsel of Empire Blue Cross-Blue Shield to Forum for Health Care Planning) (on file with Professor Schepard).

Other Blue Cross/Blue Shield Groups as well as private carriers have varying policies as to medical underwriting, availability of coverage and exclusions of pre-existing conditions.

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), Pub. Law No. 99-272, 100 Stat 82 (1986), requires continuation of an employee's group health insurance plan (if requested and with the employee or dependent paying the premium therefor) for 18 months for terminated employees and for 36 months for (1) a spouse and dependents of deceased employees and (2) a divorced or legally separated spouse and dependents of covered employee. COBRA does not apply, however, to employers who have less than 20 employees, to governmental plans or to self-insured plans.

⁴⁹ N.Y. DOM. REL. LAW § 240(1) (McKinney 1986)

⁵⁰ See *Hatz v. Hatz*, 116 Misc.2d 490, 455 N.Y.S.2d 535 (N.Y. Fam. Ct. 1982), *aff'd*, 97 A.D.2d 629, 4468 N.Y.S.2d 943 (3d Dep't 1983) (court denies father's request to change custody of son after auto accident which left custodial mother a paraplegic). The landmark case nationally on the custody rights of handicapped parents is the California Supreme Court's decision in *In re Marriage of Carney*, 24 Cal.3d 725, 598 P.2d 36, 57 Cal. Rptr. 383 (1979).

⁵¹ *Friederwitzer v. Friederwitzer*, 55 N.Y.2d 89, 432 N.E.2d 765, 447 N.Y.S.2d 893 (1982).

⁵² See *Gosler v. Gosler*, 115 A.D.2d 695, 698, 496 N.Y.S.2d 521, 524 (2d Dep't 1985). Cf. *Boyles v. Boyles*, 119 Misc. 2d 16, 462 N.Y.S.2d 736 (N.Y. Fam. Ct. 1983) (allowing results of blood test into evidence in custody proceeding where paternity is questioned). The recently enacted bill (see *supra* note 24) specifically exempts HIV tests ordered under the authority of CPLR § 3121. N.Y. SEN.B 9265A, § 2781 (July 15, 1988).

⁵³ *Van Ess v. Van Ess*, 100 A.D.2d 848, 474 N.Y.S.2d 90, 91 (2d Dep't 1984). See *Corsel v. Corsel*, 848, 133 A.D.2d 604, 519 N.Y.S.2d 710, (2d Dep't 1987); *McMahan v.*

tions, the courts, based on the potential for abuse, have often issued protective orders.⁵⁴

For public policy reasons previously discussed, concern about abuse of involuntary medical examinations in divorce actions are especially salient when an AIDS issue is raised. The probative value of the information that may be gained on issues of grounds, economic distribution and custody from a seropositive blood test is outweighed by its prejudicial effect.

Procedure in AIDS Divorce Cases.

A. Resources for the AIDS-Afflicted Divorcing Family.

The divorcing family, especially the children, face the two potentially overwhelming tragedies of divorce and death virtually simultaneously. The family is in need of emotional and financial counseling. All family members should be educated about how to cope with the disease medically, financially and emotionally.

B. The Special Responsibilities of Counsel.

Lawyers in AIDS related divorces bear a special responsibility to reduce acrimony, facilitate communication and planning for the future, and protect the welfare of the children.

The spouse who has not revealed his infection to the other spouse should strongly be encouraged to do so by counsel. If the client refuses, the lawyer faces an ethical dilemma and potential liability in deciding whether to reveal the infection to the other spouse.⁵⁵

Both counsel should discourage vindictiveness and hysteria. They should recognize the fear that AIDS inspires but help their clients place it in a realistic context. The lawyer should also help a client carefully consider whether divorce is, in fact, the most appropriate course of action. Both counsel should also encourage realistic financial planning. Insurance is an area of special con-

cern, as is estate planning. Above all, counsel should encourage the clients to keep open the spousal lines of communication.

The Responsibilities of the Courts

Because of the heightened need for expeditious resolution and cooperative planning in an AIDS divorce, the court should strongly urge the parties to mediate.⁵⁶

If mediation efforts fail, the court should make full use of all procedures to facilitate expeditious, informed decision making including appointment of neutral custody experts,⁵⁷ financial appraisers,⁵⁸ and a guardian ad litem for the children.

Courts with AIDS-related cases on their divorce dockets have a special responsibility to become familiar with and to foster use of all available community resources for the parties' benefit.

McMahan, 100 A.D.2d 826, 474 N.Y.S.2d 974 (1st Dep't 1984). In the Third Appellate Department restrictions on pre-trial disclosure concerning matrimonial fault are "left to individual protective orders to prevent abuse, rather than embodied in a blanket prohibition." *Nigro v. Nigro*, 121 A.D.2d 833, 834, 504 N.Y.S.2d 264, 265 (3d Dep't 1986). See *Semon v. Sardis*, 125 A.D.2d 882, 883, 510 N.Y.S.2d 236 (3d Dep't 1986).

⁵⁴ The leading case is *Wegman v. Wegman*, 37 N.Y.2d 940, 343 N.E.2d 288, 380 N.Y.S.2d 649 (1975), in which the Court of Appeals said:

"CPLR 3121 does not prohibit [medical] examinations in matrimonial proceedings, and although we recognize the potential for abuse in these cases, the court's broad discretionary power to grant a protective order to prevent unreasonable annoyance, expense, embarrassment, disadvantage, or any other prejudice to any person or the courts (CPLR 3103) should provide adequate safeguards." (emphasis added).

Other courts, following *Wegman*, have recognized the potential for harassment and abuse in § 3121 examinations in matrimonial actions and have carefully limited the conditions under which they will allow them. E.g. *Lohmiller v. Lohmiller*, 118 A.D.2d 760, 761, 500 N.Y.S.2d 151, 152 (2d Dep't 1986) (§3121 "applies to matrimonial actions, but the potential for abuse is so great in these actions that the court is given broad discretionary power to grant a protective order. . ."); *Rosenblitt v. Rosenblitt*, 107 A.D.2d 292, 294, 486 N.Y.S.2d 741, 743 (2d Dep't 1985).

⁵⁵ Counsel faces a serious ethical dilemma if the client refuses to reveal his infection to his spouse despite counsel's urgings. The client's conditions would be a protected confidence. On the other hand, under the Model Rules of Professional Conduct, a lawyer has discretion to reveal client confidences "to the extent that the lawyer reasonably believes necessary. . . to prevent the client from committing a criminal act that the lawyer believes is likely to result in imminent death or substantial bodily harm." MODEL RULES OF PROFESSIONAL CONDUCT RULE 1.6(b)(1). (1983) (not adopted in N.Y.) As discussed *supra*, intentional transmission of the AIDS virus to an unsuspecting spouse can be both a crime and a tort; infection with the HIV virus may result in death, although perhaps not "imminent death". See also MODEL CODE OF PROFESSIONAL RESPONSIBILITY DR 4-101(c)(4) (1980) (allowing, but not requiring, a lawyer to disclose "intention of client to commit a crime and information necessary to prevent the crime" despite client confidences). A lawyer might also be subject to liability to the deliberately infected spouse under a *Tarasoff* theory if he fails to disclose his client's infection. See *Tarasoff v. Regents*, 17 Cal.3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976). On the other hand, the lawyer who discloses the client's confidences will discourage other AIDS carriers from the kind of candid client communication informed legal advice and representation requires; he might be liable to the client for breach of confidence if he discloses HIV infection against the client's wishes. This complicated, conflicted subject deserves study by the Bar.

The American Medical Association has recently resolved this conflict in favor of protection of potential AIDS victims. Its House of Delegates adopted a policy statement requiring physicians to notify and counsel endangered third parties if patient persuasion fails and notified public health authorities take no action to protect the third party. The AMA resolution also calls for legislation immunizing physician from liability for disclosure. The President of the AMA called the resolution a "landmark in the history of medical ethics." *N.Y. Times*, July 1, 1988 at A1, col. 3 & All col. 1. The recently enacted legislation allows physician disclosure after a patient's informed consent to HIV testing. See *supra* note 24.

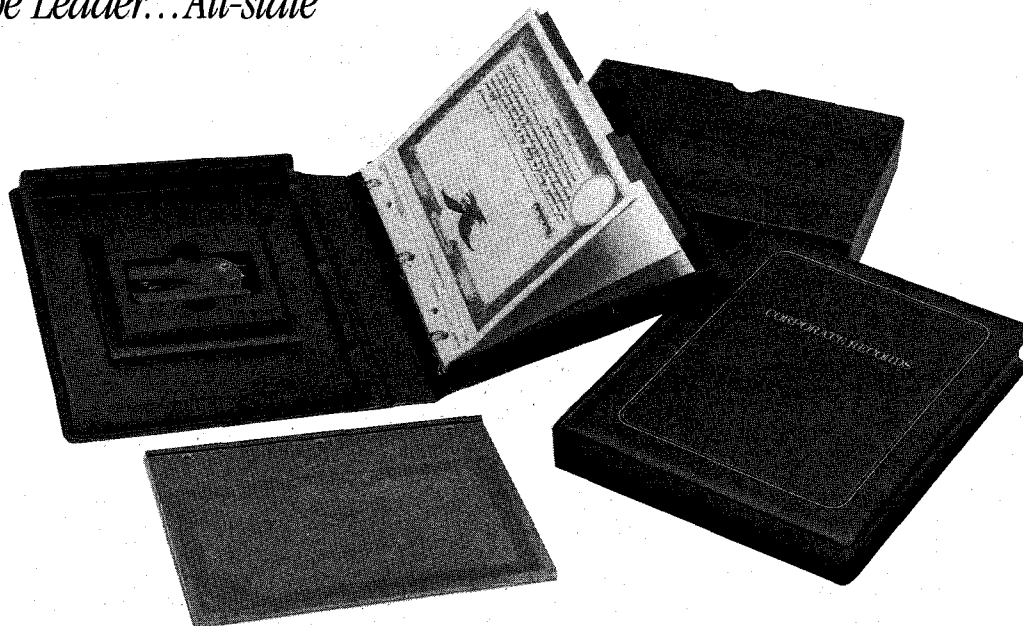
⁵⁶ See generally, *Recommendations of the Law Revision Commission to the 1985 Legislature: Relating to the Child Custody Decision-Making Process*, 19 COLUM. J.L. & SOC. PROBS. 105 (1985) (describing the advantages of mediation and alternate dispute resolution in child custody disputes).

⁵⁷ *Kessler v. Kessler*, 10 N.Y.2d 445, 180 N.E.2d 402, 225 N.Y.S.2d 1 (1962) is the basic case in New York authorizing the appointment of neutral experts to facilitate custody determinations.

⁵⁸ See *Zirinsky v. Zirinsky*, 138 Misc.2d 775, 525 N.Y.S.2d 464 (Sup. Ct. 1987) *aff'd*, 529 N.Y.S. 2d 298 (1st Dep't 1988) (authorizing appointment of independent appraiser).

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