South Carolina Law Review

Volume 7 | Issue 1 Article 14

Fall 1954

Insurance Decisions during the Past Year

Joseph L. Nettles

Follow this and additional works at: https://scholarcommons.sc.edu/sclr

Part of the Law Commons

Recommended Citation

Nettles, Joseph L. (1954) "Insurance Decisions during the Past Year," *South Carolina Law Review*: Vol. 7 : Iss. 1 , Article 14.
Available at: https://scholarcommons.sc.edu/sclr/vol7/iss1/14

This Article is brought to you by the Law Reviews and Journals at Scholar Commons. It has been accepted for inclusion in South Carolina Law Review by an authorized editor of Scholar Commons. For more information, please contact digres@mailbox.sc.edu.

INSURANCE DECISIONS DURING THE PAST YEAR

JOSEPH L. NETTLES*

Fraudulent Breach of Contract

Two cases during the year involved "fraudulent breach" of the insurance contract. While it has long been declared that breach of contract accompanied by "fraudulent intent" is not sufficient to warrant an award of punitive damages, but that there must be a "fraudulent act" accompanying the breach, the distinguishing characteristics of such "fraudulent" act have been more hinted at than delineated. In the two cases decided by the Court during the year upon this point, little appears which could be taken as rationale: The Court holds only that the evidence is sufficient to raise the inference that a fraudulent breach had occurred.

In *Yarborough v. Bankers Life & Casualty Company*,[1] the insurer notified the insured that it would not renew his monthly health and accident policies unless he consented to a rider to the policies with certain exclusions. The purpose of the letter apparently was to reject the premium due February 20, 1951, and tendered on February 26, 1951; but the letter was not written until March 22, by which time another premium would have been due. Plaintiff immediately replied, electing to rescind, and requesting the refund of the "last $15.85 payment." Apparently only $7.50 had actually been paid on February 26, but the insurer made the requested refund. However, this refund was not made until May 1951, and meanwhile the plaintiff had made two other payments of $15.85. Demand was made for the return of the two additional payments. The company denied knowledge of any further payments, but later refunded one. Finally, suit was brought and a verdict for $7.50 actual damages and $1,000.00 punitive damages was returned. The Supreme Court affirmed the lower court. The Court seemed much impressed that the defendant offered no evidence to explain the incongruities. It held that while some of the separate acts of the insurer might not evidence bad faith, all the circumstances, considered to-

*Attorney at Law, Columbia, S. C.

1. 81 S.E. 2d 359 (S.C. 1954).

gether, warranted an inference of fraudulent acts accompanying a breach of contract.

Simmons v. Service Life and Health Insurance Company[2] likewise was a case of unexplained questionable acts, though the defendant's failure to present evidence was apparently not voluntary but the result of the trial court's directing a verdict for the plaintiff of its own motion. Plaintiff was apparently as illiterate as he was uninsurable when the agent issued the policy to him. Premiums were collected which aggregated considerably more than the death benefit; these premiums had always been picked up at the plaintiff's home by the insurer's agent. But the agent ceased to call, and the insurer thereupon lapsed the policy for non-payment of premium. Suit was brought for fraudulent breach in the cancellation. The insurer moved for a nonsuit; this motion was denied and the trial court of its own motion directed a verdict in favor of the plaintiff for $150.00 (the death benefit payable under the policy) actual damages. Plaintiff appealed, contending that the evidence presented a jury issue as to fraudulent breach. The Supreme Court concurred. Here again, the Court does not go into discussion as to what is a "fraudulent act" but simply holds that plaintiff's evidence, standing alone (unexplained?), was sufficient on motion for nonsuit.

Contingent Beneficiary's Suit for Cancellation

Babb v. Paul Revere Life Insurance Co.[3] seems to represent a departure. The plaintiff's husband had a policy with the defendant providing for disability benefits and a $7,500.00 accidental death benefit; the plaintiff was the beneficiary, but the right was reserved under the policy to change the beneficiary. In 1948, the insurer paid $638.00 to plaintiff's husband for surrender of the policy. Plaintiff's husband died in 1951; plaintiff demanded the death benefit, was refused, and brought suit. Although originally brought upon three counts, the case narrowed down to the question whether the plaintiff, as beneficiary, could bring an action in tort for fraud practiced upon her husband to secure the cancellation of the policy in which she was named beneficiary.

The Court held that she was so entitled. In so doing, it

2. 223 S.C. 407, 76 S.E. 2d 288 (1953).
3. 224 S.C. 1, 77 S.E. 2d 267 (1953).

would seem that the Court effectively overruled the case of *Shuler v. Equitable Life Assurance Society,*[4] though it rather sought to distinguish it. The *Shuler* case was a suit by the beneficiary for wrongful cancellation of her husband's policy, and was brought while her husband, the insured, was still alive. The right was reserved to change the beneficiary and the Court held that the action therefore would not lie. The majority of the Court in the *Babb* case construed the *Shuler* case as holding only that the action by the beneficiary was premature until the insured had died without changing the beneficiary, thereby inferring that the action might be maintained after the death. Mr. Justice Oxner dissented, pointing out the anomaly of holding that no right of action arose in the plaintiff when the alleged fraud was committed, but did arise several years later when her husband died, at which time the policy had by hypothesis been cancelled for some years.

It is difficult to see how this case and the language of the *Shuler* case can live in the same state. The use of the word "premature" in the *Shuler* case is ambiguous, but there is no ambiguity in the flat statement there made that the interest of the beneficiary was too hypothetical to be made the ground of damages: "It is a mere expectancy of unascertainable value, and hence cannot be made the basis of a claim for damages." It would seem that the real decision in the *Shuler* case is that although the cancellation of the policy in which the insured was a contingent beneficiary was a wrong as to such rights as the plaintiff had, nevertheless it was *damnum absque injuria* and hence gave rise to no action.

Total Disability

Adair v. New York Life Ins. Co.,[5] decided during the year, was in line with the Court's previous decisions in similar circumstances. Adair was issued a policy by defendant in 1935 when he was then about twenty-two years of age and a clerk in a drug store. In 1940, he changed his job to selling ladies' hosiery on commission basis over a large territory which he covered by automobile. He began having trouble with his left foot in 1942, which handicapped his travelling. In 1944 the foot was amputated below the knee and he used an artificial

4. 184 S.C. 485, 193 S.E. 46 (1937).
5. 224 S.C. 344, 79 S.E. 2d 316 (1953).

leg. In 1949, he changed to a job as automobile salesman. Finally, in 1951, plaintiff and another formed a corporate automobile agency. Adair was one-third owner and was named president and secretary. His salary in 1951 was $4,200.00 a year; his commissions in 1942 were $4,800.00 a year. On suit for compensation under the total disability clause of the policy, the insurer claimed that the plaintiff was able to carry out the new employment, which reasonably approached his former employment prior to the disability and hence was not totally disabled. The insured contended that he was unable to do everything usually done by one in his present occupation.

On defendant's appeal from denial of a directed verdict, the Court gave judgment for the defendant, holding that as a matter of law the insured was not totally disabled. The Court's decision was to be expected in view of *Moyle v. Mutual Life Insurance Company of New York*,[6] as the cases were almost on all fours. Plaintiff made the rather interesting point that $4,200.00 in the year 1951-52 was not comparable to $4,800.00 in 1942, but the Court held that the comparison should rather be what the plaintiff earned in 1951-52 as against what he would have earned in his former occupation in the same period —as to which there was no evidence.

Vickery v. American National Insurance Company,[7] decided in February 1954, seems to be the first case which has come before the Court upon a policy in which the criterion of benefits is whether or not the insured is "continuously confined within doors." However, the Court does not construe this provision of the policy, nor is the evidence recounted. The holding simply is that it was improper for the trial court to direct a verdict in favor of the plaintiff when there was a conflict in the evidence.

Fire Insurance

Only two of the cases decided during the year involved fire insurance. *Hurst v. Donegal & Conoy Mutual Fire Insurance Company*[8] involved the clause in the standard policy suspending coverage while the property is vacant or unoccupied beyond a period of sixty consecutive days. Prior to December

6. 201 S.C. 146, 21 S.E. 2d 561 (1942).
7. 224 S.C. 549, 80 S.E. 2d 233 (1954).
8. 224 S.C. 188, 78 S.E. 2d 189 (1953).

12, 1950, the plaintiff applied for insurance on a farm tenant house; the agent inspected the house, which was vacant then, and prepared a policy dated December 12. Before delivering the policy, the agent required the plaintiff to obtain some instrument from his father, the owner of the property, showing that the plaintiff had an insurable interest. This was done about January 15, 1951, whereupon the premium was paid and the policy delivered by the agent to the plaintiff. On February 16 the house was destroyed, having remained vacant until that time. The lower court held that the parties did not intend the policy to become effective until the condition precedent (furnishing proof of insurable interest) had been complied with; that this was done and the policy delivered on January 15; and that since the premises had not been unoccupied for sixty days from that date at the time of its destruction the exclusion was inapplicable.

Although the facts of the case would seem to fall within the majority rule that issuance of a policy with knowledge that the premises are vacant waives the vacancy exception in the policy insofar as the existing vacancy is concerned,[9] the Court did not base its decision upon that ground. Instead, it construed the exclusion as requiring sixty days of unoccupancy while the policy was in force without regard to previous condition. It is one of the few decisions upon this point.[10]

The policy was held never to have become effective in *Hinson v. Catawba Insurance Company*.[11] There, the plaintiff wrote from his home in Laurens to an insurance agent in Charleston, wishing to insure his house at "507 W. Ashley Avenue." A policy was issued, describing the location of the risk as "507 W. Ashley Avenue, Charleston, S. C." Plaintiff did not read the policy. The house was in fact located on Folly Beach, where the premium rate was about three times as high as for the City of Charleston. The Supreme Court held that the lower court properly directed a verdict in favor of the insurer, since the minds of the parties had not met as to the risk.

It would seem that there unquestionably was no real contract here, since the risk was never correctly identified. Probably the most significant thing about the opinion is the prop-

---

9. See note, 96 A.L.R. 1259 (1935).
10. 4 APPLEMAN, INSURANCE LAW AND PRACTICE, § 2844 (1941).
11. 224 S.C. 227, 78 S.E. 2d 235 (1953).

osition that a correct description of the risk is as much the responsibility of the assured as the insurer.

Automobile Insurance

Padgett v. Calvert Fire Ins. Co.[12] is concerned with the extent of the insurer's obligation under an automobile collision policy. There was evidence that the insured car suffered a hole in the oil pan when, unknown to the driver, it collided with some object in the road. The oil leaked from the engine, which became extensively damaged from operation without oil. Plaintiff undertook to have repairs made. Later, he made claim on the insurer. The Court held that the plaintiff was entitled to have his car placed in as good condition as before the collision damage, even if it required a new engine; however, he was limited to this amount less his deductible. He could not recover the original cost of repairs, together with a further sum claimed for depreciation in value on account of defective performance. The Court assumed, without actually deciding, that the collision policy would cover damage to the engine by operation without oil, where a hole drained the oil out of the engine. This is one of the few cases in the country where this particular point was involved.

Marine Insurance

Land v. Franklin National Ins. Co.[13] is one of the few South Carolina cases of recent years involving the marine insurance contract. Plaintiff operated a boat on Lake Murray. The boat sank in quiet waters. The only explanation offered for the sinking was that of the plaintiff, that the seams had opened as a result of high speed operation, and this was not disputed. The lower court held that sinking came within the coverage of the policy as by "peril of the sea" or by "latent defect." The Supreme Court held that it was not due to latent defect; it then held that the evidence warranted a finding that the sinking was by a peril of the sea.

The writer confesses to bias, in view of his having been the losing attorney. Nevertheless, the opinion does seem open to the criticism that its effect is to make any sinking a peril of the sea, something which several hundred years of marine insurance decisions have consistently denied. While there are

12. 223 S.C. 533, 77 S.E. 2d 219 (1953).
13. 225 S.C. 33, 80 S.E. 2d 420 (1954).

decisions that the unexplained sinking of a seaworthy craft will raise an inference that the sinking was caused by some peril of the sea, the undisputed explanation here was that of general hull weakness. This was not an unexplained sinking and does not fall within that rule.