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# Insurance

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*Fraudulent Breach of Contracts Accompanied by a Fraudulent Act*

During the period of this survey, there were seven cases decided by the Supreme Court involving actions for the recovery of both actual and punitive damages resulting from the breach of insurance contracts accompanied by a fraudulent act. In actions of this nature a major problem has been the determination of what constitutes a fraudulent act. These seven cases, however, clearly define one such act, *i. e., the refusal of the company to collect premiums with the intention of cancelling out policies.*[1] Other than this, these seven cases have little in common and will be separately reviewed.

*Hutcherson v. Pilgrim Health & Life Insurance Company*[2] was defended on the grounds that the payments on the premium were four weeks in arrears and that, by its terms, the policy had lapsed. The trial court was affirmed in holding that whether or not the insurer's departure from its established custom of collecting premiums at insured's home resulted in waiver of this provision presented issue for the jury. The insurer further contended that its offer in its answer to remit any premiums now due or in arrears and to reinstate the policy eliminated any damage the plaintiff might have suffered by reason of the cancellation. The trial Judge was held to be correct in submitting this issue to the jury.

*Davis v. Bankers Life and Casualty Company*[3] held that an action could be maintained for punitive in addition to actual damages where the insurer had sent a notice to the insured stating that his policy had lapsed, when in fact the premium had been paid, notwithstanding the insurer's contention that the notice had been sent in error and had no effect on the validity of the policy. In addition to this holding, this case is important in that it reiterates the courses an insured may pursue where his insurer wrongfully cancels, repudiates, or terminates the contract of insurance, *viz:* 1 — He may elect to treat the policy as still in force, and let the test of the validity of the cancellation or repudiation await until the policy is payable and is sued upon; 2 — He may sue in equity to set aside the cancellation,

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1. Harris v. United Insurance Company, 227 S.C. 593, 88 S.E. 2d 672 (1955).
2. 227 S.C. 239, 87 S.E. 2d 685 (1955).
3. 227 S.C. 587, 88 S.E. 2d 658 (1955).

and to have the policy declared to be valid and in force; or 3 — He may maintain an action at law to recover damages for the wrongful cancellation or repudiation.

*Harris v. United Insurance Company*[4] held that the trial Judge was correct in directing a verdict for the defendant as to punitive damages where there was no showing that the breach was accompanied by a fraudulent act. The Supreme Court held there was no showing of illiteracy or over-reaching, and *there was no evidence from which it might be reasonably concluded that the company refused to collect the premiums with the intention of cancelling out the policies.* This case also held that the trial Judge was correct in overruling the defendant's motion for a directed verdict as to actual damages where the policy provided that the insured would be notified in writing if the insurer decided to discontinue collection of premiums at insured's home and where the insured had been informed of the company's position on the date of the last premium payment but such was not done in writing as required under the policy.

*Patterson v. Capital Health Insurance Company*[5] held that the complaint stated no facts entitling plaintiff to recover punitive damages and that, therefore, the trial court was correct in granting defendant's motion to strike from the complaint all allegations pertaining to the recovery of punitive damages.

*Goodman v. George Washington Life Insurance Co.*[6] held the evidence to be insufficient to sustain verdict for insured in action for alleged fraud and deceit where the insured testified that defendant's agent had said the policy would be in full force and effect after fifteen days, and the policy actually required six months waiting period before any benefits for surgery would be applicable. Plaintiff was not damaged as a result of this misunderstanding because his operation came more than six months after the policy was issued.

*Blackman v. The Independent Life and Accident Insurance Company*[7] was an action by the beneficiary of a life insurance policy who sought both actual and punitive damages for the alleged breach of the insurance contract accompanied by a fraudulent act. The complaint alleged that the policy was in full force at the time of the insured's death, but that the insurer refused to pay the plaintiff the amount due and that insurer represented that the policy was no good

4. 227 S.C. 593, 88 S.E. 2d 672 (1955).
5. 228 S.C. 297, 89 S.E. 2d 723 (1955).
6. 228 S.C. 306, 89 S.E. 2d 753 (1955).
7. 229 S.C. 54, 91 S.E. 2d 709 (1956).

and had lapsed. The trial Judge held that this complaint stated a cause of action ex contractu and granted defendant's motion to strike all allegations in the complaint sounding in tort.

On appeal, this was affirmed, the court holding that where a complaint states a cause of action in contract, the nature of the action as ex contractu is not affected by allegations sounding in tort and such allegations may be disregarded as surplusage. The court also had the following to say:

> Although there is a broad distinction between causes of action arising ex contractu and those arising ex delicto, the dividing line between breaches of contract and torts often lies in a twilight zone, where it is difficult to determine whether the case applied strictly to the one or to the other. There is no certain test by which the court can be guided in determining whether a particular action is ex delicto or ex contractu. The question must be determined solely from the pleadings with an eye as to what is the real nature of the grievance.

*Raines v. The Life Insurance Company of Virginia*[8] is a case that supports the rule, stated above, that where it clearly appears that an insurance company discontinues the collection of premiums with the intention of causing the policy to lapse, a verdict for punitive damages will not be disturbed. However, in this case the court held that the policy lapsed for non-payment of premiums and was not the result of the insurer's failure to collect the premiums.

### *Fire Policies*

*McSweeney v. Utica Fire Insurance Company of Oneida County, N. Y.*[9] involves an action on two fire insurance policies which was defended on the grounds "that the fire was brought about by the illegal acts of the plaintiff herself, acting through her agent or representative, to wit, arson." The court was held to have properly excluded the insured's evidence that she had been tried and acquitted of arson, the court saying that under the South Carolina rule, convictions and acquittal in criminal actions are not admissible in civil actions.

*Foster v. Canal Insurance Company*[10] was an action to recover the face amount of an automobile fire policy. The policy had been procured by a finance company as a lien holder on the automobile

8. 228 S.C. 601, 91 S.E. 2d 286 (1956).
9. 224 F. 2d 327 (1955).
10. 227 S.C. 322, 88 S.E. 2d 59 (1955).

involved and the insured had never seen the policy or a copy thereof. The policy contained a provision whereby no recovery could be had in cases where the loss occurred outside the fifty mile limitation area. The insured was an undertaker in the City of Gaffney, S. C., and the loss occurred in the State of Virginia.

The trial Judge refused to grant defendant's motion for nonsuit and the verdict was directed for the plaintiff. On appeal this was reversed and the court ordered judgment to be entered for the defendant, the court saying that the insured could not recover where the loss occurred outside the fifty mile limitation area even though the insured was not aware of the provision.

*Harwell v. Home Mutual Fire Insurance Company*[11] dealt with a provision in a policy which provided that, should a loss occur and the parties not be able to agree on the extent of damage caused thereby, the extent of damage should be determined by arbitration. The assured brought suit without resort to this provision and the insurance company requested that the provision be complied with. The court held that where such a provision is not made a condition precedent to an action on the policy, compliance therewith is not necessary, but where the policy forbids insured from bringing suit until after amount of loss has been submitted to arbitration, as in the instant case, compliance with such provision, if demanded by the insurer, is a condition precedent to an action on the policy, and consequently held the present action to have been brought prematurely.

### *Estoppel or Waiver*

*Matthews v. National Fidelity Insurance Company*[12] was a case in which the policy in question was issued contemporaneously with the insured's becoming a member of a club, and was the last in a series of five yearly insurance policies issued by the insurer on the life of the deceased. It appears that while the policy for the previous year was in force, the deceased filed a claim for benefits thereunder. This claim had not been paid when the policy expired and the new one, here in question, was issued. Later, the deceased's agent was notified that the policy had been cancelled because of non-payment of premiums. She then contacted the insurer and it was agreed that the past due premiums would be paid from the proceeds of the claim filed under the old policy. Thereafter, insurer issued its check marked payment in full and "in consideration of said payment the

11. 228 S.C. 594, 91 S.E. 2d 273 (1956).
12. 228 S.C. 124, 89 S.E. 2d 95 (1955).

policy is hereby reinstated". Thereafter, the deceased died and the beneficiary files this claim for death benefits, the insurer defends by asserting the lapse of the policy because of non-payment of premium. The court held the insurer to have waived this defense because of the wording on the check in payment of the first claim. Since the first policy had expired, it could not be reinstated and hence the wording was held to apply to the policy under which the beneficiary here claims.

*Pilot Life Insurance Company v. Pulliam Motor Company*[13] is an action by Pilot against the beneficiary of a policy insuring the life of R. C. Pulliam to cancel the policy on the grounds that Pulliam fraudulently answered some of the questions on his application for insurance. Pulliam had been examined by Dr. Spivey, Pilot's medical examiner, who was also Pulliam's personal physician, and the doctor submitted the entire medical history to Pilot.

After finding that Pulliam had not fraudulently answered the questions, the court went on to say that Pilot had waived their defense because the knowledge of its examiner, Dr. Spivey, was knowledge to the company, unless Dr. Spivey had fraudulently withheld information from Pilot, in which case his knowledge could not be imputed to Pilot. There was no contention that Dr. Spivey had withheld anything from Pilot. The court states the South Carolina rule that where it is sought to rescind and cancel a policy upon the grounds of fraud, the insurer must prove all the following five elements, to wit:

1. The statements complained of must be untrue.
2. Their falsity must have been known to the applicant.
3. They were material to the risk.
4. They were relied on by the insurer.
5. They were made with the intent to deceive and defraud the company.

*Raggio v. Woodmen of the World Life Insurance Society*[14] holds that Section 37-161 of the 1952 Code of Laws of South Carolina, providing that an insurance company, after two years from date of issuance of a policy of life insurance, is deemed to have waived right to dispute the truth of representations in application for insurance, is applicable as well to fraternal benefit associations, such as the defendant.

This ruling appears to be in violation of Section 37-857 providing

13. 229 F. 2d 912 (1956).
14. 228 S.C. 340, 90 S.E. 2d 212 (1955).

that fraternal benefit associations shall be governed by the provisions of that chapter and not by the general insurance laws, such as Section 37-161, unless express provision therefor is made.

The court, in effect, held that a review of the history of Section 37-161 and the cases concerning it disclosed that the legislature intended fraternal benefit societies to be included within its terms.

*Comprehensive Crime Policy*

The case of *American Mutual Liability Insurance Company v. Thomas & Howard Company of Columbia, South Carolina*[15] was the only case of significance pertaining to a crime policy. In this case the insured's employees had stolen over a period of time $17,000.00 worth of food stuffs. Insurer defends the action by contending that insured failed to keep a proper record of all property covered by the policy. The Court of Appeals held that their requirement was adequately met by the annual inventory together with the invoices covering sales and purchases, and although a perpetual inventory would facilitate the determination of the loss, such was not necessary to fulfill the requirements of the policy.

*Disability Benefits*

The case of *Mallinger v. New York Life Insurance Company*[16] was one of this type in which the insurer defended the action by alleging that the insured had assumed a gainful occupation. At the time the insured became disabled, he was engaged in the business of dismantling buildings, etc. This was in 1932. In 1950 he was given a job as a policeman and the insurer contends this warrants its discontinuance of payments for total disability. The trial Judge directed a verdict for the plaintiff and this was reversed on appeal, the Supreme Court holding that whether the insured was totally disabled from engaging in his former occupation, and whether insured's income as a policeman was comparable to earnings in his former occupation were for the jury.

*"Double Indemnity" Clause*

*Long v. Metropolitan Life Insurance Company*[17] was an action to recover under the "double indemnity" clause. The trial Judge directed a verdict for the defendant upon the ground that the only reasonable inference to be drawn from the testimony was that the insured had committed suicide. This was affirmed.

15. 228 F. 2d 550 (1955).
16. 227 S.C. 530, 88 S.E. 2d 578 (1955).
17. 228 S.C. 498, 90 S.E. 2d 915 (1956).

The court held that the presumption against suicide was not evidence and does not of itself require submission of the case to the jury when the only reasonable inference is that the insured took his own life and that the beneficiary has the burden of proving death by accidental means in an action on the double indemnity.

*Compulsory Insurance*

In the case of *Dobson v. American Indemnity Company*[18] the insured was a common carrier and required by the Public Service Commission to carry public liability insurance in the amounts of $5,000.00 for bodily injuries to one person and $1,000.00 for property damage. In this instance, however, the insured filed with the Public Service Commission a policy with limits of $50,000.00 for bodily injury, and the plaintiff, under the authority of CODE OF LAWS OF SOUTH CAROLINA, 1952 § 10-702, joined the insurer and set forth the limits of the policy in his complaint. The lower court granted defendant's motion to strike from the complaint the allegation of the amount of the policy. This was affirmed on appeal, the court holding that the amount of the policy in excess of the statutory requirements is in effect private insurance and the existence of it should not come to the attention of the jury in the trial of the action.

*Certain Provisions of Policies*

A clause in an accident and health policy which excluded coverage of any disability while insured was not continuously under professional care and regular attendance, at least once in seven days, of a legally licensed physician or surgeon, other than himself was held to be plain and unambiguous, and a valid portion of an insurance contract by our court in the case of *Sample v. Reserve Life Insurance Company.*[19]

The case of *American Casualty Company of Reading v. Denmark Foods, Inc.*[20] involved an endorsement extending coverage to "hired automobiles". This was an action for a declaratory judgment whereby the insurer sought to have its rights declared under this endorsement where the insured had been sued for damages resulting from a collision involving a truck owned and operated by an independent contractor of the insured. The court held that the insurer was not liable under the "hired automobiles" endorsement where the vehicle involved was that of an independent contractor. The court held

18. 227 S.C. 307, 87 S.E. 2d 869 (1955).
19. 227 S.C. 206, 87 S.E. 2d 476 (1955).
20. 224 F. 2d 461 (1955).

that the parties had contemplated vehicles actually hired or rented by the insured and operated by it.

The last case to be considered here is one of novel impression in our State. The case of *McAllister v. Motor Insurance Company*,[21] deals with the following provision:

> This policy does not apply . . . (b) under any of the coverages, while the automobile is subject to any bailment lease, conditional sale, mortgage or other encumbrance not specifically declared and described in this policy.

The policy set forth the mortgage that was then in existence.

Plaintiff thereafter gave three mortgages on the car in question. This policy was in force when the car was damaged by fire.

In interpreting this provision, the court held it to have no relation to the mortgage placed on the car subsequent to the issuance of the policy. There was no provision made for reporting any subsequent mortgages and such mortgages could not be known at the time.

The court said that this provision was at best ambiguous and must, therefore, be resolved in favor of the insured.

21. 227 S.C. 475, 88 S.E. 2d 621 (1955).