South Carolina Law Review

Volume 8 | Issue 1 Article 13

Fall 1955

Insurance

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INSURANCE

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FIRE

In *Hunt v. General Insurance Company of America,*[1] an agent issued two policies of insurance upon the same house, one policy in favor of the life tenant and the other in favor of the remainderman, each covering the "interest" of named assured. A partial loss occurred. The insurer (which had issued both policies) contended that its obligation to both insureds was the amount of the loss, which would be divided according to the respective interests. Each assured claimed the full amount of the partial loss. The lower court held the remainderman limited by the "interest" provision of the policy to her proportionate share of the partial loss based upon her interest in the property, but held the insurer liable to the life tenant for the full amount of the partial loss. On appeal the Supreme Court affirmed, with a vigorous dissent by Justice Oxner.

The decision has already been the subject of a case note in the *Quarterly*[2] and attention is directed thereto for a rather full analysis. The writer confesses bias in view of his connection with the litigation; we would merely point out that the decision is a departure from the rule prevailing in South Carolina even prior to the adoption of the "interest" policy to the effect that the holder of a limited interest in property can recover no more than his loss — *i. e.,* "interest". The majority opinion seems unsupported by the Standard Policy or the Valued Policy Law.

LIFE

Fraud in the Application

The question of fraud in the application for a life insurance contract was the subject of two cases during the year. In *Phillips v. Life and Casualty Insurance Company of Tennessee*[3] a father applied for insurance on his two year old child; in answering the questions asked in the application, he concealed the child's history of convulsions in connection with serious illnesses, which illnesses were likewise concealed. The lower court submitted the question of fraud to the jury, which returned a verdict for the plaintiff, the beneficiary

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1. 87 S.E. 2d 34 (S.C. 1955).
2. 7 S.C.L.Q. 665 (Summer 1955).
3. 226 S.C. 336, 84 S.E. 2d 197 (1954).

of the policy. The Supreme Court reversed, holding that under the circumstances the only reasonable inference was that the policy had been procured by fraud. The question whether the application and receipt of premium by the agent constituted a binder was not passed upon, the court treating the case as though the insurance contract was in existence at the time of the child's death (from convulsions).

Arnold v. Life Insurance Company of Georgia[4] also turned, eventually, upon the issue of fraud in the application. There, a husband accompanied his 19 year old bride of a few weeks to the agent's office and participated in her answers to the questions in the application. At about the same time a number of other policies on her life were taken out under similar circumstances. A few weeks later the husband murdered his bride. While the murder of the insured by the beneficiary will void the beneficiary's rights to the insurance, it does not avoid the insurance entirely; the insurance remains in effect for the benefit of the estate of the insured;[5] in this case the suit was brought by the estate of the insured to recover the proceeds. But the rule, that the insurance is not rendered void if the beneficiary murders the insured, is subject to an exception: where the beneficiary procured the policy, intending at that time to murder the insured, the policy is void for all purposes.[6] The evidence in this case pointing to that inference is so strong that it would seem that the court would have been justified in holding that a verdict should have been directed for the insurer on that ground. However, there was no question but that the application concealed the fact that the insured had been hospitalized in a mental institution, and the court held that fraud in this respect entitled the insurer to a directed verdict. On this point the case is one of novel impression in this State.

One other point is worthy of consideration; it was contended that since the insured was only 19 years old, fraudulent misrepresentations made by her in the application for insurance could not be set up against her. Although there is some authority for this position,[7] the South Carolina court followed the majority rule to the contrary.

CASUALTY

School Bus Insurance

School bus insurance was the subject of two cases decided by the court during the past year. Both cases were brought by the same

4. 226 S.C. 60, 83 S.E. 2d 553 (1954).
5. APPLEMAN, INSURANCE LAW AND PRACTICE § 381 (1941); Smith v. Todd, 155 S.C. 323, 152 S.E. 506, 70 A.L.R. 1529 (1930).
6. APPLEMAN, *op. cit. supra* note 5, § 382; Henderson v. Life Insurance Co. of Va., 176 S.C. 100, 179 S.E. 680 (1935).
7. See Annotation, 143 A.L.R. 331.

plaintiff, a pupil who was injured when a school bus backed over him while he was playing on the school grounds. Insurance, under Section 1 (A)(1) of the Act,[8] was provided by a policy issued by Indemnity Insurance Company of North America. Insurance, under Section 1 (A)(2), was provided by a policy issued by National Surety Corporation. Plaintiff sued both insurers, claiming to be covered by both provisions of the Act. National Surety Company demurred to the complaint in the suit against it. The demurrer was sustained, and the Supreme Court affirmed.[9] The facts are almost the same as *Farmer v. National Surety Corporation*,[10] and the court reaffirmed the proposition that a pupil is covered by Section 1 (A)(1) but not 1 (A)(2).

The Indemnity Insurance Company of North America had accepted the claim as compensable under its policy. It paid, apparently as they were presented, bills for medical expenses aggregating $1,953.00. These payments were made directly to the doctor and nurses. When a hospital bill for $1,620.20 was presented the insurer tendered to the hospital $1,047.00, the difference between the $3,000.00 limit of benefits and the amount previously paid. This was refused by the hospital. The minor then brought suit, claiming that the entire $3,000.00 should be paid to him. The insurer claimed credit for the amounts previously paid directly to the doctor and nurses, and the lower court allowed the credit. On appeal, the Supreme Court reversed, holding that direct payment by the insurer to those rendering medical services was improper, but subrogating the insurer to whatever right the parties paid by it would have against the estate of the minor.[11]

Although the statute did not directly specify the party to whom payments should be made, the policy provided that payment for medical expenses should be made "to the insured employee" which term included the plaintiff. The decision seems hard, because the insurer apparently had tried to discharge its obligation in the best of faith; however, good faith is no protection where funds to which a minor's estate are entitled are paid otherwise than strictly according to law. Also, of course, there would be the danger of preference if it should be left entirely up to the insurer to determine who should be paid.

8. 47 STAT. 546, 671 (1951).
9. Collins v. National Surety Corp., 225 S.C. 405, 82 S.E. 2d 789 (1954).
10. 223 S.C. 143, 74 S.E. 2d 580 (1953).
11. Collins v. Indemnity Insurance Co. of North America, 86 S.E. 2d 578 (S.C. 1955).

Automobile

Of interest to the South Carolina practitioner is the case of *Continental Casualty Company v. Padgett,*[12] decided by the Fourth Circuit Court of Appeals. Even though, of course, the decision is not authoritative, save for the Federal District Courts, in declaring the law of South Carolina, it indicates what the court concludes is the South Carolina law in the absence of direct authority of our Supreme Court thereabout.

In that case, the policy contained an "Omnibus Clause". Such clauses provide policy coverage not only for the named assured but also for any person operating the insured automobile provided the "actual use" is with the permission of the named assured. An employee of the named insured was allowed to use the insured's truck to take some scrap wood to the employee's mother. Following that, he was to park the truck at the employer's place of business over the weekend, and get it again on Monday morning to pick up certain other employees. The employee completed his errand and left the truck as directed. Later, on Saturday night, he got the truck again; and while on an apparent joy ride with some friends, he had a collision. The insurer brought an action for declaratory judgment seeking a declaration that the employee was not, in the circumstances, within the coverage afforded by the "Omnibus Clause".

The trial court charged the jury that express permission for a given purpose constituted permission for all purposes, and that so long as the car was delivered to the employee with permission of the named assured, the employee would be covered even though the car was driven to a place, or for a purpose, not contemplated by the insured when he parted with the possession. The insurer appealed from judgment against it. The Court of Appeals reversed the trial court and found it in error in refusing the insurer's motion for directed verdict and in submitting the case to the jury under the instructions given.

Decisions construing the "Omnibus Clause" have evolved three rules. The rule which is probably the majority rule is that so long as the vehicle is used for a purpose reasonably within the scope of the permission granted, and within the time or geographic limits contemplated, the operator will be covered. Stated otherwise, the operator is covered unless the use made of the automobile by the bailee so exceeds the scope of the permission as to make him liable for conversion of the automobile.[13] Another rule, somewhat more

12. 219 F. 2d 133 (1955).
13. APPLEMAN, *op. cit. supra* note 5, § 4367.

liberal, provides coverage for the bailee even though there is a deviation from the terms of the bailment, so long as the use made is not a gross violation of the bailment.[14] Finally, there is the so called "Hell or High Water" rule, which holds that so long as the vehicle was originally entrusted to the bailee by the named assured, the bailee is covered throughout the operation of the vehicle, no matter how far he departs from the terms upon which the car was entrusted to him.[15]

The trial court followed the "Hell or High Water" rule; the Court of Appeals refused to assume that the South Carolina court would hold this extreme view.

A more limited coverage provision was involved in *Barkley v. International Insurance Company.*[16] There the policy provided coverage for the named assured and for any member of the insured's "immediate family" operating the automobile with the insured's permission. The insured, with his wife and child, lived in Alabama and later moved to North Carolina. His brother maintained his home in Sumter, South Carolina where he lived with his family. The brother apparently borrowed the insured's automobile and was involved in a collision in Sumter, South Carolina. The insurer contended that the brother was not a member of the "immediate family" of the insured. The lower court so held; on appeal, the Supreme Court affirmed. The contract was written and delivered in the State of Alabama, and the court relied on the Alabama law. However, the inference is clear that the court felt the Alabama rule was correct; and it is not unlikely that the same result would be reached were the court passing on a South Carolina contract. The result seems reasonable: the obvious intent of the policy is to insure a family group, that is, members of a given household, who may be reasonably expected to operate the automobile on occasion. It is the "immediacy" with reference to which the parties contract the "immediacy" in this sense rather than geneological nicety should determine the group envisioned by the coverage. Hence, a distant cousin who actually lives in the insured's household is more "immediate" as to the operation of the automobile than would be a brother, sister, or parent living separate and apart.

Where a person owns two automobiles and is insured against liability by separate insurers with respect to each car, which insurer is required to defend and indemnify if the insured is sued for a wreck

14. APPLEMAN, *op. cit. supra* note 5, § 4368.
15. APPLEMAN, *op. cit. supra* note 5, § 4366.
16. 86 S.E. 2d 602 (S.C. 1955).

occurring while he is driving one car and towing the other (driverless)? That question was presented in *American Fire & Casualty Co. v. Allstate Insurance Co.*,[17] decided by the Fourth Circuit Court of Appeals. The insurer covering the towing vehicle paid judgments in two cases arising out of such a collision, and then sued the insurer of the towed car for contribution. The ground of defense was that the injuries sued for did not arise out of the ownership, maintenance, or use "of the towed car." Held: the towed car was on the road by means of its running gear, and this constituted "use" within the contemplation of the policy, and contribution allowed. The question whether the third party's injuries were caused by the towing car, the towed car, or both, was not discussed.

In *Farm Bureau Mutual Insurance Company v. Bobo*[18] a six-months automobile policy expired on February 20. Prior to expiration the insured was told by the agent that she could "let (the premium) ride for thirty days". On March 20, the premium was mailed to the insurer and thereafter on the same day the automobile was demolished in a collision. The insurer never returned the premium. It wrote the insured on April 7, after it learned of the accident, stating that the premium had arrived too late to prevent cancellation of the old policy but could be applied upon a new policy beginning March 22. On appeal by the insurer, the judgment against it was affirmed. The court held that the agent of the insurer had authority to grant the thirty days grace for payment of the premium, but relied more heavily on the fact that the insurer had retained the premium, even after the insured refused to accept any new policy. This was in accord with South Carolina holding that even where an agent exceeded his authority in issuing a policy, the insurer cannot retain the premium and still insist that the insurance never came into effect. Assuming the facts as found by the lower court, which the Court of Appeals was required to do, the case seems merely to involve the extension of credit for premium, which does not, in the absence of a contrary provision of the policy, keep the insurance from coming into effect.[19]

Mention of insurance coverage in evidence or argument of counsel is regarded as so likely to prejudice a jury that it is regarded as ground for declaring a mistrial.[20] But what results when the damning accusation is sought to be injected into a trial by examination of the panel on *voir dire?*

17. 214 F. 2d 523 (1954).
18. 214 F. 2d 575 (4th Cir. 1954).
19. APPLEMAN, INSURANCE LAW AND PRACTICE § 8007 (1941).
20. Harsford v. Carolina Glass Co., 92 S.C. 236, 75 S.E. 533 (1912); Anderson v. Ballenger, 166 S.C. 44, 164 S.E. 313 (1932); *cf.* Pardue v. Pardue, 167 S.C. 129, 166 S.E. 101 (1932).

That question was presented in *Wood v. England.*[21] So far as appeared from the pleadings, the suit was an ordinary negligence suit between individuals over a motor vehicle collision. Upon call of the case, plaintiffs' counsel submitted a request that the court ask the panel whether any prospective juror was connected with either of two specified casualty insurers. The request was refused, the jury found for the defendants, and plaintiff moved for new trial, on the ground of the refusal of its request. The motion was denied and on appeal the Supreme Court affirmed.

No clear rule was laid down by the court regarding the propriety of such questioning: instead, the court held that, since there was no showing in the pleadings or by affidavit that liability insurance was involved, there was no showing of prejudice or abuse of discretion in denying the request. The somewhat more interesting question of what would have been the courts' ruling had insurance actually been *(sub rosa)* involved remains unanswered.

Hospitalization

A hospital insurance policy in *Jones v. National Bankers Life Insurance Company*[22] contained the provision that it did not cover disability or hospitalization while the insured was "confined to any institution wherein the insured is entitled to services without cost to himself." The insured was an employee of the Atlantic Coast Line Railroad Company and a member of its Relief Department, for which he paid $3.50 monthly dues. Plaintiff was hospitalized and made claim for benefits under the policy. The insurer contended that since the hospitalization had been furnished to plaintiff by the Relief Department, the claim was within the exclusion. The court held that no showing that the hospital services received by the plaintiff were without cost to himself was disclosed where he contributed part of the cost of maintaining the Relief Department.

Two other cases involved insurance and hence deserve mention here, although they add nothing to the subjective law of insurance. Both cases turned upon the sufficiency of pleading. In *Gardner v. Mutual Health and Accident Association,*[23] the complaint jumbled allegations sounding in tort with allegations pointing toward fraud in the inception. A motion to strike the allegations that the plaintiff was, by fraud of the agent, induced to cancel a policy with another insurer was denied, and Supreme Court affirmed. The ground of

21. 226 S.C. 73, 83 S.E. 2d 644 (1954).
22. 86 S.E. 2d 871 (S.C. 1955).
23. 226 S.C. 219, 84 S.E. 2d 637 (1954).

the decision is vague; indeed, the decision may be authority for nothing more than that the order was not appealable.

The complaint in *Williams v. United Insurance Company*[24] contained two causes of action, one for fraudulent breach and the other for fraud in the inception. The gravamen of the first cause of action was that after the insurer's agent had for a long time made weekly visits to the plaintiff's house to collect the premium, he ceased so to do; at his last visit he tore up the premium receipt book stating that the policy was no good, but collected the premium. This was held by the Supreme Court to state a cause of action for fraudulent breach. The demurrer was sustained as to the second cause of action claiming fraud in collecting the premium for two policies, each of which contained a provision avoiding the policy in the event of other insurance; the court held that, in the absence of allegations that the insurer had declared the policy void on account of the provisions, no damage was shown.

24. 86 S.E. 2d 486 (S.C. 1955).