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Insurance

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Those decisions affecting the area of insurance rendered during the preceding year are noteworthy to the extent that various points previously touched upon have been given substantially wider treatment than heretofore, although it would probably be improper to conclude that any new principles have been developed with respect to insurance.

Termination of Policy

In *Turner v. Pilot Life Ins. Co.*,[1] the insured had been notified by the defendant company that his life insurance policy had lapsed because of failure to pay premiums, but that the policy would be reinstated if defendant received the insured's printed application, together with all past due premiums, by November 15, 1958. On that date the insured mailed the application and check for the premium, and the company received them on November 17, thereupon depositing the check. On November 20, the check was presented to the drawee bank, which refused payment, the reason being the death of the insured two days earlier, on November 18.

The defendant company contended that all premium checks were accepted on the condition that they would be honored upon presentation, and that the banks refusal of same in the instant case rendered the policy forfeited for non-payment of premium. The Supreme Court rejected this contention and affirmed the decision for the plaintiff, holding that the acceptance of the check, whether conditional or absolute, at least bound the company not to declare a forfeiture during the time required for the check to be sent through regular banking channels to the bank on which it was drawn, and since the insured had died during this period, the rights of the parties became fixed and would not be affected by the fact that the payment of the check was refused by the drawee bank after the death of the insured.

The case of *Moore v. Palmetto Bank & Texitile Ins. Co.*[2] involved the cancellation of an automobile policy, notice of

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1. 238 S. C. 387, 120 S. E. 2d 223.
2. 238 S. C. 341, 120 S. E. 2d 231.

which the company had allegedly mailed to the insured, but receipt of which the insured denied. In reversing a judgment entered on a verdict for the insured, the Court held that where the evidence conclusively showed that the insurer mailed the notice of cancellation in full compliance with the provisions of the policy, the insured's denial of receipt of such notice was not sufficient to support the jury's finding that notice had not been mailed, and a directed verdict should have been granted the insurer.

In *Nance v. Blue Ridge Ins. Co.*[3] the Court pointed out that where the policy provides the manner of cancellation and does not make payment or tender of an unearned premium a condition thereof, the failure to tender or return the unearned portion of the premium does not operate to destroy the effectiveness of the cancellation of the policy. Upon such cancellation a debtor — creditor relationship arises between insurer and insured for the amount of the unearned premium.

Another case dealing with the termination of an insurance policy was *Williams v. Mutual of Omaha*[4] which was brought in the United States District Court for the Eastern District of South Carolina. However the subject policy was a Florida contract and under the conflict of laws doctrine was governed by the law of Florida rather than of South Carolina.

Persons Covered Under Omnibus Clause

An interesting application of the principle of extended coverage is found in the case of *Coletrain v. Coletrain*,[5] where a passenger in a taxicab instituted suit against her husband and the insurer of the taxicab for injuries sustained when the husband closed the door on her hand as the two of them were alighting from the cab. The term "insured" under the policy included any person using the automobile with the permission of the named insured. The insurer demurred to the complaint on the ground that the use contemplated by the policy was that of driving or operating the vehicle.

The majority opinion, which affirmed the overruling of the demurrer, said:

> The provisions of the policy under consideration did not confine the use of the automobile to any part thereof or

3. 238 S. C. 471, 120 S. E. 2d 516.
4. 297 Fed. 2d 876.
5. 238 S. C. 555, 121 S. E. 2d 89.

> restrict its use to driving or operating same. The coverage extends to the ownership, maintenance, or use of the automobile with the named insured's consent; and the use to which the automobile was being put at the time required the opening and closing of its doors, which was being done by the defendant, Coletrain, a fellow passenger rather than the driver.

In the Case of *Rakestraw v. Allstate Ins. Co.*[6] the defendant issued its insured an automobile liability policy containing the standard omnibus clause provisions. The insured subsequently left the vehicle with a filling station operator for purposes of his obtaining a sale. Without the knowledge or permission of the insured, the filling station operator delivered the vehicle to the plaintiff to paint the same. After the paint job was completed the plaintiff was involved in an accident while taking his wife on a Sunday visit in the automobile. Suit was instituted by the plaintiff seeking coverage under the medical payments provisions of the policy.

The Supreme Court affirmed the lower court's decision that plaintiff was not an insured under the omnibus clause of the policy, stating that:

> The permission which puts the omnibus or extended coverage clause of the policy of insurance into operation may be either express or implied, but whether the permission be expressly granted or impliedly conferred, it must originate in the language or the conduct of the named insured or someone having authority to bind her in that respect.

The Court discussed the various views as to the granting of permission and pointed out that South Carolina had not adopted the so-called liberal or extreme view relative thereto. The Court further stated that in the absence of legislation requiring automobile policies to provide a broader coverage than is afforded by the usual omnibus clause, it did not feel justified in extending the terms of an insurance contract beyond its plain meaning.

In *Eagle Fire Ins. Co. v. Mullins*[7] the Court was again confronted with the question of permissive use under the omnibus clause of an automobile liability policy. The evidence indi-

6. 238 S. C. 217, 119 S. E. 2d 746.
7. 238 S. C. 272, 120 S. E. 2d 1.

cated that the named insured had knowledge of the fact that one of his employees was accustomed to driving the insured automobile to and from work and that the employee's son occasionally used the automobile about town. There was no evidence of express permission having been given to either the employee or his son. On the occasion in question the son had taken the automobile on a trip to the beach and on the way an accident occurred in which one of the passengers was injured. The question was, whether the son was covered under the subject policy as a permissive user. Over the insured's objections the trial judge charged the family purpose doctrine and the jury answered the above question in the affirmative.

On appeal the Supreme Court reaffirmed its position that permission should be limited to the purpose for which it is given. In reversing and remanding the case the Court held that there was no evidence that the named insured had impliedly consented to any but the limited use of the automobile of which he had knowledge. Therefore, the trial judge's charge on the family purpose doctrine was unwarranted and prejudicial.

Agent's Right to Commissions

In *Taggart v. Home Fin. Group, Inc.*[8] the plaintiff alleged that from February, 1957 to October, 1959, he was manager of the Lancaster office of the defendant loan company; that during this period he was a licensed agent for the defendant insurance compaines which were foreign companies doing business in South Carolina, and that he sold policies for said companies sufficient to entitle him to commissions in the amount of at least $120,576.64; that none of the commissions were paid to plaintiff but were paid to the defendant loan company which was not licensed to solicit or write insurance. Plaintiff further alleged under Sections 37-246, 37-247 and 37-254 of the 1952 Code, as amended, he was entitled to commissions on all policies sold by him and that payment on same to the defendant loan company was in violation of his rights under the insurance law. He thus demanded an accounting.

Section 37-246 prescribes conditions under which a nonresident may be licensed as an agent to do business in South

8. 239 S. C. 345, 123 S. E. 2d 250.

Carolina. Section 37-247 provides that all business done by insurance companies must be done through authorized agents; and Section 37-254 provides that:

> No licensed agent representing any company doing the business of insurance as defined herein shall pay directly or indirectly any commission, brokerage or other valuable consideration on account of any policy of insurance on any risk in this state to any non-resident or to any resident not duly licensed to act as agent for the type of insurance involved . . . .

The defendants demurred to the complaint on the ground that it failed to state a cause of action and the demurrer was sustained both in the trial court and on appeal.

The Supreme Court held that the statutes relied on by the plaintiff are in no way statutes of entitlement and create no right to receive commissions but only regulate and prohibit certain splitting by agents of commissions otherwise earned. The Court stated that while there are provisions imposing a penalty upon insurance companies for the violation of Section 37-247 and various other sections of the insurance laws, these penalties are not imposed for the benefit of private individuals and may, according to the express terms of the statute, be recovered only in an action brought in the name of the State.

Agent's Authority

In the case of *Skinner & Ruddock, Inc. v. London Guar. & Acc. Co.*[9] the plaintiff alleged in its complaint that the defendant insurance company through the defendant agency issued to plaintiff a policy of insurance in September of 1954, to indemnify plaintiff in its contracting business against any losses which might be incurred by it in the course of certain construction then under contract; that on February 8, 1955, the defendant agency issued a rider or endorsement extending coverage of the policy to any loss incurred by the plaintiff in the wreckage or demolition of certain buildings; that damage in fact occurred while plaintiff was demolishing one of these buildings and that claim was made to the defendant agency which, with Crawford & Company, Adjusters, instructed plaintiff to prepare an estimate of the cost and proceed with repair, both of which were done by the plaintiff;

9. 239 S. C. 614, 124 S. E. 2d 178.

that the insurance company thereafter denied coverage on the grounds that the agent had not been authorized to issue the rider of February 8, 1955. The defendant agency demurred to the complaint on the ground that it failed to state a cause of action against said defendant. The trial court overruled the demurrer and the agency appealed. The Supreme Court affirmed the lower court, holding that the complaint stated a cause of action against the appellant based upon its alleged unauthorized adjustment of the claim of the plaintiff under the policy endorsement. The Court also pointed out that plaintiff would not be entitled to recover against both defendants; that recovery would be against the insurance company, if the agent had adjusted the loss within its authority as agent; and that if the loss had been adjusted under the policy endorsement in question without authority to do so the agent would be held liable on contract.

In *Fuller v. Eastern Fire and Cas. Ins. Co.*[10] plaintiff, without designating a particular insurer, purchased an automobile liability policy from one Gillespie, who was not an authorized agent for the defendant insurance company. Gillespie collected a down payment on the premium and gave plaintiff and oral binder to the effect that he was covered as of May 1, 1959; Gillespie then forwarded the down payment and the application to the authorized agent of the company and the policy was issued with effective date of May 5, 1959. However, on May 2nd plaintiff was involved in an automobile accident, and thus arose the question regarding the effect of the oral binder given by Gillespie.

The insurance company denied that the policy was in effect on May 2nd for the reason that Gillespie was not its agent at the time application was made by the plaintiff; that he had no authority to bind the company; and that the attempt to do so was ineffectual since he only made an oral binder without designating the company which would issue the policy. A verdict was returned for the plaintiff and insurance company appealed.

In affirming the judgment the Supreme Court held that the acts of the defendant company in accepting the premium and application of plaintiff and in issuing the policy were sufficient to support a finding that the company had ratified the oral agreement made by Gillespie and was therefore

10. 240 S. C. 75, 124 S. E. 2d 602.

bound by same. The Court stated that although the failure to designate any company is ordinarily fatal to the validity of an oral binder, the omission is fully taken care of when the policy is actually issued as was done in this case.

Accidental Death While Intoxicated

The most noteworthy feature in *Outlaw v. Calhoun Life Ins. Co.*[11] was the Court's treatement of the "intoxication clause" in a double indemnity life insurance policy. The pertinent provision was:

> The agreement to pay accidental death benefit hereunder shall be null and void if death shall have resulted from bodily injury sustained by insured while intoxicated.

On appeal the Superme Court reaffirmed the general proposition that the burden is on the insurer to prove that the insured died under conditions which made his death a risk not assumed by the subject policy. Accordingly, the Court held that under the quoted provision the mere showing that the deceased was intoxicated at the time of his death is insufficient to relieve the insurer of liability for accidental death benefits. To achieve this end the insurer must also show a causal connection existing between the intoxication of the deceased and his death.

Coverage of Goods in Transit

The case of *Huckabee Transp. Corp. v. Western Assur. Co.*[12] involved a question of coverage with respect to an item of freight which was damaged while being transported by plaintiff-insured without its knowledge. This particular piece of freight had been inadvertently included in a fully loaded trailer under seal which trailer was transferred to the insured from another carrier. The bill of lading purported to cover the entire shipment but did not list the item in question. Subsequent to the transfer the trailer was involved in an accident in which most of the contents were damaged. The insurer paid for the damage to freight listed on the bill of lading but refused to pay for the item in question contending that it was not within the terms of coverage.

By the subject policy it was provided that the insured would be protected against ". . . liability to others as a private

11. 238 S. C. 199, 119 S. E. 2d 685.
12. 238 S. C. 565, 121 S. E. 2d 105.

or common carrier or under bills of lading or shipping receipts . . .", and further that the "insurance shall attach and cover . . . only while the said goods are in the custody of the assured and in due course of transit."

In affirming a judgment for the plaintiff-insured the Supreme Court held that the word "or" in the above provision was used as a co-ordinating conjunction introducing an alternative and thus there was no requirement that the goods be transported by the insured under a bill of lading or shipping receipt because this was the alternative of the insuring agreement. The Court also held that the item in question was in the custody of the insured and in the due course of transit at the time of the loss. The Court relied on the testimony that it was customary in the trucking business for a carrier to receive and accept a fully loaded trailer under seal without making any examination of the contents and without knowing the contents other than what was revealed on the bill of lading or shipping receipt.

Obligation of Insurer to Defend

In the case of *Miles v. State Farm Mut. Auto. Ins. Co.*,[13] the insurer issued to the insured an automobile liability policy providing coverage in the amount of $5,000.00 per person for injuries received in any one accident. The policy expressly excluded from coverage "bodily injury to the insured or any member of the family of the insured residing in the same household as the insured." While this policy was in force, an accident occurred in which the insured's daughter-in-law, Laverne Miles, was injured. For some time prior to the date of the accident, Laverne had lived with the insured but was living elsewhere at the time of the accident. Notwithstanding this fact, the insured gave a written statement to the insurer's claims representative to the effect that Laverne was residing with the insured at the time of the accident. Laverne brought suit against the insured for injuries sustained as a result of the accident. The insurer refused to defend this suit and Laverne obtained a default judgment against the insured for $12,500.00. Laverne then brought a suit against the insurer for $5,000.00 which was the limit of coverage under the policy. The question of Laverne's residence at the time of the accident was submitted to the jury who found that

13. 238 S. C. 374, 120 S. E. 2d 217.

Laverne was not residing in the same household as the insured at that time and, therefore, returned a verdict against the insurance company for $5,000.00. The insured then instituted this action against the insurer for $7,500.00, being the excess of Laverne's judgment against the insured, alleging negligence and bad faith on the part of the insurer in not properly investigating the matter of Laverne's residence and in failing to settle her claim. A verdict was directed for the insurance company and the case was appealed.

In affirming the judgment for the insurer, the Court held that the company had the right, so far as the issue of good faith was concerned, to rely upon the statement given to it by its insured. The Court pointed out that had the company probed further into the question of residence by way of testing the correctness of insured's statement, it might have resolved that question otherwise than it did; but its failure to do so afforded no basis for the charge of bad faith. The Court also added that the determination of the issue of residence in the suit between Laverne and the insurance company had nothing to do with the issue of good faith in this case.

Construction of Policy

In *Quinn v. State Farm Mut. Auto. Ins. Co.*[14] the plaintiff-insured sought medical payment benefits under a policy provision insuring against injuries resulting from "being struck by an automobile." The complaint alleged that plaintiff had stopped along the highway to watch a wrecker get out of a gully near the road and while so doing the wrecker spun a piece of timber which had been placed under the wheel for traction against plaintiff's leg and broke it. Defendant demurred on the ground that the complaint failed to state a cause of action in that it affirmatively showed that the injury received by plaintiff was due to his being struck by a piece of timber and not by an automobile. The trial court overruled the demurrer and defendant appealed.

In reversing this decision the majority of the Court found no uncertainty or ambiguity in the language of the policy and held that plaintiff was not struck by an automobile within the meaning thereof. Although stating that the language was too plain to call for judicial construction the Court cited

14. 238 S. C. 301, 120 S. E. 2d 15.

decisions from other jurisdictions which interpreted the provisions as requiring personal contact with the automobile itself.

In a dissenting opinion Mr. Justice Lewis took the position that the language in question was susceptible of other meaning than the strict interpretation adopted by the majority. He pointed out that the word "by" has been defined as meaning "through", "through the medium of", "through the means of", and "in consequence of". Accordingly, Mr. Justice Lewis was of the opinion that it was immaterial that the plaintiff was struck with a piece of timber rather than some part of the automobile itself.

The case of *Miller v. British America Assur. Co.*[15] involved a dispute between an insurance company and its insured as to the extent of damage to the insured's cabin cruiser during a windstorm. The insurer, among other things, set up as a defense that the policy contained provisions providing for arbitration through the appointment of appraisers in the event the amount of loss was in dispute. The Supreme Court upheld the validity of such provisions in the policy and determined that compliance with such provisions, if demanded by the insurer, is a condition precedent to the right of the insured to maintain an action on the policy unless such provisions are waived by the insurer.

In *Rhame v. National Grange Mut. Ins. Co.*,[16] the plaintiff sought to recover under the medical payment provision of his liability insurance policy for medical expenses incurred on behalf of two of his employees who were injured while riding in the insured vehicle. It was admitted that the injuries arose out of and in the course of employment for the insured. The defendant insurance company contended that recovery was excluded by the following provision:

> This policy does not apply:
> (g) under division 1 of coverage C, to bodily injury to or sickness, disease or death of any employee of the named insured or spouse arising out of and in the course of (1) domestic employment by the named insured or spouse, if benefits therefor are in whole or in part either payable or required to be provided under any workmen's compensation law, or (2) other employment by the named insured or his spouse.

15. 238 S. C. 94, 119 S. E. 2d 527.
16. 238 S. C. 539, 121 S. E. 2d 94.

The trial judge ruled that the provision was ambiguous and allowed the plaintiff to offer extrinsic evidence on same. On appeal the Supreme Court reversed the trial judge, holding that there was no ambiguity in the subject policy. The Court stated that:

> A careful reading and study of the exclusion provision as is contained in Section (g) of the policy in question convinces us that the truck driver and his assistant, both of whom were employees, as farm laborers, of the respondent, are excluded from medical coverage under portion (2) of Section (g) above quoted.

For this reason the Court concluded that the trial judge should have directed a verdict for the defendant insurer.

In the case of *Stanley v. Reserve Ins. Co.*,[17] plaintiff had been involved in a collision with an insured of the defendant company. The policy in question designated the insured's truck as the insured vehicle, but not the trailer, and it contained a clause excluding coverage when the insured vehicle was used for towing a trailer not covered by like insurance in the company. When the accident with plaintiff occurred, the trailer which the insured truck was towing was not covered by like insurance in the company, and for this reason, defendant denied liability. In holding for the defendant, our Court held that an automobile liability insurer whose policy excluded a truck or automobile from coverage while towing an uninsured trailer was not liable for damages sustained when the insured's truck, while towing such an uninsured trailer, collided with another vehicle, even though the policy concededly was procured to comply with the Motor Vehicle Safety Responsibility Act, which provided that no violation of the policy should defeat or void the policy.

In the case of *Charles v. Canal Ins. Co.*,[18] the insurer had issued to the plaintiff a policy covering the latter's tractor and trailer against loss or damage by collision or upset. In the main body of the contract, the policy purported to give coverage to each unit to the extent of its actual cash value less a specified deductible amount. However, the policy contained an endorsement, issued the same date as the policy, delivered with the policy and attached to the policy, which the defendant alleged limited the amount of coverage on each

17. 238 S. C. 533, 121 S. E. 2d 10.
18. 238 S. C. 600, 121 S. E. 2d 200.

unit to $2,000.00 less the deductible amount. The endorsement referred to the coverage afforded under a portion of the policy designated as "B-1 COLLISION OR UPSET." There was no such clause contained in the policy although there was in Item 3, Sub-section "B" of the DECLARATIONS just such a provision as that referred to. In a suit instituted under the policy for recovery of the actual value of the units which were a total loss, less deductible and salvage, the lower court affirmed the trial judge's direction of a verdict for the plaintiff for the full amount claimed, leaving to the jury simply the duty of designating the value of the units. The Supreme Court in a three to two decision through Acting Justice McFadden affirmed the decision of the trial judge holding that the disparity as to the reference in the endorsement constituted an ambiguity in the policy and that in such event it became necessary to construe that provision to the benefit of the insured.

In a rather vigorous dissent concurred in by Justice Moss, Justice Legge wrote that there was no ambiguity and that the endorsement attached to the policy was effective to limit coverage as to each unit to a maximum of $2,000.00 less deductible since the endorsement obviously referred to Section B pertaining to the amount of coverage.

Other questions of policy construction were involved in the case of *South Carolina Elec. & Gas Co. v. Aetna Ins. Co.*[19] which was decided during this survey period. However, the facts were so unusual that it is felt that this case is of little significance with respect to the general application and practice of insurance law in this State.

Actions For Fraudulent Breach of Contract

In the case of *Dunnaway v. United Ins. Co. of America,*[20] the plaintiff had made claim for certain sick benefits and hospital payments under a policy issued by the defendant. The claim was denied and the defendant's agent returned to the plaintiff the premiums paid under the policy receiving in consideration therefor a release of all claims. The check was thereafter negotiated by the plaintiff who at no time prior to commencing an action for fraudulent breach of contract accompanied by a fraudulent act offered to return to the

19. 238 S. C. 248, 120 S. E. 2d 111.
20. 239 S. C. 407, 123 S. E. 2d 353.

defendant the amount for which the check had been drawn. Our Court once again applied the general principle that one who seeks to avoid the effect of a release must first return or tender the consideration paid therefor and that since plaintiff had not done this, the lower court properly directed a verdict for the defendant.

Disability and Medical Benefits

In the case of *Shealy v. United Ins. Co. of America,*[21] the insured brought an action on a sickness benefit policy claiming total disability under the following provision:

> If such sickness causes continuous total disability and total loss of time, and requires continuous confinement within doors and regular and personal attendance therein by a licensed physician, surgeon, osteopath or chiropractor, other than the insured, the Company will pay at the rate of the monthly benefit stated in the policy schedule . . . .

The evidence showed that the insured was 61 years of age, living alone, and was afflicted with chronic thrombphlebitis; that on occasions he drove to his doctor's office, went to see his neighbors, and went to a nearby store to get medicine and supplies. The defendant-insurer denied liability, contending that the insured was not totally disabled within the quoted terms of the policy. The question was submitted to the jury and a verdict rendered for the plaintiff. On appeal the judgment was affirmed, the Supreme Court holding that the purpose of the "continuous confinement within doors" clause is to make certain of the disability of the insured and that it should be construed as merely expressing the required degree of disability, not necessarily requiring actual confinement within doors. In rejecting a literal construction the Court stated that there was no evidence that the insured was able to resume the ordinary duties or pleasures of life and the fact that at intervals he may have stepped into his yard or made visits to his physician's office and other short and unusual trips was not sufficient within the meaning of the insurance contract to say as a matter of law that he was not continuously confined within doors and regularly attended therein by a licensed physician.

21. 239 S. C. 71, 121 S. E. 2d 345.

The case of *Garrett v. Mut. Benefit Life Ins. Co.*[22] was an action to recover total disability benefit on several policies issued by the defendant insurance company. Each policy contained a provision defining total disability as the inability by reason of accidental bodily injury or sickness to earn in excess of one-fourth of the insured's former earned income. The policies further defined "earned income" as follows:

> As herein used the term "earned income" means wages, salaries, professional fees, and other amounts, received as compensation for personal services actually rendered in any profession, trade or business, not including therein amounts received as a pension or retirement allowance, or as a temporary continuance in whole or in part of customary earned income during the insured's enforced absence from business on account of accidental bodily injury or sickness.

On appeal from a judgment for the insured the Supreme Court in accordance with its earlier decision in *Dunlay v. Maryland Cas. Co.*[23] construed the quoted provision to mean income received by the insured either from his *customary* employment or from any other employment in a profession, trade or business *for which his training and aptitude fit him.* The Court rejected the insurance company's contention that it was entitled to a directed verdict because the evidence showed that the insured had been engaged in a coin collecting business in which he earned more than one-fourth of his former earned income. The Court pointed out that there was no evidence that the insured was engaged in coin collecting as a business and held that the benefit dervied from the pursuit of a hobby would not deprive the insured of his right to recover for total disability under the terms of the subject policies.

In *Gordon v. Fidelity & Cas. Co.*[24] the insured was injured in an accident and was hospitalized and treated at the Fort Jackson Hospital. Being a career soldier his medical expenses were paid by the Federal Government. In due time insured filed claim under the medical payment provisions of his liability insurance policy for a sum which he estimated to be the reasonable cost of his hospitalization and medical expenses.

22. 239 S. C. 574, 124 S. E. 2d 36.
23. 203 S. C. 1, 25 S. E. 2d 881.
24. 238 S. C. 438, 120 S. E. 2d 509.

The defendant company refused payment contending that the subject policy only obligated the insurer to pay "expenses incurred" and that the plaintiff had not "incurred" any expenses for the hospitalization and treatment at Fort Jackson. Suit was instituted and upon the trial court's refusal to sustain a demurrer to the complaint, the insurer appealed. After quoting from numerous decisions interpreting the term "expenses incurred" the Supreme Court held that since there was no obligation on the part of the insured to pay for the hospitalization he received at Fort Jackson Hospital, he "incurred" no expenses within the meaning of the provision of the policy or insurance issued by the insurer.