South Carolina Law Review

Volume 17
Issue 1 *1963-1964 Survey Issue*

Article 13

1964

Insurance

Wesley M. Walker

INSURANCE

WESLEY M. WALKER*

Those cases involving legal principles of insurance in South Carolina during the previous year present the usual assortment of facts and issues with few notable exceptions. By far the largest majority of these cases relate to the problem of policy construction.

Construction of Policy

The case of *Miller v. Stuyvesant Ins. Co.*[1] was a declaratory judgment action brought by the appellant Miller against the respondent company to determine the rights and obligations of the parties under a contract of liability insurance. The facts were that Miller and his wife owned a 1950 Ford automobile which was identified in the subject policy. However, Miller later transferred the title to the car to his wife, who retained the automobile from that time on. Miller himself purchased a 1955 Chevrolet, which he was driving when he was involved in an accident with the appellant Greene who was made a party defendant to this action.

The appellant Miller contended in his complaint that the 1955 Chevrolet was a substituted vehicle and as such was covered by the insurance policy. Respondent took the position that the Chevrolet was a newly acquired automobile and thereby not entitled to coverage.

Sub-section (4) of Insuring Agreement IV (a) reads as follows:

> Newly acquired automobile—An automobile, ownership of which is acquired by the named insured or his spouse if a resident of the same household if (i) it replaces an automobile owned by either and covered by this policy or the company insures all automobiles owned by the named insured and such spouse on the date of its delivery, and (ii) the named insured or such spouse notifies the company within 30 days following such delivery date; that such notice is not required if the newly acquired automobile replaces an owned automobile covered by this policy. The insurance with respect to the newly acquired automobile does not apply to

* Leatherwood, Walker, Todd & Mann, Greenville, South Carolina.

1. 242 S.C. 322, 130 S.E.2d 913 (1963).

> any loss against the named insured or such spouse as other valid and collectible insurance; the named insured shall pay any additional premium required because of the application of the insurance to such newly acquired automobile.[2]

Neither Miller nor his wife notified the company within thirty days following the delivery date of the 1955 Chevrolet automobile, and neither Miller nor his wife gave notice of the acquisition of the Chevrolet prior to the date of the accident with appellant Greene.

The South Carolina Supreme Court said that in order for Miller to have been covered under the omnibus clause set forth in the policy, he must have been operating the automobile described in the policy, which he was not, or a newly acquired automobile as defined in Insuring Agreement IV(a)(4). Referring to the pertinent policy provision, the court pointed out that there were only two methods whereby a newly acquired automobile would be covered under the terms of the policy; first, if it replaced an automobile owned by either the insured or his spouse; or, second if the company insured all automobiles owned by the insured or his spouse, notice was given to the company, and any additional premium required was paid. The court held that the first method was obviously inapplicable since Miller or his wife retained ownership of the Ford; and the second method was dispensed with on the basis that no notice was given within thirty days as required, nor was the company ever notified of the acquisition of the Chevrolet prior to the date of the accident. Further, no additional premium was paid or offered to respondent company to cover said Chevrolet automobile.

The court adopted the following statement from *American Law Reports (Second)*:

> It is well established that where the "automatic insurance" clause requires notice of the acquisition of a new automobile to be given the insurer within a specified time after delivery, the period generally being either ten or thirty days, the failure to give notice prior to an accident occurring after the expiration of the designated period precludes coverage of the new automobile.[3]

Kingman v. Nationwide Mut. Ins. Co.[4] was an action for medical expenses under the family compensation clause of an auto-

2. *Id.* at 325, 130 S.E.2d at 915.
3. *Id.* at 327, 130 S.E.2d at 916.
4. 243 S.C. 288, 134 S.E.2d 706 (1963).

mobile liability policy. Plaintiff was riding in an automobile owned and operated by her brother when it was involved in a collision, she suffering certain personal injuries. Her medical expenses exceeded 2,000 dollars and she was confined indoors for a period of sixty-four days. At the time plaintiff suffered her injuries, Nationwide had previously issued to her brother a policy of insurance covering the automobile in which she was riding as a passenger. Nationwide had also issued to the plaintiff's husband a policy identical in terms and provisions with that held by her brother. Both policies had a family compensation clause. According to the family compensation schedule, which formed a part of each policy, an injured person was entitled to recover up to 2,000 dollars in medical expenses and five dollars per day for continuous confinement indoors due to the injury. Under the schedule of either policy, plaintiff was entitled to a total recovery not exceeding 2,300 dollars. Because of the accident, plaintiff tried to recover the maximum amount allowed under the family compensation schedule in both her husband's and her brother's policies. Nationwide contended that because of the clear non-ambiguous provisions of the identical policies, plaintiff was not entitled to recovery under both of them. Section D(1) of the family compensation clause of the policies had the standard provision providing coverage for any person who suffered injury arising out of the ownership or maintenance and use of the insured automobile, and section D(2) provided coverage to the policyholder and his family arising out of injuries sustained by being struck by another non-owned motor vehicle while entering or leaving such a vehicle. The trial judge refused a motion for directed verdict, holding that an ambiguity was created by the use of the words "family compensation" in the caption of section D, thereby raising a jury issue.

The court first held that resort may be had to a caption only to explain an ambiguity, not to create an ambiguity where none exists, and where the operative part of the policy is explicit, the operative part controls. Secondly, the court held that each of the insurance contracts limited Nationwide's obligation to plaintiff by providing that the payments to any one person made under D(1) and D(2) would discharge the company's liability for family compensation "under this or any other policy." The court held there was no ambiguity in the policies, further ruling that the expression "any other policy" logically and obviously means any other policy issued by Nationwide.

Johnson v. Wabash Life Ins. Co.[5] involved an action on a hospital insurance policy. The company had issued a hospitalization policy to the plaintiff, agreeing to pay hospital and medical expenses incurred, and plaintiff was subsequently hospitalized. Wabash refused to pay the claim, alleging that the plaintiff was hospitalized for a condition that existed prior to the effective date of the policy and was thus not covered under the terms and provisions of the policy. Plaintiff admitted that the illness existed prior to the issuance of the policy, but took the position that the company had waived the provisions of the policy and was therefore estopped from relying thereon. Plaintiff's claim of waiver and estoppel was based upon the fact that Wabash's agent knew of her physical condition at the time the application for insurance was taken, and upon the further fact that after the policy was received it was returned to the agent by the plaintiff because prior physical conditions had not been correctly stated in the application, the policy being later returned to the plaintiff without any change being made therein.

The court held that insurance contracts cannot be created by waiver. The doctrine cannot be invoked by an insured to create a primary liability of the insurer for which all elements of a binding contract are lacking. The court further held that a waiver is an intentional relinquishment of a known right, while the essential elements of estoppel are the ignorance of the party who invokes the estoppel, representation or conduct of the party estopped if it misleads, and an innocent and deleterious change of position in reliance upon such representations or conduct. The court said there was no estoppel in this case because plaintiff had read the policy and the application and had in fact sent the policy back to be changed to reflect true conditions. There were no representations which misled the plaintiff and caused her to change her position in reliance upon such representation.

Baker v. American Ins. Co.[6] was an action on an accident policy under which defendant had agreed to pay all sums for which the insured should become legally obligated as damages because of harm to property caused by accident, and to defend any suit against the insured alleging such harm. American refused to defend the suits brought against Baker for damages arising out of grading done in connection with a construction project. Baker settled the cases and brought this action to recover the expenses

5. 244 S.C. 95, 135 S.E.2d 620 (1964).
6. 324 F.2d 748 (4th Cir. 1963).

of defense and the settlement payments. The question was whether the circumstances on which the claims were made against Baker constituted an accident within the meaning of the insurance policy.

In constructing a shopping center, Baker had graded a seventeen-acre tract, removing the trees and vegetation therefrom. At a time in the early part of July, 1959, when the grading was almost completed, this area suffered unusually heavy rains. Because of the grading, the bare ground did not retard the run-off of rainfall, with the result that the large volume of water from the construction area overflowed onto abutting residential properties. The insured property owners sought recovery from Baker, premised upon allegations of wilfulness and negligence in clearing the construction site with respect to drainage, and the creation and maintenance of a nuisance on the construction site. American's refusal to defend the action or to pay the compromise amount was based upon the contention that liability did not arise from an accident, but from the negligence of Baker.

The court stated that an accident is an unintended and unexpectable injurious happening. The court further stated that ordinarily "accident" would exclude an event caused by negligence or nuisance alone and followed by a foreseeable or natural consequence, for then neither the cause nor the effect is unexpectable. The court reasoned, however, that the object and terms of the subject insurance policy required the conclusion that if the negligence or nuisance is accompanied by an unintended and unexpectable factor effectively contributing to the cause or consequence of the incident, then the incident can be an "accident" within the policy coverage. The court held that an action in the pleadings which would require the insurer to defend does not mean only such an "accident" as would absolutely excuse the insured, but it refers to an "accident" which could include an occurrence embracing negligence or nuisance. When the declarations did not preclude the presence of an "accident," and if the allegations left the answerability of the insurer in doubt, that doubt generated a duty to defend. South Carolina does not distinguish between an accidental cause and an accidental consequence, so even if the shopping center site had been negligently cleared, the heavy rainfall was certainly an unintended and unexpectable factor which contributed effectively to the damage suffered by the property owners.

Johnston v. Commercial Travelers Mut. Acc. Ass'n[7] was an action to recover for the loss of a hand and certain medical expenses under an accident policy. Plaintiff, a South Carolina resident, was the holder of an accident insurance policy issued by the defendant, a New York insurer. The policy was secured through the mail, and the defendant had neither offices nor agents in South Carolina. While the policy was in effect, plaintiff accidentally lost four fingers on his left hand and had his foot severed above the ankle. The policy provided coverage of 10,000 dollars for the loss of one hand and one foot and 5,000 dollars for the loss of one hand or one foot. The policy also provided that the word "loss" as used therein in reference to the hand or foot meant a natural severance at or above the wrist or ankle. After the accident, plaintiff was hospitalized and subsequently made demand under the policy for the loss of his foot and his hand and for medical expenses. The defendant forwarded its draft for 5,279 dollars, denying the benefit for the loss of the hand on the ground that the hand was not amputated at or above the wrist. Thereafter, plaintiff commenced suit to recover for the loss of his hand.

In addition to the policy provision defining loss of hand as meaning actual severance at or above the wrist, defendant relied on policy provisions which provided that no action to recover under the policy could be brought after the expiration of two years and that the insurance contract was to be construed in accordance with the laws of the State of New York.

The court held that the foregoing policy provisions were in conflict with the provisions of the South Carolina Insurance Code; particularly with section 37-141,[8] which states that all contracts of insurance on property, lives or interests in this state shall be deemed to have been made therein and subject to the laws thereof; with section 37-456,[9] which states that the loss of a hand provision of an accident insurance policy issued in the state shall include and mean the loss of four fingers entire; and with section 37-474 (11),[10] which provides for a six-year statute of limitations in actions arising out of health and accident policies.

7. 242 S.C. 357, 131 S.E.2d 91 (1963).
8. S.C. Code Ann. § 37-141 (1962).
9. S.C. Code Ann. § 37-456 (1962).
10. S.C. Code Ann. § 37-474 (11) (1962).

The court said that in light of section 37-141,[11] it was immaterial where the contract was technically entered into, since South Carolina has sufficient connection with the formation of such a contract to demand that it conform to our Insurance Code; thus, since the contract is subject to our insurance laws, any policy provision inconsistent therewith is void and the pertinent provisions of the statute apply and prevail as much as if expressly incorporated in the policy.

Tyler v. United Ins. Co. of America[12] was an action on a disability policy. The question was whether the plaintiff's confinement was "continuous confinement within doors" so as to allow continued insurance payments of disability benefits.

The facts were simply that, after a period of hospitalization for heart disease, plaintiff was confined to his home; and during said confinement plaintiff took short walks, drove to the hospital to see the doctor and visited a neighbor occasionally. The defendant argued that this violated the requirement of "continuous confinement."

The court held, in accordance with the majority rule, that substantial confinement constituted sufficient compliance with the provision of the policy in question. The court approved the idea that a person may be totally incapacitated and confined to his house within the meaning of the policy, even though he takes some exercise outdoors or visits his physician, so long as he does not leave his house for primarily business or personal reasons.

The validity of a loan receipt was upheld in the case of *Singletary & Son, Inc. v. Lake City State Bank*,[13] which involved the following circumstances. Singletary's employee caused checks to fictitious payees to be drawn on Singletary's account with the bank and cashed them on forged endorsements. Singletary was insured under a fidelity bond and the surety advanced the amount of the checks to Singletary in return for the loan receipt by which Singletary agreed to repay the "loan" if recovery was made from the bank. In the action by Singletary against the bank, the bank plead as a defense that Singletary had been paid by its insurance company and was not entitled to a dual recovery, and the insurance company, having been paid to assume the risk, was not entitled to right of subrogation. The court granted plaintiff's motion to strike this defense, pointing

11. S.C. CODE ANN. § 37-141 (1962).
12. 243 S.C. 114, 132 S.E.2d 269 (1963).
13. 243 S.C. 180, 133 S.E.2d 118 (1963).

out that the insurance company had not been paid to protect the bank, and holding that the loan receipt would not be regarded as fictional.

Insurable Interest

The significant case of *Ramey v. Carolina Life Ins. Co.*[14] involved an action against an insurer for injuries sustained by an insured as a result of the alleged negligence on the part of the defendant in issuing a policy of life insurance without the knowledge or consent of the plaintiff insured, which situation normally renders such a policy speculative or a wager due to a lack of insurable interest. In the instant case, the plaintiff's wife, who had procured the policy from the defendant, had been named as beneficiary. She subsequently attempted to poison her husband with arsenic in order to collect the proceeds of the insurance. The defendant demurred to the complaint on the ground that in South Carolina a wife has an insurable interest in the life of her husband and that, therefore, the consent or knowledge of said husband was not essential.

The court, incorporating the circuit court opinion, held that a wife does not always have an insurable interest in the life of her husband. Conceding that usually a wife does possess such an interest, there are certain situations in which this is not the case. Citing *Crosswell v. Connecticut Ind. Ass'n*,[15] the court said:

> There seems to be a clear distinction between cases in which the policy is procured by the insured bona fide on his own motion and cases in which it is procured by another. It is a very different thing for a man to create voluntarily an interest in his termination and to allow someone else to do so at their will.[16]

Quoting from *American Jurisprudence*,[17] the court said:

> It is a general rule that a policy of life insurance taken out without the knowledge or consent of the insured person is against public policy and unenforceable. A wife, for example, cannot be permitted to obtain insurance on the life of her husband without his knowledge and consent; such a

14. 244 S.C. 16, 135 S.E.2d 362 (1964).
15. 51 S.C. 103, 28 S.E. 200 (1897).
16. 244 S.C. 16, 21, 135 S.E. 2d 362, 364 (1964).
17. 29 Am. Jur. *Insurance* § 231 (1960).

practice, it has been deemed, might be a fruitful source of crime.[18]

In overruling another feature of the demurrer, which asserted that there was no breach of duty owed by the defendant to the plaintiff, the court cited the Alabama case of *Liberty Nat'l Life Ins. Co. v. Weldon*:[19]

> [A]n insurance company has a duty to use reasonable care not to issue a policy of life insurance in favor of a beneficiary who is obtaining such policy without the knowledge or consent of the insured, and this would especially be true where as here the company knew or had reason to know that such was the situation. The rule against issuing policies on the life of a person without his knowledge or consent is designed to protect human life. Policies issued in violation of this rule are not dangerous because they are illegal; they are illegal because they are dangerous.[20]

Another interesting aspect of the insurable interest principle is raised by the case of *Laurens Fed. Sav. & Loan Ass'n v. Home Ins. Co.*[21] Here the defendant had issued a fire policy payable to the plaintiff due to the fact that the plaintiff held the mortgage of one Billy Ray Adams covering the subject property. The purpose of the policy was of course to protect the interest of the plaintiff-mortgagee, and the mortgagor was charged for the premium payments which the plaintiff had paid to the defendant. Subsequently, Adams, the mortgagor, took out a separate fire insurance policy with another company, insuring her personal equity in the premises. While both policies were in effect, the dwelling was destroyed by fire.

The insurance policy issued by the company contained the provision that:

> [I]nsurance on any building covered under this policy in excess of that fixed in the valuation clause is prohibited. If, during the term of this policy, the insured shall have any such other insurance, whether collectible or not, and unless permitted by written endorsement added hereto, the insurance under this policy, insofar as it applies to the building

18. 244 S.C. 16, 22, 135 S.E.2d 362, 365 (1964).
19. 267 Ala. 171, 100 So. 2d 696, 61 A.L.R.2d 1346 (1958).
20. 244 S.C. 16, 25, 135 S.E.2d 362, 366 (1964).
21. 242 S.C. 226, 130 S.E.2d 558 (1963).

> on which other insurance exists, shall be suspended and of no effect.[22]

It was the position of the company that under the foregoing provision of the policy, when Adams obtained other insurance upon the same building in excess of the amount fixed in the valuation clause, the policy here was suspended and of no effect. It asserted that the trial judge was in error in not so holding.

The court however, was quick to point out that the plaintiff's policy was purchased to protect the interest of the mortgagee association, and the other policy was to protect the interest of the mortgagor, Adams. The court cited numerous authorities to the effect that the association, as mortgagee, had an insurable interest by virtue of its mortgage to the extent of the balance due it from the mortgagor, and that where insurance was taken out by the mortgagor, even without the knowledge or consent of the mortgagee, it did not constitute other insurance within the purview of the section referred to above. Specific reference was made to the case of *Brant v. Dixie Fire Ins. Co.*[23] in which it was held that the owner of a house and a mortgagee had separate insurable interests in the house so as to entitle the mortgagee to recover on a fire policy insuring his interest in the house, notwithstanding the fact that the policy contained the provision that it would be void if there was other insurance on the property, when in fact the owner of the house carried other insurance on her interest therein.

An attempt was also made to render the contribution feature of the policy effective, but the court, using the same reasoning, held:

> Contribution between insurers cannot be enforced unless their policies cover the same interest. Accordingly, if an owner and a mortgagee of the same property have procured insurance on their separate interests therein, and the owner seeks to recover on his policy, the defendant insurer is not entitled to contribution against the insurer of the mortgagee's interest.[24]

The United States Court of Appeals, Fourth Circuit, heard the case of *Lynch v. United States Branch, Gen. Acc. Fire & Life*

22. *Id.* at 230, 130 S.E.2d at 559.
23. 179 S.C. 55, 183 S.E. 587 (1935).
24. 242 S.C. 226, 233, 130 S.E.2d 558, 561 (1963), citing 29 AM. JUR. *Insurance* § 1340 (1960).

Assur. Corp.,[25] which is another case primarily concerned with the issue of insurable interest. Here the administrators of the estate of a deceased had recovered a judgment against one James Alexander for the wrongful death of their intestate as a result of an automobile collision. Alexander was driving a 1960 Chevrolet automobile obtained from the Bob Edwards Chevrolet Company on a conditional sales agreement. It seems that Alexander had left his old Ford automobile, which he was trading, with Bob Edwards Chevrolet Company, agreeing to return the next day bringing the title certificate for the Ford and enough money for a down payment as well. He was then allowed to drive the Chevrolet away, although at no time did he receive any paper title representing ownership to the Chevrolet. It later developed that the Ford was subject to a lien amounting to its entire value. The insurer for Bob Edwards Chevrolet Company was General Accident, and the liability insurance carrier for Alexander was American Casualty. After a verdict and judgment in the circuit court this action was begun in the United States District Court, Eastern District of South Carolina, to secure a declaratory judgment to determine primary and secondary liability as between General Accident and American Casualty.

The district court adjudged, as a matter of law, that there was not an issue of facts to be submitted to the jury; that there was not a sale of the Chevrolet by Bob Edwards Chevrolet Company to Alexander; and that the Chevrolet was being used and driven by Alexander by and with the permission of Bob Edwards Chevrolet Company at the time of the collision. The district court adjudged that General Accident was primarily liable and that American Casualty was secondarily liable. General Accident appealed to the court of appeals. The court of appeals found a wide split in the cases as to whether the purchaser of an automobile under a conditional sales contract has "sole and unconditional" ownership as required by various kinds of insurance policies, including liability insurance. It has been held, however, that where the prospective purchaser is in possession, he may have an equitable title sufficient to satisfy the requirement of "unconditional and sole ownership" and the seller may be held to have lost his sole ownership. The court of appeals reasoned that the sole criterion was whether or not the Chevrolet had been sold or transferred to Alexander so as to make it an owned

25. 327 F.2d 328 (4th Cir. 1964).

automobile under American Casualty's policy of liability insurance. The court of appeals said:

> We think that equitable ownership coupled with possession and the right to operate the automobile is sufficient ownership to make the automobile an "owned" one within American Casualty's liability insurance policy.[26]

Fraud and Misrepresentation

The case of *Mulkey v. United States Fid. & Guar. Co.*[27] was one in which the defendant had issued to the plaintiff a fire insurance policy covering a dwelling, together with a subsequent endorsement covering the contents thereof. While the policy was in full force and effect, the plaintiff's dwelling and contents were destroyed by fire. Plaintiff filed a sworn statement claiming the value of the contents destroyed as 3,045 dollars. Defendant declined to make payment of the claim. Thereafter, this action was instituted in which plaintiff sought 2,500 dollars damages for the loss of contents as provided in the policy. Defendant, by way of answer, plead a general denial, admitting only the issuance of the policy, and, as separate defenses, alleged that plaintiff was not entitled to recover under the policy in that he had wilfully concealed or misrepresented material facts, was guilty of fraud and false swearing, and that the fire was caused by or at the request of the plaintiff or someone acting on his behalf.

Upon trial, the jury found for the plaintiff in the amount of 2,000 dollars. Defendant's motions for a directed verdict, judgment n.o.v., or in the alternative for a new trial or a new trial nisi were refused, and this appeal follows.

The South Carolina Supreme Court said the exceptions presented the following general questions for determination:

1. Did Plaintiff carry the burden of proof as to the value of the contents allegedly destroyed?
2. Did Plaintiff wilfully conceal and misrepresent material facts or was he guilty of fraud and false swearing?
3. Did Plaintiff refuse to answer material questions during his pre-trial examination under oath?[28]

26. *Id.* at 332.
27. 243 S.C. 121, 132 S.E.2d 278 (1963).
28. *Id.* at 125, 132 S.E.2d at 280.

The court dispensed with the first exception on the ground that although as a general rule proofs of loss are admissible to show compliance with the provisions of the policy but are not competent independent evidence as to the amount of loss or the value of the property, there was testimony as to the value of the contents destroyed independent of the proof of loss, both on direct and cross-examination of the plaintiff and by defendant's witnesses, sufficient to sustain the amount of the verdict.

The second exception contained three distinct elements, namely that plaintiff wilfully concealed or misrepresented material facts or was guilty of fraud and false swearing, (1) by overvaluing the contents contained in the proof of loss, or (2) by including in the proof of loss items of which he was not the owner, and (3) by false swearing with regard to the existence of other insurance. As to the first two, the court held that there was no evidence indicating that the plaintiff had acted in bad faith even though the jury found that the loss sustained by the plaintiff was 2,000 dollars when he himself had claimed the property was worth 3,045 dollars, and even though some of the personal clothing destroyed in the fire actually belonged to the plaintiff's son. The third element was the allegation on the part of the defendant that the plaintiff was guilty of false swearing when he indicated there was no other insurance covering any part of the contents upon which he predicated his claim, which the court dismissed on the ground that the two interests which were insured were separate and that therefore the condition against additional insurance was not broken.

Defendant's third exception related to the plaintiff's refusal to answer certain questions during his examination under oath subsequent to the fire. The policy provided that as often as may be reasonable the insured shall submit to examination under oath. The two questions of which the defendant complained related to the plaintiff's police record and to where the plaintiff kept his personal papers. The trial judge ruled that the plaintiff's police record was immaterial and that refusal to disclose the whereabouts of his hiding place of his personal papers was also immaterial in the light of further questions propounded concerning papers relating to the personal property destroyed in the fire. The court held that the questions were not material per se to the plaintiff's claim; however, when considered in the light of possible arson, plaintiff's whereabouts does become material. At the time of the examination, plaintiff was appar-

ently unaware of the possibility of arson, whereas defendant knew of such possibility as it had obtained its investigation by an arson expert a few days after the fire. It was the reasoning of the court that defendant could not rely on a refusal to answer a question which is not material on its face to avoid the policy, when it is aware that the question is material or may become material because of special knowledge it has acquired, and thereby lull the insured into a violation of the cooperation clause.

Graham v. Aetna Ins. Co.[29] was an action to recover upon four insurance policies issued to the plaintiff by the four defendants, covering a building and contents thereof in which the plaintiff operated a restaurant.

The plaintiff alleged that he filed the required proof of loss, cooperated completely and complied with every request of the defendants, but that the defendants had failed to comply with the payment provisions of the policy. The defendants admitted issuance of the policy but brought forth evidence to the effect that the plaintiff had received payment for a fire loss that he had sustained in 1955 on a dwelling and its contents located on property belonging to plaintiff approximately three or four miles from the site of the plaintiff's restaurant. The defendants contended that this constituted a breach of the following provision:

> This entire policy shall be void if, whether before or after a loss, the insured has wilfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto.[30]

The defendants further alleged that had the facts of the previous loss been disclosed, the agent would not have issued the policies to the plaintiff. Plaintiff did not admit or deny that he had told the agent that this was the only previous loss, but explained the unreported loss by saying: "I was talking about that farm out there where I lived."[31]

The South Carolina Supreme Court reasoned that an applicant has a duty to fully answer questions propounded without evasion, misrepresentation or concealment, but that the present record did not contain the alleged interrogatories asked of the

29. 243 S.C. 108, 132 S.E.2d 273 (1963).
30. *Id.* at 110, 132 S.E.2d at 274.
31. *Id.* at 112, 132 S.E.2d at 275.

plaintiff by the agents of the insurer, only his purported answers, and without some evidence of the actual questions proposed, it was impossible to determine precisely whether the plaintiff's answers were false or were mistakenly made in good faith. The court further held that ordinarily, in the absence of fraud, failure of an insured to disclose a fact with reference to which no questions are asked is not such concealment as will void a policy, and, as has been stated, where the company asks no information and the insured makes no representations, the insured being asked nothing may presume that nothing as to the risk is desired from him. "Mere silence on the part of the assured as to a matter not inquired of is not to be considered such a concealment as to void the policy."[32]

Corley v. Coastal States Life Ins. Co.[33] involved an action to recover on a life policy alleging fraudulent breach of contract accompanied by fraudulent acts. A policy issued on the life of plaintiff's husband had a face value of 5,000 dollars and provided two additional death benefits. The first benefit was called a "Bonus Participation Fund," and the second benefit provided for a full refund of premiums. The dispute arose primarily out of the refund of premium benefit because the return of premium rider listed the annual premium at 200 dollars, whereas the annual premium on the face of the policy was listed at 213 dollars. The insurance company contended the return of premium benefit was not meant to include thirteen dollars which was added to the premium for disability and double indemnity provisions.

The basis of the claim for punitive damages was the company's statements concerning the full amount due under the policy. It first told plaintiff that 5,096 dollars was owing. After inquiry by the Insurance Commission, the company told the Commission that 7,296 dollars was the amount due. Then the company later told plaintiff that 6,371 dollars was due. It was held and affirmed that plaintiff was entitled to actual and punitive damages.

The company maintained there was nothing showing a fraudulent intent or a fraudulent act but that the erroneous offer was arrived at through mistaken calculations. The South Carolina Supreme Court held that tort liability exists for false statements

32. 243 S.C. 108, 113, 132 S.E.2d 273, 275 (1963), citing 45 C.J.S. *Insurance* § 473 (3) (1946).

33. 244 S.C. 1, 135 S.E.2d 316 (1964).

which, though made without actual knowledge of falsity, are made in a manner or under such circumstances that knowledge of falsity is imputed to the person making representations. False statements made recklessly, and without knowing or caring whether they are true or false, will support a fraud and deceit action. The company's conduct in attempting to settle the claim for less than the amount quoted to the Insurance Commission, an amount it was in a position to know was incorrect, is evidence from which fraud can be legally inferred.

Termination of Policy

Spencer v. Republic Nat'l Life Ins. Co.[34] was an action for death benefits under a group policy. In the lower court, there was a directed verdict against the insurer which had issued a group policy for Florence County and its employees on February 1, 1961. The wife of the respondent, who was a county employee, died on February 2, 1961. There was a standard provision in the application and in the policy that if the employee was not actively at work full time when the policy was issued, then the policy would not be effective as to that person until they returned to work full time. The South Carolina Supreme Court upheld the lower court in ruling that the insurer was estopped to assert this provision. It was argued that the court erred in admitting testimony relating to estoppel, since such estoppel was not plead, and further that the court was in error in admitting parol testimony tending to vary the provisions of the contract. The court said that estoppel was different from waiver, and that estoppel *in pais* need not be plead unless required by statute. The court further held that while the contract may have been ambiguous, there was no necessity in pursuing that question, since the evidence admitted was for the purpose of proving estoppel.

It was further argued that coverage could not be extended by waiver or estoppel. The court said that where estoppel exists, an insurer may be precluded from asserting that the loss was not within the terms of the policy.

The case of *Burns v. Prudence Life Ins. Co.*[35] was one in which the insured gave a check for a premium on a life policy and was promptly notified of dishonor of the check. The insured applied for reinstatement and tendered the same check, which was again dishonored. The insurer held the check until the time

34. 243 S.C. 317, 133 S.E.2d 317 (1963).
35. 243 S.C. 515, 134 S.E.2d 769 (1964).

of the trial; at no time was there sufficient money in the bank to cover it. The court held that the check was not unconditionally accepted even though a receipt by the insurance company was issued and the insurer was not negligent in its failure to notify the defendant in the nine day period from the time of dishonor until the death of the insured. The court further held that physical retention of the check under the circumstances did not constitute a waiver of the forfeiture of the policy since there was no inference that the check was held by the insurer other than for the purpose of evidence that the premium was not paid.

Surety Indem. Co. v. Estes[36] involved an insured who paid his premium on an automobile liability policy with a check that was dishonored because of non-payment of an item which the insured had previously deposited in his account. The insured then brought the account up to a figure sufficient to pay the premium check upon presentment within the grace period.

The court stated that this was a continuing policy of insurance and the question presented was whether the insured had forfeited his rights under that contract. In holding that the contract had not been forfeited, the court stated that the check was not accepted as absolute payment, but on condition that it would be paid on proper presentment. According to the court, the failure of this condition did not result in forfeiture since the grace period had not expired, and a tender of the check at any moment before such expiration would suffice to prevent forfeiture. Since there were sufficient funds and the condition was met, there was no forfeiture.

Allstate Ins. Co. v. Austin,[37] was an action under the Uniform Declaratory Judgments Act[38] to determine whether the Guaranty Insurance Exchange had in force a valid liability policy which had been issued to one Roy Dalton. The latter had borrowed from his county bank money for a premium on the liability policy which was paid in full to Guaranty. Upon being in arrears in payment of installments, a notice of cancellation of the policy was sent to Dalton by the agent of Guaranty, a Mr. Cothran, which notice Dalton never received.

The court held that Guaranty had no right to cancel the policy since the premium had been paid in full for the entire year and the insurer had no interest in installment payments. Any agree-

36. 243 S.C. 593, 135 S.E.2d 226 (1964).
37. 225 F. Supp. 523 (W.D.S.C. 1964).
38. S.C. CODE ANN. § 10-2001 (1962).

ment between the agent and Dalton to cancel the policy upon default in the installment payments was void and unenforceable as against public policy, since it was in violation of the laws of the State of South Carolina. Also, there was no authority granted to the agent for the cancellation for this particular policy by the insurance company. In any event, the cancellation notice was not effective, since it was mailed to the wrong address.

In the case of *Odell v. United Ins. Co. of America*,[39] there was an action for disability benefits under a policy of accident and health insurance. The defendant was in default, and therefore this case involved only the measure of damages. The court set out the rule for damages in an action to recover under such a situation to be only the amount of benefits accrued up to the point of the commencement of the action. The plaintiff contended that the action was for damages sustained by reason of wrongful cancellation by the defendant. The court held that the complaint stated only an action for recovery on the policy "since under the allegations of the complaint the attempted cancellation had no effect upon the legal status of the policy." No cause of action was alleged for the wrongful cancellation; therefore, the plaintiff could only recover for benefits which had accrued up to the commencement of the action, and benefits thereafter must be recovered by a subsequent action.

Uninsured Motorist Coverage

In *Motors Ins. Co. v. Surety Ins. Co.*,[40] the question was raised as to whether or not a collision insurer is subrogated to the rights of the collision insured under the uninsured motorist provisions of a liability policy. The court stated first that in the common law of subrogation, in order for one to be subrogated to the rights of another, that person seeking subrogation must have a superior equity. The court pointed out that the appellant (liability carrier) did not cause or contribute to the loss and that there was no privity of contract between the respondent and the appellant. Also, the appellant was required by law to provide coverage under the uninsured motorist act and received no expectation of profit. The purpose of the act was to relieve insured motorists, within specified limits, of risk of injury from tortious acts of financially irresponsible uninsured motorists, and nothing in the act was to relieve other insurers of primary responsi-

39. 243 S.C. 35, 132 S.E.2d 14 (1963).
40. 243 S.C. 487, 134 S.E.2d 206 (1964).

bility for their own contract, since the purpose of the act was not to benefit them. Therefore, the court denied subrogation both under the act and under equitable consideration.

Laird v. Nationwide Ins. Co.[41] involved a suit which was brought under the Motor Vehicle Safety Responsibility Act[42] to require payment by the insurance company of punitive damages awarded against an uninsured motorist. The South Carolina Supreme Court, in reversing, stated:

> There is no provision in the uninsured motorist act which, either expressly or by implication, requires that the uninsured motorist endorsement must insure against any and all liability.[43]

In this case the court placed strong emphasis for justification upon the rule that courts must not engage in judicial legislation.[44] This decision is in general agreement with other conclusions in other jurisdictions. By an amendment to the South Carolina Code, [45] this holding has been overruled so that now an insurance company under the uninsured motorist provision must pay both actual and punitive damages.

41. 243 S.C. 388, 134 S.E.2d 206 (1964).
42. S.C. CODE ANN. § 46-701 (1962).
43. 243 S.C. 388, 396, 134 S.E.2d 206, 210 (1964).
44. *Id.* at 395, 134 S.E.2d at 209.
45. S.C. CODE ANN. § 46-750.31 (4) (1964).