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Insurance

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INSURANCE

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The cases reviewed during this survey year do not contain any great departures from the established rules and decisions. While one might contend the *Watts*[1] decision to be a departure from the prior decision of *Bryant v. Blue Bird Cab Company*,[2] it is squarely in line with *Massey v. War Emergency Co-op Assn.*,[3] and is a sound, well-reasoned decision. A unique case, factually speaking, is that of *St. Paul Mercury Indemnity Company v. Palmetto Quarries Company*.[4] The Supreme Court also considered three cases[5] dealing with the defense of the insured's alleged failure to cooperate. Because of the variety of the subject matter of the decisions, classification was difficult.

Procedure

The following cases are not related except insofar as each pertains to a procedural question involved in insurance litigation.

United States Casualty Company v. Hiers, et al.[6] involved an action by the insurer against its agents for the amount of a judgment and costs which had previously been rendered against the insurer in an action on the policy by the insured. This case involved two procedural questions, one being a judgment rendered upon the pleadings and the other dealing with vouching.

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1. Watts v. Baker, et al., 233 S. C. 446, 105 S. E. 2d 605 (1958).
2. 202 S. C. 456, 25 S. E. 2d 489 (1943).
3. 209 S. C. 292; 39 S. E. 2d 907 (1946).
4. 234 S. C. 246, 107 S. E. 2d 453 (1959).
5. Tucker v. State Farm Mutual Automobile Ins. Co., 232 S. C. 615, 103 S. E. 2d 272 (1958); Brown v. State Farm Mutual Automobile Liab. Ins. Co., 233 S. C. 376, 104 S. E. 2d 673 (1958); Pharr v. Canal Ins. Co., 233 S. C. 266, 104 S. E. 2d 394 (1958).
6. 233 S. C. 333, 104 S. E. 2d 561 (1958).

The Complaint alleged the facts which were found in the prior action of the insured,[7] one Taylor, against the insurer, and reference should be made to this decision for more complete details with regard to the factual situation giving rise to the litigation. Briefly, Taylor had instituted an action against the insurance company for the wrongful cancellation of his automobile liability policy. Cancellation was the result of the failure of the insurance agent, Hiers, to return the premium to Taylor. The insurance company cancelled the policy and returned the insurance premium to Hiers, who retained the same in his possession. The insurance company now brings this action to recover over against Hiers, and the lower court held that in view of the fact that it was practically conceded by Hiers that he was the agent of the insurance company and that he had negligently retained the premiums which should have been forwarded to Taylor, that Hiers' answer was sham. Judgment was accordingly entered upon the pleadings under the well-settled general rule that the failure of an agent of an insurer to comply with the instructions of the latter, whereby loss to it results, is liable over to the insurer.

It appears from the report of this case that the insurance company had written a letter through its attorneys to Hiers advising of the pendency of motions in the *Taylor* case for judgment *n. o. v.* and for a new trial. This letter contained a notice that the insurer would look to the agent for payment of the judgment and reimbursement of expenses if the judgment be entered against the insurer, and the agents were invited to have their counsel assist in the argument of the motions. A second letter advised the agent of the adverse ruling upon the motions and repeating the insurer's position that the ultimate liability would be placed upon the agent. The letter also advised that notice of an appeal had been filed and asked for the agent's "reaction" as to perfecting the appeal and inquiring as to what the agent would like to have done in regard to it. These letters were ignored by the agent. The Supreme Court held that it was the duty of the agent to voice at that time their opposition to the appeal, if they were opposed, and that under the circumstances their silence amounted to acquiescence. The agent contended that they had not been vouched

7. Taylor v. United States Casualty Co., 229 S. C. 230, 92 S. E. 2d 647 (1956).

to defend the *Taylor* action, but the Supreme Court held that there was no duty upon the insurer to formally vouch the agent. The Court stated that the agent had full knowledge of the *pendency* of it, were consulted with reference to the defense, and that Hiers had testified for the insurer who was the defendant in the *Taylor* case. The Supreme Court said that in none of the many authorities reviewed did it appear that the practice of vouching was followed, much less required, in order to fix liability upon the misfeasant agent.

The case of *Watts v. Baker, et al.*[8] is the latest of a host of cases relating to the proper joinder of an insurance company with the insured as a party defendant in an action by the injured party for damages. The plaintiff was a passenger in a taxi-cab and brought an action against the owner of the taxi-cab and his insurer for injuries sustained in the accident. The defendants had previously filed a motion to make the complaint more definite and certain by requiring the plaintiff to allege whether or not the insurance policy referred to in the complaint was filed pursuant to the requirements of any statute or ordinance and by setting forth in detail the citation and reference to any such statute or ordinance. The lower court had granted this motion and the plaintiff had complied with the lower court's order by serving an amended complaint setting forth the Columbia ordinance relating to taxi-cabs. To this amended complaint the defendants demurred on the grounds that the amended complaint did not state facts sufficient to constitute a cause of action against the insurer in that it appeared on the face of the complaint that the plaintiff was suing the insurance company upon a liability policy issued to the insured and that no cause of action existed under such policy until a final judgment was recovered against the insurer. It was further contended by the demurrer that since it did not appear on the face of the complaint that the plaintiff had recovered a final judgment against the insured, that there was a misjoinder of causes of action in the complaint. The lower court overruled the demurrer and defendants appealed from this ruling.

The Columbia City Ordinance is set forth in the opinion, a pertinent portion of which is as follows:

8. 233 S. C. 446, 105 S. E. 2d 605 (1958).

". . . the bond or policy shall stipulate that any person who may recover final judgment for damages, such judgment remaining unpaid thirty days, shall have the right of action on such bond or policy in the event the owner of the taxicab is insolvent and does not pay the same within thirty days."

The Supreme Court stated that it had held in numerous cases that where insurance was given as required in Section 58-1481 of the 1952 Code of Laws of South Carolina, that it was proper, pursuant to Section 10-702 of the Code, to join the insured and the insurance company as parties defendant in an action by a third person based upon the negligence of the insured.

The Court stated that it should be noted that Section 58-1481 requires the filing with the Public Service Commission of liability and property damage "insuring or indemnifying" passengers receiving personal injuries from any act of negligence. Under this statutory requirement the Court stated that it had held that the policies filed are liability rather than indemnity policies and that an injured party has a direct right of action thereon. The Court stated that the words "insuring or indemnifying" present in the statute and in many of the city ordinances, formed the basis on which most of the cases decided by the Court on the joinder question have turned. It was noted that these words were absent from the Columbia taxi-cab ordinance. In view of the absence of such words the Supreme Court concluded that the ordinance of the City of Columbia gave to the injured party a cause of action on the insurance policy filed with the city only in the event of a recovery of a final judgment againt the taxi-cab owner; his insolvency; and his failure to pay the judgment within thirty days. It was held that the injured party had no cause of action against the insurer until these conditions had been met and that the insurer had no obligation directly to the public until after final judgment against the taxi-cab owner and operator had been obtained. Accordingly, the insurer was held not to be properly joined as a party defendant in the action and the case was remanded to the lower court for the purpose of an Order sustaining the demurrer, thereby elemininating from the case the insurer and all references in the complaint to insurance coverage.

The case of *South Carolina Electric and Gas Company v. Aetna Insurance Company*[9] involved primarily the question as to whether or not South Carolina procedure permitted a trial judge to grant a new trial upon the issues of damages only.

The trial resulted in a jury verdict for the plaintiffs for $138,000.00. The usual defensive motions were overruled, except the trial judge granted a new trial upon the issue of damages only. He found the verdict to be excessive but declined to reduce it by order for new trial *nisi*, which course was within his discretion.

The first question upon appeal concerned itself with whether or not under the evidence the loss may have been reasonably found to be within the terms of the subject policy. The Court concluded that this was a jury issue.

The second question was whether the insured had proven any recoverable damages. The Court overruled the insurer's objection stating that the evidence as to the amount of the loss was not so deficient as to warrant a directed verdict because of the failure of proof in that respect.

Finally, with regard to the procedural question at issue, which was the main point in the appeal, the Court held that the trial judge had committed reversible error in granting a new trial limited to the issue of damages. The Court recognized that this practice was followed in the Federal Courts under rule 59 (a), but stated that modern decisions of our Court did not countenance such procedure, and that in the absence of an authorizing statute or rule, the Court did not feel warranted in making such an important innovation in our procedure.

Accordingly, the case was reversed and remanded.

In the case of *St. Paul Mercury & Indemnity Company v. Palmetto Quarries Company*,[10] the insurance company had filed with the Industrial Commission an "A" card indicating Palmetto Quarries to have Workmen's Compensation coverage. Under the Compensation Act quarries were not a type of business which came within the mandatory provisions of the Act. The action was brought by the insurance company to recover premiums due by the insured and the insured admitted this indebtedness and interposed two counterclaims, one in tort and one in contract. The counterclaim based on contract

9. 233 S. C. 557, 106 S. E. 2d 276 (1958).
10. 234 S. C. 246, 107 S. E. 2d 453 (1959).

was subsequently abandoned and the counterclaim based in tort was the real issue before the Court. This counterclaim was based upon the following factual situation: An employee of Palmetto Quarries, one Garvin, sustained an injury while at work and through his attorney filed a claim with the South Carolina Industrial Commission for compensation. Palmetto Quarries did not want the case handled as a Workmen's Compensation case because it was afraid the Industrial Commission might impose penalties upon it for failing to comply with the law. The insurance company refused to pay the amount demanded by Garvin to settle his claim but offered to the quarry to defend the claim before the Industrial Commission on the grounds that the quarry was exempt from the mandatory coverage of the law. The insurance company further offered to pay any judgment that might result against the quarry from this claim if it should be found that the filing of the "A" card has extended the coverage to include industrial claims. Palmetto Quarries, however, refused to permit the insurance company to oppose the employee's claim and ultimately entered into an agreement with the claimant's attorney whereby the claim was withdrawn and a common law action, based on the employee's injuries, was brought against the quarry and as a part of the agreement it was agreed to settle the common law action for the consideration of $3,500.00. This was done and Palmetto Quarries counterclaimed to have the insurance company contribute to the settlement. The insurance company had originally declined to contribute and stood on its offer to oppose the claim before the Industrial Commission or to defend against the subsequent common law action and to pay any judgment resulting therefrom.

The Supreme Court affirmed the Circuit Judge who directed that Palmetto Quarries pay to the insurance company the premiums due and dismissed the counterclaims. The Supreme Court stated that while it might be conceded that the actions of the insurer led the Industrial Commission to take the position that Palmetto Quarries had elected to come under the Workmen's Compensation Act and had caused the employee, Garvin, to seek Workmen's Compensation rather than to bring a common law action. The Court stated, however, that it would be difficult to see how this could have caused any loss to the quarry in view of the willingness of the insurance company to pay any recovery by the employee resulting from the

mistakes of the insurer, which had offered to pay any award that might be rendered by the Industrial Commission or to pay any judgment that might result from the common law action.

Primary and Secondary, or Excess, Coverage

In *American Surety Company of New York v. Canal Insurance Company*,[11] the Fourth Circuit Court of Appeals reversed the United States District Court decision. The question involved which of two insurers had the primary coverage, or whether the insurance coverage should be pro-rated. Johnson Motor Lines had leased a truck from Mary B. Southerland, d/b/a S & S Produce Company, for a trip from Greenville to Philadelphia, Pennsylvania. In route it was in a collision in Virginia, and thereafter suits for personal injury and property damage were filed against Johnson Motor Lines in North Carolina. American Surety Company of New York was the insurer for Johnson Motor Lines and Canal Insurance Company was the insurer for S & S Produce Company. Canal was called upon under its omnibus clause to defend these actions in North Carolina and to pay any judgment which might be obtained against Johnson Motor Lines, up to the limits of its coverage, but Canal refused to do so. American Surety thereupon defended the actions and satisfied the judgments after they were entered. American Surety then filed this suit in the District Court for the Western District of South Carolina by which it seeks reimbursement from Canal of so much of its payment in satisfaction of the judgments as was within the limits of Canal's coverages, plus its attorney's fees, costs and expenses incurred in the defense of the North Carolina tort actions.

The District Court concluded that the two coverages were concurrent and that the loss should be pro-rated between the carriers.

The Fourth Circuit Court of Appeals, speaking through Judge Haynsworth, concluded that the insurer of the owner of a described vehicle has the first and primary obligation. Having thus concluded, the Court then held that a non-ownership clause, such as was contained in American Surety's policy, with regard to the use of a hired vehicle, with an excess cover-

11. 258 F. 2d 934 (4th Cir. 1958).

age provision, does not constitute other valid and collectible insurance, within the meaning of a primary policy with an omnibus clause. Canal's policy limits its liability to a proportion of the loss, based upon the relation of the policy limits, if there was other valid and collectible insurance available to the insured. Accordingly, it was held that the American Surety policy did not constitute other valid and collectible insurance insofar as the Canal policy was concerned and Canal was held to be the primary insurer and directed to reimburse American Surety up to the limits of its policy, for the judgments rendered in tort actions and for all costs, expenses and attorney's fees.

Interest of The Public In Insurance Matters

In *Batchelor v. American Health Insurance Company*[12] the appellant purchased a hospital expense policy from the respondent insurance company and instituted this action to recover the benefits allegedly due under the policy. The insurance company defended primarily upon the grounds that the appellent had obtained numerous other policies of hospital insurance which, together, would provide benefits in an amount greatly in excess of his earnings and it was thereby contended that the obtaining of the instant policy and the other policies constituted a wagering contract and was contrary to public policy. The testimony showed that the appellant had a gross weekly income of some $65.00 and that under the varous policies by which he was insured, some ten in number, he would be entitled to approximately $745.00 per week plus additional benefits for certain medical and hospital charges for each week he was hospitalized.

Our Court stated that a wager policy of insurance is a pretended insurance, where the insured has no interest in the thing insured and can sustain no loss by the happening of the misfortunes insured against. The Court stated that a wager policy had also been defined as one made when the insured had no insurable interest. In the subject case the Court stated that the appellant had an insurable interest in his own health and he could sustain a loss by the happening of the event against which the respondent had issued its policy of insurance. The Court accordingly held that the policy did not constitute a wagering contract.

12. 234 S. C. 103, 107 S. E. 2d 36 (1959).

With regard to the public policy, the Court has the following to say:

> There is no established public policy which prevents one from purchasing as many hospital expense policies as one may desire. This is so because there is no prohibitory statute, and there are no judicial decisions establishing a public policy which prevents such.
>
> . . . Thus, in the absence of policy restrictions, the rule is that a person having insurable interest may insure such interest in whatever amount and in as many companies as he desires.

In *State v. National Postal Transport Association,*[13] our Supreme Court held that a foreign insurance company was not liable for the statutory penalty of $10.00 per day imposed by § 12-737 of the 1952 Code of Laws for South Carolina. The Court held that the provisions of the Code dealing with the domestication of foreign corporations did not pertain to foreign insurance companies who do business within this state and that the legislature had placed the supervision of foreign insurance companies in the hands of the insurance commissioner.

Requirements for Cooperation by the Insured

Edward Tucker v. State Farm Mutual Automobile Insurance Company[14] involved an appeal from the direction of verdict in favor of the insurer because of breach by the insured of the assistance and cooperation provision of an automobile liability policy. The insured had refused to sign the verification of an answer prepared for him by an attorney engaged by the insurer saying that he did not want to have anything more to do with the action for damages against him. Also, insured failed to respond to notices and letters sent to him by insurer's attorney and subsequently, judgment by default was taken which constituted the basis of the action here. The Supreme Court held that consideration of all the evidence required the conclusion that the only reasonable inference was that insured completely failed to comply with his obligations under the pertinent provision of the policy, whereby insurer was released from liability. In this decision the Court did not

13. 234 S. C. 260, 107 S. E. 2d 763 (1959).
14. 232 S. C. 615, 103 S. E. 2d 272 (1958).

reach the point of whether failure of cooperation of insured must be prejudicial to the rights of the insurer in order to release it from liability, but said there could be no doubt of existence of prejudice under the facts of this case.

In *Pharr v. Canal Insurance Company*[15] certain parties, who had been injured in an automobile accident and had recovered judgments against the insured driver, brought suit directly against insurer to the extent of the policy limits. In the Circuit Court verdicts were directed in favor of the plaintiffs which were reversed on appeal as the Supreme Court held that questions of cooperation by insured with insurer in defense of suits and whether such failure to cooperate had resulted in substantial prejudice of insurer were for jury.

The insurer had obtained a declaratory judgment against insured on the basis of failure to cooperate but the Court concluded this was not res adjudicata as to injured plaintiffs who were not parties to the declaratory action. Furthermore, the insurance contract between two parties for the benefit of a third could be enforced by such third party beneficiary even though he was not named therein.

Brown v. State Farm Mutual Automobile Liability Insurance Company[16] was an action brought by a personal injury judgment creditor and his assignee against an insurer under an automobile liability policy. The insurer denied liability on the grounds that the insured had failed to comply with the terms of the policy in that proper notice of the accident had not been given to the company and that the insured had failed to fulfill the requirements of the cooperation clause.

The Court sustained the trial judge's refusal to hold as a matter of law that the insured did not cooperate as required by the policy where the evidence showed that the insured notified the insurer's attorney two days before the trial that he could not remember the details of the accident even though he gave a prior detailed statement concerning such details. The question of whether the insured was wilfully trying to help the plaintiff recover against the insurer or whether he was suffering from traumatic amnesia in this instance was properly for the jury. The Court restated its position that:

> Ordinarily, therefore, whether or not an insured has performed his duty in each case will present perplexing

15. 233 S. C. 266, 104 S. E. 2d 394 (1958).
16. 233 S. C. 376, 104 S. E. 2d 673 (1958).

> problems of fact, properly for a jury to determine .... If there is any contradictory testimony thereabout, it must be submitted to a jury.

The Court further held that there was no error in allowing proof of the insurer's waiver of the policy requirement of written notice of accident where a membership identification card provided for the giving of oral notice, even though the complaint did not allege waiver.

It is interesting to note that not one of the three cases cited in this section resolved the effect of subsection (3) of Section 46-750.26 of the South Carolina Motor Vehicle Safety Responsibility Act, that:

> No statement made by the insured or on his behalf and no violation of the policy shall defeat or avoid the policy;

The *Pharr v. Canal Insurance Company* issue arose before the enactment of the statute, and neither the *Tucker* case nor the *Brown* decision raised this point.

Waiver and Estoppel

In *American Mutual Fire Insurance Company v. Green*[17] the insurer brought an action against the insured to foreclose two mortgages executed by the insured and subsequently assigned to the insurer. The insured by way of counterclaim sought judgment against the insurer on his fire policy. The insurer denied liability upon the grounds that (1) the building had been "unoccupied beyond a period of sixty consecutive days" prior to the loss, and (2) that the insured had failed to furnish written proof of loss within sixty days after the fire as required by the policy.

The Court, affirming the judgment for the insured, held that the insurer waived the requirement of the policy requiring proof of loss when liability was denied on grounds not related to the proof of loss. The conduct of the adjuster in telling the insured during the investigation not to remove any of the salvage and that the insured would hear from the company was held tantamount to waiver and estoppel. The argument by the company that the non-waiver agreement executed by the insured averted the operation of waiver and estoppel was overruled on the grounds that the wording of the non-waiver agreement related to the investigation of the loss and the insured claimed waiver and estoppel by the conduct

17. 233 S. C. 588, 106 S. E. 2d 265 (1958).

of the company prior to the execution of the agreement and after the investigation was completed rather than during the investigation. The Court stated:

> These agreements are always construed strictly against the insurer and will not be extended so as to prevent a waiver by acts not within their terms.

Special Provisions

In *Deloache v. Carolina Life Insurance Company* [18] an action was brought against the insurer to recover under the double indemnity provision of a life policy.

The Court held unanimously that where the double indemnity provision provided that no such additional amount would be paid in the event of death resulting from injuries intentionally inflicted by another person, that the insurer would not be liable when the insured was shot following an exchange of words with another person, regardless of whether that person was mentally or legally responsible.

Products Liability

In *Ducker v. Central Surety and Insurance Corporation*[19] an action was brought by the insured on a products liability policy to recover the amount of a judgment obtained against the insured by a customer for damages resulting from an exploding furnace installed by the insured in the customer's home. The policy provided for payment of "all sums which the insured should become legally obligated to pay as damages because of injury to or destruction of property caused by accident and arising out of goods or products manufactured, sold, handled, or distributed to others by the insured . . . . " The defendant refused to pay the loss because it contended that it was not a loss resulting from accident. At the conclusion of plaintiff's evidence, the trial court granted the defendant's motion for nonsuit upon the conclusion that an accident, within the terms of the policy, had not been established.

Chief Justice Stukes, delivering the unanimous decision of the Court to reverse the trial Court and grant a new trial, held that where evidence indicated that the furnace repeatedly accumlated soot and gas which resulted in explosions

18. 233 S. C. 34, 104 S. E. 2d 875 (1958).
19. 234 S. C. 228, 107 S. E. 2d 342 (1959).

that smoked the walls of the house and where it was shown that one of the explosions dislodged the smokestack, that the question of whether the damage was caused by accident within the terms of the policy was for the jury.

Fraud and Insurance Conracts

During the survey year, the South Carolina Supreme Court resolved two insurance cases involving issues of fraud, while the United States Circuit Court of Appeals for the Fourth Circuit resolved only one case involving such issues.

In *Blackmon v. United Insurance Company*[20] the Court held that the trial judge properly refused the defendant's motion to strike the allegations of plaintiff's complaint seeking punitive damages for alleged fraudulent respresentations by the insurer's agent in obtaining a life insurance policy and premium receipt book from the beneficiary under the policy.

The Court pointed out that while breach of contract, however fraudulent the intent accompanying it, does not of itself give rise to a cause of action for punitive damages, that where the fraudulent intent is accompanied by a fraudulent act, liability will arise for punitive as well as actual damages. The trial Court properly construed the cause of action in this instance as one for fraudulent breach of contract accompanied by a fraudulent act. The Supreme Court went further to point out that refusal of the defendant's motion to strike such allegations as irrelevant was not appealable, citing *Sparks v. D. M. Dew & Sons, Inc.*[21] and *Winchester v. United Insurance Company*[22].

The case of *Ward v. Liberty Life Insurance Company*[23] involved an action for damages for fraudulent breach of an alleged undertaking by the defendants to procure and put in force a policy of insurance on the life of plaintiff's intestate. Plaintiff alleged that application for a "decreasing term" policy was made to the defendant on May 19, 1955 naming the mortgagee of the plaintiff's intestate as beneficiary. The policy was prepared under date of July 1 and forwarded to the agent. It is noteworthy that the policy contained a provision that it would not take effect until the first premium was paid and that such premium was never paid. Plaintiff's

20. 233 S. C. 424, 105 S. E. 2d 521 (1958).
21. 230 S. C. 507, 96 S. E. 2d 488 (1957).
22. 231 S. C. 288, 98 S. E. 2d 530 (1957).
23. 232 S. C. 582, 103 S. E. 2d 48 (1958).

intestate died August 1, 1955 with the policy still in the hands of the agent. Thereafter suit was brought by the administratrix alleging that the fraudulent acts consisted of: (1) the failure by the agent to notify the insured that the policy had been written and was in his possession; and (2) in not paying the initial premium either from the escrow account or out of the funds of the savings and loan association. The Supreme Court affirmed the order of nonsuit entered by the lower court on the grounds that the evidence was insufficient to establish that the insurer was guilty of such unreasonable delay in effecting delivery of the policy as to estop the insurer to deny that the policy was in force and that the evidence was also insufficient to establish that the insurer or the agent was guilty of fraud in failing to deliver the policy to the intestate or to notify him of the premium due. The Court pointed out that, while such circumstances did not appear here, that in a proper case that:

> Unreasonable delay by the insurer's agent in effecting delivery of the policy just as such delay on the part of the insurer in acting upon an application, may, if accompanied by circumstances such as retention of the premium, misleading representation relied upon the applicant, and the like, estop the insurer to deny that the policy is in force.

The case of *Nationwide Life Insurance Company v. Attaway*[24] involved an action brought by the beneficiaries on a life policy against the defendant insurer who contended that the beneficiaries were entitled only to a return of the insured's premium because of certain false statements made in the application for the policy concerning the prior medical history of the insured. The examining physician was also the personal physician of the insured and was alleged to have made the false statements as to the insured's prior medical history on his application with the knowledge that he had treated the insured for extensive illnesses in the past. The physician had not acted as agent of the company prior to the application for the policy in question and therefore was not the company's agent at the time of his prior examinations and treatment of the insured.

The Court reversed the judgment of the lower Court in favor

24. 254 F. 2d 30 (4th Cir. 1958).

of the defendant. The Court recited the prevailing rule in South Carolina to the effect that:

> If an insurance company issued a life policy with knowledge that the insured has misrepresented his physical condition and is in fact not in good health, the company is deemed to have waived the right to object and is bound by its contract; and in such case the knowledge of an agent of the company, who is aware of the misrepresentation, is imputed to it, unless it is shown that the agent as well as the insured was guilty of fraud. The agent's knowledge, however, is not imputed to the company unless it was acquired during the period of his agency, or if previously acquired, unless the agent had the information in mind when he undertook to act for the company in the issuance of the policy.

The Court further pointed out that the conclusion woud be the same in this instance whether the physician had the facts in mind and became a party to the fraud or did not have them in mind when he approved the risk, for in either case under the rule cited, the company would not be charged with knowledge of the truth and could not be held to have waived the right to deny liability.

No Liability of Insurer to Owner Under Operator's Policy

In *Booth v. American Casualty Company*,[25] an action was brought by a liability insurer against the insured's administratrix and another motorist involved in a collision for a declaratory judgment that the insurer was not liable on an operator's or nonowner's policy where the insured owned the automobile he was driving at the time of the collision. The facts indicated that the vehicle had been purchased and registered in the name of the insured's sister.

The plaintiff sought to invoke the provisions of the South Carolina Motor Vehicle Safety Responsibility Act alleging its design was to protect the motoring public and to effectuate coverage, notwithstanding the specific language of the policy to the contrary. The Court affirmed the lower court's judgment for the insurer and restated its position that:

> We cannot read into the insurance contract, under the guise of public policy, provisions which are not required

25. 261 F. 2d 389 (4th Cir. 1958).

by law and which the parties thereto clearly and plainly have failed to include.

The Court pointed out that subsection (3) of Section 46-750.26 of the Act came nearer to imposing liability on the insurance company than any other section. This subsection is as follows:

"No statement made by the insured or on his behalf and no violation of the policy shall defeat or avoid the policy;"

The Court held that all the subsections of Section 46-750.26 refer to "the policy" as issued, however, and that there was nothing in that section or any other section of the Act sufficient to make an entirely new and different contract or to substitute an owner's policy for an operator's policy.

Group Policies

The case of *Waltz v. Equitable Life Assurance Society*[26] involved an action brought by a beneficiary under a group accidental death policy. The policy in question contained a provision that coverage would automatically cease on termination of employment. On December 22, 1955, the insured was arrested and charged with misappropriating his employer's money. On December 29, 1955, the insured died.

The Court affirmed the lower Court's decision that the testimony conclusively showed that the insured's employment was terminated at the time of his arrest. The employee's own act was held to have brought about the termination of his employment.

26. 233 S. C. 210, 104 S. E. 2d 384 (1958).