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# Insurance

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## I. Introduction

During the preceding survey period the substantive law of insurance has been relatively prolific as evidenced by the number of decisions rendered by the courts of this jurisdiction—both state and federal. As could be expected, however, there are few instances in which more than one of the decisions is related to the same particular facet of the law as would facilitate the discussion thereof on a topic rather than an individual case basis. Accordingly, most of the decisions will be discussed separately with grouping by subject matter attempted wherever possible.

## II. Application for Insurance

Perhaps the most appropriate jumping off place in this area is the application for a policy of insurance and related problems. The case of *Smiley v. Woodmen of the World Life Insurance Company*[1] involved an application which the defendant-insurer alleged contained fraudulent misrepresentations that rendered the life insurance policy of the plaintiff's deceased null and void. Because it is virtually impossible to appreciate or to fully understand the decision without a full discussion of the facts, they are presented in such detail as the author deems essential to their comprehension.

In February 1964 the insured, William A. Smiley, became ill and contacted his family physician who referred him to another doctor for a possible tonsillectomy. This second doctor diagnosed Smiley's illness as leukemia and referred him to the South Carolina Medical College Hospital in Charleston where this diagnosis was confirmed. Smiley was confined for six days during which time he improved considerably and, upon being released, returned to full time employment. He remained an out-patient, returning to the hospital at intervals of six to eight weeks, during which time he continued to take medicine. Since the insured was only twenty years old at this time, his family did not reveal the nature of his illness to him, and except for the periodic visits to the Medical College Hospital and one occasion when he was treated for a sore throat, Smiley saw no physician again until May 25, 1965.

1. 154 S.E.2d 834 (S.C. 1966).

On April 20, 1965, Smiley was solicited by an agent of the defendant who offered him up to 15,000 dollars life insurance coverage without a medical examination. Smiley agreed to take out a 1,000 dollar policy at that time, and the policy was issued on April 28, 1965. Subsequently Smiley's condition deteriorated, and he was readmitted to the Medical College Hospital on May 25, 1965, where he remained until June 2, 1965. Following this discharge he returned to normal activities but had to be readmitted on July 17, 1965. On July 27, 1965, Smiley died of leukemia.

In an action by Smiley's wife, as named beneficiary, to recover the proceeds of the policy, the insurance company defended on the grounds that the policy contained false and fraudulent representations, to wit:

> 6. Have you ever been under care or treatment in any hospital or similar institution?
>
> A. No
>
> 7. Have you within the past ten years had any mental or bodily disease or infirmity or within that time consulted a physician?
>
> A. No
>
> 8. Do you regularly take medication? If so, state below the name of drug and condition requiring it.
>
> A. No
>
> 9. Are you now in good health?
>
> A. Yes[2]

In support of its motions, the defendant argued: (1) even if Smiley was unaware of his condition, he withheld pertinent information with respect to his medical treatment and (2) Mrs. Smiley, who was present during a portion of the interview of April 20, 1965, should have revealed the nature of her husband's illness. With respect to this latter contention the defendant relied upon the case of *Gamble v. Metropolitan Life Insurance Company*[3] in which the insurer's liability on a life insurance policy was denied by the court on a finding that the insured's husband, in applying for the policy on her life, had withheld information of the insured's terminal illness.

2. *Id.* at 837.
3. 92 S.C. 451, 75 S.E. 788 (1911).

In rejecting the defendant's argument the court reiterated the well settled proposition[4] that

> [I]n order to void a policy of insurance on the ground that the fraudulent misrepresentations were made in the procuring of such policy, the burden of proof rests upon the insurer to show, by clear and convincing evidence, not only that the statements complained of were untrue, but in addition thereto that their falsity was known to the applicant, that they were material to the risk, were relied on by the insurer, and that they were made with intent to deceive and defraud the company.[5]

Having adopted this position, the court proceeded to resolve several factual issues: (1) Smiley was obviously unaware of his physical condition; (2) with regard to question 8. above, the insured had been informed that the pills he was taking were vitamins, and this was admitted to the agent; (3) there was evidence that Smiley had informed the defendant's agent of his prior hospitalization, and this evidence must be viewed in the light most favorable to the plaintiff; and (4) there was evidence that the original interview of April 20th had been recorded on scratch paper, that the insured had admitted prior hospitalization during the interview, that his responses had been altered on the final form which the insured gave only a cursory examination before signing.

In considering Mrs. Smiley's failure to disclose the nature of Smiley's illness to the agent, the court determined that it was not she who was being interviewed, that she was present during only a portion of the interview, and that it was only logical that she not reveal this information to a total stranger in front of her husband, the very one from whom she was concealing it, especially in view of the fact that she thought that subsequent medical examination would reveal the illness if it still existed. In this regard the court distinguished the *Gamble* decision on the grounds that there the insured's husband had requested that the policy be issued, had participated in the interview, had paid the premiums and had knowingly rendered false information. The court focused on this *active participation*, stating, "[I]t was

4. Hood v. Security Ins. Co., 247 S.C. 71, 145 S.E.2d 526 (1965); Small v. Coastal States Life Ins. Co., 241 S.C. 344, 128 S.E.2d 175 (1962); Metropolitan Life Ins. Co. v. Bates, 213 S.C. 269, 49 S.E.2d 201 (1948).

5. Smiley v. Woodmen of the World Life Ins. Co., 154 S.E.2d 834, 835-36 (S.C. 1967).

reasonable to infer that the husband was the agent of his wife in the transaction, and that, therefore, his knowledge about her condition should be imputed to her."[6] In the instant case there was nothing in the record to indicate that Mrs. Smiley had any knowledge that the policy had ever been issued or that she had been named the beneficiary thereof. Accordingly, the court concluded, "The lower court, under these circumstances, would not have been warranted in holding, as a matter of law, that the respondent was derelict in her duty or guilty of fraud which would preclude her recovery."[7]

It should be noted that in *Gamble* the husband of the insured was aware of his wife's terminal disease at the time he signed the application, thereby certifying the contents as true. The court there, however, stated that

> As between the plaintiff and the insurance company, the law imposed upon him the duty of informing his wife of her condition to the end that she should not impose upon the insurance company in his behalf, and it will not allow him to say, in enforcing his claim, that he did not perform his duty.[8]

It appears that the court in *Gamble* focused more on this *duty* in imputing the husband's knowledge to his wife than it did in the instant case. This knowledge-duty criterion was, at least inferentially, subordinated to the seemingly distinct and somewhat more liberal "active participation" standard employed to sustain recovery in *Smiley*.

The case of *Hinds v. United Insurance Company of America*[9] represents a recent development in South Carolina with regard to the insurer's failure, within a reasonable time, to act upon an application for an insurance policy. This action was instituted by the plaintiff, John M. Hinds, to recover damages from the defendant allegedly occasioned by United's negligence in handling his applications. The complaint alleged that United had issued a policy of health and accident insurance to Hinds about January of 1961 which was later replaced by a more comprehensive policy issued about December 1, 1961. Hinds subsequently learned that this second policy was not actually in

6. *Id.* at 838.
7. *Id.* at 839.
8. Gamble v. Metropolitan Life Ins. Co., 92 S.C. 454, 75 S.E. 789 (1911).
9. 248 S.C. 285, 149 S.E.2d 771 (1966).

accordance with his understanding thereof at the time he applied for it; and, after making two or three quarterly payments, he allowed this second policy to lapse some time in 1962. He was approached by one of United's agents in late 1962 or early 1963 and advised that he could reinstate the first policy provided he did so before March 15, 1963—it being alleged that the agent knew or should have known that such statement was not true. On February 19, 1963, Hinds remitted his check to the defendant in payment of the first quarterly premium due on the policy to be reinstated. He assumed that this application had been acted upon until July 23, 1963, at which time he was informed by another of United's agents that the time for reinstatement had expired prior to the application on February 19, 1963. Immediately upon receipt of this information Hinds applied for a new policy, giving the agent an additional amount which, together with the check of February 19, 1963, constituted the quarterly premium due on this policy. This new policy was not issued until September 25, 1963, and contained a provision excluding coverage for a heart attack occurring within six months after the issuance thereof. On March 20, 1964, just five days before the new policy would have been in effect for the requisite six months, Hinds suffered a heart attack. It was further alleged that Hinds would have had coverage at the time of his heart attack but for the negligent, reckless, wilful and wanton acts on the part of the defendant and its agents in misleading him into believing that the original policy could be reinstated and that it had been reinstated, and in failing to accept or reject his application for reinstatement, as well as his application of July 23, 1963, within a reasonable time. Both actual and punitive damages were demanded.

The defendant demurred, asserting that the facts alleged did not give rise to a cause of action ex delicto. In this regard the court reviewed the conflicting decisions from other jurisdictions, concluding that, considering the allegations in the light most favorable to the plaintiff, United had breached "the duty owed by an insurer and its agents to an applicant to avoid representations which would mislead the applicant to his detriment, and at the same time handle the application with care and without unreasonable delay."[10] Accordingly, the complaint was deemed to have contained a valid cause of action ex delicto.

10. *Id.* at 291, 149 S.E.2d at 775.

To the defendant's argument that Hinds had either waived or become estopped to assert his rights by virtue of having accepted the policy, the court replied,

> However negligent, reckless willful or wanton [United] may have been, such conduct would not give rise to a cause of action in the absence of damage to [Hinds]. When [Hinds] accepted the new policy, he had then sustained no damage and had no cause of action, so that there was at that time no known enforceable right which he could waive.[11]

United's further contention that the complaint was demurrable as indicating on its face Hinds' contributory negligence was likewise rejected:

> There is ample authority for the proposition that a complaint based upon negligence is demurrable if it state facts from which plaintiff's contributory negligence must be inferred. On the other hand, if the facts stated do not conclusively show contributory negligence, or may support an inference to the contrary, then the question of contributory negligence becomes a jury question. . . . Even assuming that the complaint shows [Hinds] to be contributorily negligent, simple contributory negligence on his part would not defeat a recovery, if the conduct of [United] was willful and wanton as alleged by [Hinds].[12]

United's final contention was that any recovery by the plaintiff should be limited to actual damages and in no event could it be held liable for punitive damages. In ruling on this point the court acknowledged the absence of a similar local situation in which punitive damages were sought, but it concluded that there was

> no sound reason for holding that the tort alleged in the complaint in this action should be governed by a rule different from that applicable in other tort actions. It is, of course, elementary that a tort committed in a willful and wanton manner entitles a complainant in this jurisdiction to exemplary or punitive damages.[13]

Justice Legge, however, refused to concur with the majority on this point, apparently viewing the action as one ex contractu

11. *Id.* at 292, 149 S.E.2d at 775.
12. *Id.* at 292-93, 149 S.E.2d at 775-76.
13. *Id.* at 293, 149 S.E.2d at 776.

for which punitive damages cannot be supported by an allegation of gross negligence.[14]

Although, as noted by the court, there appear to be no prior cases of this nature in which the plaintiff sought to recover damages for the negligent delay in acting upon an application for insurance, there was at least one relatively recent decision involving a similar factual situation in which the insurance company was found to have been estopped to deny that there was a contract of insurance.[15] It would be impossible to generalize as to which theory would provide the best approach when faced with a similar factual situation, for the needs of the individual plaintiff should govern in every instance.[16] The advantage of the principle recognized in *Hinds*, however, is obvious to one familiar with the law of damages in this area. Not only were actual damages or policy benefits recoverable, but in addition, the court acknowledged the propriety of the prayer for punitive damages which would never be appropriate in an action to recover for the alleged breach of a previously executed contract.[17]

## III. ESTOPPEL TO DENY COVERAGE

The case of *Preferred Risk Mutual Insurance Company v. Thomas*[18] likewise involved a controversy centering around the application for an insurance policy. In this situation the court considered the information divulged by the applicant in determining whether the insurer would be allowed to assert an ex-

14. *See* the textual discussion of *Felder v. Great American Ins. Co.*, *infra* p. 584.

15. Moore v. Palmetto State Life Ins. Co., 222 S.C. 492, 73 S.E.2d 688 (1952).

16. The two choices are: (1) sue in an action ex contractu, as in *Moore*, alleging that the defendant insurance company is estopped by its unreasonable delay to deny the existence of the contract; or (2) commence an action ex delicto, as in the instant case, asserting the insurer's wilful and wanton negligence in failing to act upon the application within a reasonable time. One might wonder why an action ex contractu should ever be maintained when one ex delicto is available by which punitive damages may be recovered; but there are situations in which the plaintiff would be benefitted by the existence of an actual contract. An example would be where the injury occurred after a time sufficient for processing the application but before passage of enough time for the applicant to have secured coverage from a second insurance company. In other words, the tort-plaintiff must be able to show that if the insurer had acted within a reasonable time, even in refusing the application, he could have procured insurance from some other source as would have provided him protection at the time in question.

17. *See* the textual discussion of *Felder v. Great American Ins. Co.*, *infra* p. 584.

18. 372 F.2d 227 (4th Cir. 1967).

clusionary provision inconsistent with this information. Robert Green applied to Preferred through its agent, Reeves, for a policy of liability insurance covering his 1958 Dodge panel truck. Green informed Reeves that the truck was to be driven some sixty miles to and from work six days a week carrying an average of five passengers per trip on a share the expense basis. All of this information, with the exception of the average number of passengers, was also included in the written application for insurance submitted by Green to the insurer. A policy was issued on July 7, 1964, effective retroactively to June 25, 1964, containing a clause specifically excluding any claim arising from the use of the vehicle for public conveyance or livery.

On July 4, 1964, while being operated by one Leola Lawrence, the truck was involved in an accident which resulted in injuries to several of the passengers. These individuals commenced actions against Green to recover for their injuries. The insurer instituted this proceeding for a declaratory judgment absolving it of any liability for such judgments as might be rendered against Green. Preferred asserted that the above stated clause should be deemed an absolute bar to liability on its part. The injured parties contended, on the other hand, that the insurer should be estopped from asserting and be deemed to have waived this defense by reason of its issuance of the policy in question with full knowledge of the use to which the insured intended to put the covered vehicle. The district court resolved this issue in favor of the insured in ruling that

> It has frequently been held in this state that if an insurance agent, at the inception of the contract, has knowledge of a fact constituting a forfeiture, such knowledge is imputed to the company, and the issuance of the policy as a valid policy estops the company from asserting the forfeiture.[19]

It is from this decision that the insurer appealed, arguing in part that the exclusionary clause was not a ground of forfeiture which could be waived in this manner but rather a limitation on the scope of the policy which neither waiver nor estoppel could be employed to broaden. In recognizing a substantive though somewhat nebulous distinction between the two, the court in the instant case concluded that

19. Preferred Risk Mut. Ins. Co. v. Thomas, 250 F. Supp. 204, 208 (D.S.C. 1966), *quoting from* McCarty v. Piedmont Mut. Ins. Co., 81 S.C. 152, 62 S.E. 1 (1907); Slawson v. Equitable Fire Ins. Co., 82 S.C. 51, 62 S.E. 782 (1907).

> [I]nsured's failure to perform a condition that would bring or keep the policy in force, such as paying periodic premiums as they fall due, would work a forfeiture while a condition going to the scope of coverage would not affect the operation of the policy except as to risks arising from specified activities. . . . The only legal effect of the clause in question, if valid and enforceable, would be to exclude from coverage liability for injuries or damage which might arise while the truck was being used for public . . . conveyance.[20]

Having reached this decision, however, the court went on to invoke a local exception[21] to the general principle that the scope of the risk cannot be extended by estoppel.[22] The facts presented in this situation were then balanced against the elements requisite to a proper invocation of this exception.[23] These facts can best be appreciated through enumeration: (1) no opportunity on the part of the insured to examine the policy prior to the accident; (2) no evidence to indicate knowledge on the part of the insured that the exclusionary clause had been included in the policy; (3) reliance by the insured on Preferred's agent's representations that the policy would meet his needs; (4) knowledge on the part of the insurer that the vehicle in question would be used to carry passengers six times a week on a share the expense basis; (5) acceptance of the premium payment with the cumulative knowledge of agent Reeves and Preferred as to Green's intended use of the vehicle; and (6) obvious prejudice to Green. Although no real insight is given as to which of these factors was most instrumental in facilitating the invocation of the exception, it would be safe to assume that not all were essential to this decision.[24]

20. 372 F.2d 227, 230 (4th Cir. 1967).

21. *See* Pitts v. New York Life Ins. Co., 247 S.C. 545, 148 S.E.2d 369 (1966); Johnson v. Wabash Life Ins. Co., 244 S.C. 95, 135 S.E.2d 620 (1964); Moore v. Palmetto State Life Ins. Co., 222 S.C. 492, 73 S.E.2d 688 (1952); Ellis v. Metropolitan Cas. Ins. Co., 187 S.C. 162, 197 S.E. 510 (1938).

22. Preferred Risk Mut. Ins. Co. v. Thomas, 372 F.2d 227, 230 (4th Cir. 1967).

23. The essential elements of estoppel as set out in the South Carolina decisions are: "(1) ignorance of the party invoking it of the truth as to the facts in question; (2) representations or conduct of the party estopped which mislead; (3) reliance upon such representations or conduct; and (4) prejudicial change of position as the result of such reliance." Pitts v. New York Life Ins. Co., 247 S.C. 545, 552, 148 S.E.2d 369, 371 (1966).

24. *Id.*

Another aspect of this case concerned the question of the admissibility of Reeves' testimony relative to negotiations with Green prior to the policy being submitted. In ruling in favor of admissibility the court relied upon what it determined to be an accepted proposition of law as supported by South Carolina decisions.[25]

## IV. BREACH OF INSURANCE CONTRACT

After having executed a note and mortgage on her home in the amount of 1,500 dollars to Home Federal Savings and Loan, Justine Felder, together with her husband, purchased a health and accident policy from the Great American Insurance Company through Home Federal as the soliciting agent. The amount of the policy was the same as that of the note with the monthly benefits approximating the monthly mortgage installments.

When Mr. Felder became disabled in December 1962, a claim blank was obtained by the plaintiff from Home Federal and submitted to the insurer. This claim was paid as were those filed in the two succeeding months. Upon their request for a fourth claim blank, however, the Felders were informed that the insurer was not going to make any further payments and that it would be useless to submit any additional claims. Mr. Felder's disability continued for some time, and in March of 1964 foreclosure was threatened as result of Mrs. Felder's failure to meet the mortgage payments. Rather than submit to the foreclosure proceedings, however, the Felders sold their home and lot for one half of its value so as to satisfy the mortgage.

In their action against the defendant insurance company,[26] the plaintiffs demanded, in addition to damages for anxiety and anguish, compensation for damaged credit and reputation. The complaint purported to contain three separate causes of action, each independent in the alternative; and this suit was commenced to determine the sufficiency of each allegation so as to ascertain whether any or all of them constituted a valid cause of action.

The first of these demands was based on the allegedly fraudulent representation by Home Federal that the filing of any further claims would be to no avail as no subsequent payments would be forthcoming. The insurer was alleged to have had

25. Bost v. Bankers Fire and Marine Ins. Co., 242 S.C. 274, 130 S.E.2d 907 (1963); Polatty v. Woodmen O. W. Ins. Soc'y, 191 S.C. 79, 3 S.E.2d 681 (1939); Norris v. Hartford Fire Ins. Co., 57 S.C. 358, 35 S.E. 572 (1900).

26. Felder v. Great American Ins. Co., 260 F. Supp. 575 (D.S.C. 1966).

knowledge of the falsity of this statement. The complaint also alleged that the plaintiffs were ignorant of this falsehood and had a right to rely on the statement. There was a further assertion that the submission of a claim blank was a condition precedent to payment and that the agent, Home Federal, knew that the failure to submit the blank would preclude payment of the policy benefits. The court viewed this allegation as establishing the basis for a claim intended to recover for fraud and deceit;[27] and in this connection, it reiterated the nine elements generally recognized as part and parcel of actionable fraud,[28] the absence of any one of which is fatal to the suit.[29] Recognizing that "[o]rdinarily the mere failure of an insurer or contractor to pay sums of money under the contract does not support actions for fraud and deceit or breach of contract accompanied by a fraudulent act,"[30] the court observed that the allegations went further by charging that the insurer, through its agent, falsely represented that no more payments would be made. The charge of falsity was substantiated by the fact that a subsequent lump-sum payment was actually made. Accordingly, the allegations were deemed sufficient to constitute a valid cause of action for fraud and deceit.

The second cause of action was for breach of contract accompanied by a fraudulent act. The alleged breach was not for the failure to pay at all but rather for the failure to pay *on time*, the defendant being aware that time was of the essence in this particular situation. In noting the plaintiff's apparent desire to include sufficient allegations upon which to base a claim for punitive damages (*i.e.*, a fraudulent act accompanying the breach) the court recognized the validity of this second demand. In so ruling it relied primarily upon the factors considered with respect to the first cause of action discussed above.

The third prayer was for damages arising out of the defendant's negligent, wilful, reckless and wanton breach of duty

27. *Id.* at 577.

28. (1) A representation; (2) its falsity; (3) its materiality; (4) the speaker's knowledge of its falsity; (5) his intent that it should be acted upon by the person; (6) the hearer's ignorance of its falsity; (7) his reliance on its truth; (8) his right to rely thereon; and (9) and his consequent and proximate injury.

29. *E.g.*, Jones v. Cooper, 234 S.C. 477, 109 S.E.2d 43 (1959); Tallevast v. Herzog, 225 S.C. 563, 83 S.E.2d 204 (1954); Weatherford v. Home Fin. Co., 225 S.C. 313, 82 S.E.2d 196 (1954); Flowers v. Price, 190 S.C. 392, 3 S.E.2d 38 (1939). *See also* Parks v. Morris Homes Corp., 245 S.C. 461, 141 S.E.2d 129 (1965).

30. 260 F. Supp. at 577.

allegedly owed to the plaintiff, said conduct resulting in the loss of the plaintiff's home. In unequivocally denying the sufficiency of this allegation the court observed, "In the case of an alleged tort arising out of contract there must exist a duty arising out of the relation created by the contract which exists apart from the contract."[31] In this respect an earlier South Carolina decision was relied on for the proposition that

> Ordinarily, where there is no duty except such as the contract creates, the plaintiff's remedy is for breach of contract, but when the breach of duty allegedly arises out of a liability independently of the personal obligation undertaken by the contract, it is a tort.[32]

Having found no duty co-existing and correlative with the contract imposed on the insurer, the breach of which would give rise to this action, the court concluded that "no set of facts could be proven under these allegations which would support a cause of action for negligence. The action is ex contractu."[33]

The reference to a duty created by and correlative with a contract but existing independently of the contractual relationship may appear at first blush somewhat incongruous. When viewed in perspective, however, such a duty may be easily recognized and understood. An excellent illustration may be found in the case of *Meddin v. Southern Railway*[34] involving a contract with a common carrier. It is readily apparent that the carrier would owe no duty to an individual with whom it had never had any dealings; but once it agreed to transport the plaintiff's property, it became bound by the terms of the contract as well as such rules and regulations as established by the Public Service Commission relative to the property. Accordingly, the defendant could be held liable in tort for damage to the property occasioned by its failure to adhere to the regulations, whereas any allegation of negligence would be improper if the action were maintained under the contract itself in the absence of such regulation. This essential distinction was also recognized by the Supreme Court in the case of *Atlantic & Pacific Railway v. Laird*.[35]

31. *Id.* at 578.
32. Dixon v. Texas Co., 222 S.C. 385, 389, 72 S.E.2d 897, 899 (1952).
33. 260 F. Supp. at 579.
34. 218 S.C. 155, 62 S.E.2d 109 (1950).
35. 164 U.S. 393 (1896).

In situations in which the distinction is not so easily recognized the controversy must be resolved in favor of an action ex contractu.[36]

The plaintiff in *Dawkins v. National Liberty Life Insurance Company*[37] filed an action in federal court to recover an amount of less than 1,000 dollars allegedly due him on a policy of insurance issued by the defendant, and 500,000 dollars punitive damages for the alleged wilful and fraudulent conversion of the 1,000 dollars by the defendant. The defendant moved to strike from the complaint all references to punitive damages, thereby reducing the amount demanded to less than the requisite jurisdictional amount. The defendant asserted that in South Carolina no punitive damages are recoverable for a mere refusal to pay a sum of money.

The court analyzed the requisite elements of conversion and concluded inferentially that the plaintiff had never established sufficient claim to the disputed sum to give rise to an independent action for conversion. This holding was apparently viewed by the court as being dictated by the South Carolina decision of *Holland v. Spartanburg-Herald-Journal Company*[38] in which punitive damages were deemed improper in an action to recover wages allegedly due on an employment contract. The court in *Dawkins* therefore determined that to allow such damages "would be equivalent to saying that every unpaid debt carries with it the implication of fraud on the part of the debtor; that the debtor has converted to his own use the money of another or that he has misappropriated that which was always his own."[39]

The complaint in this action represents an obvious attempt on the part of the plaintiff's attorney to circumvent the general prohibition against punitive damages in an action arising out of a contract, as was discussed above in *Felder*. The court, seemingly cognizant of this attempt, plugged this prospective loophole so as to maintain the prohibition against recovery of punitive damages in these situations. Had this deceptively innocent scheme been successful, the insurance industry would have stood to suffer considerably at the hands of resourceful plaintiffs' attorneys.

36. Dixon v. Texas Co., 222 S.C. 385, 72 S.E.2d 897 (1952). *See, e.g.*, Timmons v. Williams Wood Products Corp., 164 S.C. 361, 162 S.E. 329 (1931); V. P. Randolph & Co. v. Walker, 78 S.C. 157, 59 S.E. 856 (1907).

37. 263 F. Supp. 119 (D.S.C. 1967).

38. 116 S.C. 454, 165 S.E. 203 (1932).

39. 263 F. Supp. at 121-22.

The South Carolina Supreme Court was faced, in the case of *Warren v. Allstate Insurance Company*,[40] with the question of whether the unwarranted cancellation of a certificate of insurance constituted a breach of the contract of insurance. The plaintiff, Billy B. Warren, prior to regaining his previously suspended driver's license, was issued a policy of automobile liability insurance by Allstate. Allstate, in turn, filed the requisite certificate of insurance[41] with the South Carolina Highway Department, thereby acknowledging its contract with the plaintiff and enabling him to regain his license. This certificate was subsequently and admittedly without justification cancelled by the defendant, resulting in the automatic suspension of Warren's license.[42] As a result of this conduct on the part of the insurer, Warren was unable to renew his driver's license for a period of six months.

In an action by Warren to recover actual and punitive damages for the wrongful cancellation, the defendant demurred on the theory that: (1) the plaintiff's remedy was an administrative hearing by the Highway Department with judicial review if necessary; and (2) the plaintiff was attempting to recover damages resulting from the defendant's supplying the Department with allegedly false information, which is in effect an action for damages in a civil suit for perjury committed in a quasi-judicial hearing, and that such actions are forbidden by public policy. To be more precise, Allstate contended that it merely supplied the bullets with which the Highway Depart-

40. 249 S.C. 89, 152 S.E.2d 727 (1967).

41. S.C. CODE ANN. § 46-744 (1962).

> Whenever the Department, under any law of this State, suspends or revokes the license of any person upon receiving a record of conviction or forfeiture of bail and in all cases where the Department suspends or revokes the driver's license of any person under lawful authority possessed by the Department, the Department shall also suspend the registration for all motor vehicles registered in the name of that person, except that it shall not suspend the registration, unless otherwise required by law, if that person has previously given or shall immediately give and thereafter maintain proof of financial responsibility with respect to all motor vehicles registered by him. The license and registration shall remain suspended or revoked and shall not at any time thereafter be renewed nor shall any license be thereafter issued to that person nor shall any motor vehicle be thereafter registered in the name of that person until permitted under the motor vehicle laws of this State *and not then until he shall give and thereafter maintain proof of financial responsibility* (emphasis added).

In this regard the court referred to section 46-745. This is presumed to have been an oversight, however, as that section deals with financial responsibility of non-residents.

42. S.C. CODE ANN. § 46-750.5 (1962).

ment loaded the gun it used in "grounding" Warren, that Allstate had nothing to do with the actual revocation of Warren's license. Our court rejected this line of argument, however, noting that the automatic revocation was by statute effective immediately upon receipt by the Department of the cancellation notice. Thus it said, in effect, that Allstate had provided the ammunition for a weapon which fires automatically upon being loaded.

> The Department is not empowered under the provisions of the Motor Vehicle Safety Responsibility Act to determine the legality of the cancellation of a certificate of insurance, but, on the contrary, the Department is directed by Section 46-750.5 to cancel a certificate of insurance "upon request."[43]

In adopting this position the court also rejected the quasi-judicial hearing theory proposed by Allstate and apparently concluded that the action was one for the wrongful breach of a contract of insurance. Thus, the complaint was sustained on that premise with the loss of driving privileges being viewed as a proper element of damages.

## V. UNINSURED MOTORIST STATUTE

The court, in deciding *United States Fidelity & Guarantee Co. v. Security Fire and Indemnity Co.*,[44] was again concerned with a certificate of insurance. The defendant issued a policy of liability insurance to Willie Lee Hemingway on August 20, 1963, under the South Carolina Assigned Risk Plan to remain in effect for a period of one year, expiring on August 20, 1964. On April 30, 1964, Security certified its coverage of Hemingway under the policy giving its termination date. Some time prior to August 20, 1964, the defendant notified Hemingway that his coverage would terminate on August 20 unless renewed by August 5. The renewal premium was not paid, and on August 30, 1964, Hemingway was involved in an automobile accident with Norman Turbeville. Turbeville was later awarded a verdict for the injuries and damages sustained as result of this accident. Security denied liability for the judgment relying on Hemingway's failure to renew his policy and the subsequent termination of coverage prior to the date of the accident.

43. 249 S.C. 89, 95, 152 S.E.2d 727, 730 (1967).
44. 248 S.C. 307, 149 S.E.2d 647 (1966).

On the date of the accident Turbeville had in effect a policy of insurance with United States Fidelity and Guarantee Company containing the statutory uninsured motorist coverage. This company, as plaintiff, commenced this action to impose liability on Security in accordance with 1962 South Carolina Code section 46-702(7)(h), which provides in pertinent part,

> When an insurance carrier has certified a motor vehicle liability policy under § 46-748 or § 46-749, the insurance so certified shall not be cancelled or terminated until at least ten days after a notice of cancellation or termination of the insurance certified shall be filed with the department . . . .

The plaintiff contended that the defendant company's coverage could not have been terminated without submitting the requisite notice to the Highway Department.

The court accepted this construction of the statutory provision, finding that the intention of the legislature was to guarantee continuous coverage of the insured, and that, to this end, the duty devolved on the insurer to give notice before the termination or cancellation of a previously certified policy. To the defendant's assertion that this provision should be so construed with respect to *cancellation* but not to orderly *termination* of insurance coverage, the court responded, "The danger to the public from the absence of liability coverage is no greater when it results from one cause than from the other. The statutory purpose was to protect from both."[45]

The obvious effect of this decision was to impose upon all insurance companies the burden of submitting the requisite notice of cancellation or termination of all liability insurance coverage previously certified. Failure to do so necessarily extends the coverage until such time as notice is received by the Highway Department regardless of whether the insured has paid premiums for additional coverage.

The case of *Security General Insurance Company v. Bill Vernon Chevrolet, Inc.*[46] concerned an action for a declaratory judgment arising out of a somewhat unusual and complex fact situation and involving an apparent conflict between previously rendered federal and state supreme court decisions. The facts as stipulated by the parties and found by the court are as follows: R. J. Sharpton owned an automobile which he sold to Bill Ver-

45. *Id.* at 314, 149 S.E.2d at 650.
46. 263 F. Supp. 74 (D.S.C. 1967).

non Chevrolet; Bill Vernon sold this vehicle to Wilbur C. Hair on March 29, 1966, but the title, never having been transferred, remained in R. J. Sharpton; Hair never registered the vehicle with the highway department of any state but operated it without the benefit of any liability insurance protection; on April 18, 1966, as the result of negligence on the part of Hair, the vehicle was involved in a collision with a second vehicle operated by Chester L. Anderson; an action was instituted against Hair by Anderson to recover for damages occasioned by the collision; on April 18, 1966, Anderson was protected under a policy of liability insurance issued by the plaintiff, and Bill Vernon was the holder of a policy of liability insurance issued it by Universal Underwriters.

The plaintiff, in an effort to avoid liability under the uninsured motorist provision[47] of Anderson's policy, sought to impose financial responsibility for any judgment obtained by Anderson against Hair upon the defendant, Universal Underwriters. The plaintiff argued that as Vernon had had the vehicle in stock for resale, without having it titled in its own name section 46-150.16[48] of the 1962 South Carolina Code placed an affirmative obligation upon it to comply with the requirements of the law upon sale of the vehicle by seeing that the new owner had liability insurance protection or its equivalent. Going one step further, the plaintiff maintained that, for failure to comply with this statutory provision, Bill Vernon became financially responsible.

Although this appears to be an unusual factual situation, it is not the first time that our courts have been confronted with a problem of this nature. A strikingly similar situation was presented in the case of *Clouse v. American Mutual Liability Insurance Company*[49] in which liability was imposed on a dealer's insurance carrier, which occupied virtually the same position as

47. S.C. CODE ANN. §§ 46-750.32-.33 (1962).

48. If a dealer buys a vehicle and holds it for resale and procures the certificate of title from the owner within ten days after delivery to him of the vehicle, he need not send the certificate to the Department, but, upon transferring the vehicle to another person other than by the creation of a security interest, shall promptly execute the assignment and warranty of title by a dealer, showing the names and addresses of the transferee and of any lienholder holding a security interest created or reserved at the time of the resale and the date of his security agreement, in the spaces provided therefor on the certificate or as the Department prescribes, and mail or deliver the certificate to the Department with the transferee's application for a new certificate.

49. 344 F.2d 18 (4th Cir. 1965).

did Universal Underwriters in the instant case. The court in *Clouse* relied upon the dealer's failure to comply with what it deemed to be the affirmative obligation placed upon it by the South Carolina statute,[50] thereby imposing upon its insurance carrier financial responsibility for the judgment rendered in favor of the plaintiff, who occupied the same position as did Anderson in this suit.

The defendants here, however, took the position that *Clouse* was an inaccurate interpretation of section 46-150.16; and in support of this stand they relied upon the more recent South Carolina case of *Grain Dealers Mutual Insurance Company v. Julian*[51] which, if truly inconsistent with *Clouse*, would have vitiated it by virtue of the *Erie* doctrine.[52] In considering section 46-150.15,[53] the court in *Grain Dealers* concluded that "title to a motor vehicle passes to a purchaser notwithstanding the want of compliance with the Title Certificate Law."[54]

There is a factual distinction between *Clouse* and *Grain Dealers* in that there was no dealer or intermediary in the latter case; but, in so far as the actual transfer of title is concerned, the distinction seems to be more one of form than of substance. Nevertheless, in deciding the instant case, the court considered this distinction of such significance as to prevent *Grain Dealers* from modifying or superceding *Clouse* and declared the above quoted passage from *Grain Dealers* to be mere dictum. Accordingly, the instant case was deemed governed by the decision rendered in *Clouse*. In further support of its decision the court referred to what it determined to be the state legislative policy

50. S.C. CODE ANN. § 46-150.16 (1962).

51. 247 S.C. 89, 145 S.E.2d 685 (1965).

52. Erie R.R. v. Tompkins, 304 U.S. 64 (1938).

53. If an owner, manufacturer or dealer transfers his interest in a vehicle other than by the creation of a security interest, he shall, at the time of the delivery of the vehicle, execute an assignment and warranty of title to transferee in the space provided therefor on the certificate or as the Department prescribes and cause the certificate and assignment to be mailed or delivered to the transferee or to the Department.

Except as provided in § 46-150.16, the transferee shall, promptly after delivery to him of the vehicle, execute the application for a new certificate of title in the space provided therefor on the certificate or as the Department prescribes and cause the certificate and application to be mailed or delivered to the Department.

Except as provided in § 46-150.16, and as between the parties, a transfer by an owner is not effective until the provisions of this section have complied with. S.C. CODE ANN. § 46-150.15 (1962).

54. Grain Dealers Mut. Ins. Co. v. Julian, 247 S.C. 89, 99, 145 S.E.2d 685, 690 (1965).

of continuous liability coverage on a large number of secondhand cars sold throughout the state.

At this juncture a careful study of the two legislative provisions under consideration is in order. A close reading of these sections will reveal that the only documents required to be filed by the transferee under section 46-150.15 and the dealer-transferor under section 46-150.16 are the endorsed certificate of title from the former owner and the application for a new certificate in the name of the purchaser. In neither section is there any mention of a certificate of insurance or its equivalent which must accompany these documents. As has been noted in an earlier comment on the *Clouse* case,[55] this certificate of insurance need only be produced for purposes of licensing and registration prior to the operation of a motor vehicle on the highway. A person desiring to purchase a motor vehicle for purposes other than operation on the highways (*i.e.*, display, racing, removal of parts or, as is often the case with trucks and buses, for use as living quarters) has no need for liability insurance nor is he required by the laws of this state to obtain such coverage. Taking this decision literally, however, one who purchases a motor vehicle for any purpose whatsoever can never become the lawful owner until he has procured liability insurance. Moreover, the court in deciding the instant case proclaimed section 46-150.16 "a vital part of this State's scheme of insurance"[56] and declared that any attempt by contract to avoid its provisions as interpreted would be contrary to public policy and consequently invalid.

It seems that the federal court in this district has unwittingly stepped into a quagmire of policy considerations in which it is content to languish and from which it has as yet refused any attempt at rescue by the South Carolina Supreme Court.

## VI. CONTRIBUTION BETWEEN INSURERS OF JOINT TORT-FEASORS

The case of *Travelers Insurance Company v. Allstate Insurance Company*[57] represents the only decision during the survey period which was termed by at least one member of the court as "one of novel impression."[58] Whether this is truly the case will

55. Kemmerlin, *1964-1965 Survey of S.C. Law of Insurance,* 18 S.C.L. REV. 68, 78 (1966).

56. 263 F. Supp. at 79.

57. No. 18669 (S.C., June 15, 1967).

58. *Id.*

be commented on in more detail in a subsequent issue of this *Review*,[59] but the division of the court should be sufficient to warrant close scrutiny of the decision by those persons affiliated with the insurance industry.

Robert M. Gray was awarded a verdict against several named defendants in an action to recover for injuries sustained in an automobile accident allegedly occasioned by the combined negligence of the defendants. Travelers Insurance Company was the carrier for two of the defendants and, under threat of attachment, was compelled to pay the entire judgment. Having done so, it commenced this action to seek contribution from Allstate as insurer of E. D. Bessinger, the driver of the automobile in which Gray was a passenger and against whom a verdict was rendered pursuant to the guest passenger statute,[60] and against Bessinger individually. The lower court sustained the demurrer interposed by Bessinger and Allstate on the theory that "under the law of this state one tort-feasor may not require contribution from another tort-feasor where both are burdened with a common judgment growing out of a single collision."[61] Travelers appealed, arguing that its payment of the entire judgment resulted in the unjust enrichment of the respondents, Bessinger and Allstate, and that they should be made to contribute.

The majority determined at the outset that "each insurance carrier is in the same legal position as its insured,"[62] and that Allstate was liable for no more than Bessinger, should he be found liable at all. Once the position of the parties was so established, the common law rule, as recently reiterated in this jurisdiction,[63] was invoked for the proposition that "there can be no indemnity among mere joint tort-feasors."[64] The court then concluded that

> The debt to Gray as established in the original trial has been paid on behalf of one joint tort-feasor and when that debt was obliterated, the other joint tort-feasor was completely released and, accordingly, he has not and cannot suffer a

59. (Recent decision to be published in next issue).
60. S.C. CODE ANN. § 46-801 (1962).
61. No. 18669 (S.C., June 15, 1967).
62. *Id.*
63. Atlantic Coast Line R.R. v. Whetstone, 243 S.C. 61, 132 S.E.2d 172 (1963).
64. No. 18669 (S.C., June 15, 1967).

loss and there is no debt existing for his own insurance carrier to pay."[65]

In response to Travelers' attempt to invoke an exception to the common law rule the majority, while recognizing the existence of such an exception in other jurisdictions, observed that our courts have, as yet, rejected any modification of the general prohibition against indemnity among joint tort-feasors.

In dissenting, Justice Bussey, with whom Justice Brailsford concurred, criticized the position adopted by the majority, arguing that Travelers was not a tort-feasor and therefore not subject to the principles governing contribution among joint tort-feasors. In this regard he maintained that "[b]oth insurers involved are bound not as tort-feasors, but as a result of the perfectly lawful contracts they issued. . . . That Bessinger is a tort-feasor is immaterial, since Travelers is not."[66] For this reason he denied the applicability of *Atlantic Coast Line Railroad Company v. Whetstone*, inferring that the majority had been unable to differentiate between the theory of *subrogation*, in which case *Whetstone* would be apposite, and that of *contribution*, in which case it would not. Accordingly, he opined that Allstate should be compelled to bear its share of a common and equal burden imposed upon it and Travelers by the original verdict rendered against their respective insureds and that this result was dictated by the principles of equity and natural justice upon which the law of contribution is founded.

## VII. CONSTRUCTION OF SPECIFIC POLICY LANGUAGE

Surveyed under this heading are those decisions turning on the construction of single words or phrases included in the insurance policy. As these cases defy any further categorical subdision, they will be discussed in an order which lends itself to some degree of continuity, with each individual decision being analyzed under its respective case name. Most of the decisions are concerned with some isolated issue and do not warrant or permit any historical development or generalization, and for this reason the discussion of them will be confined to the narrow issues involved. The survey does not purport to edify or instruct with respect to each particular area, but rather is intended to bring these decisions to the attention of the Bar and to focus

65. *Id.*
66. *Id.* (dissenting opinion).

particular attention on those situations which justify such treatment.

*A. McAbee v. Nationwide Mutual Insurance Company*[67]

The plaintiff's deceased was struck and killed by a tractor he had been towing as he attempted to disengage the tow chain from the rear of the truck. The truck against which he was crushed was covered by a policy of insurance issued by the defendant, Nationwide, providing protection in the event of injury sustained "while in or *upon*, entering or alighting from"[68] the vehicle. The question before the court was whether the term "upon" could be construed to cover this type of situation in which the injured party was actually standing on the ground though maintaining physical contact with the vehicle.

The supreme court, noting the lack of authority in this jurisdiction and the diversity of opinion from others, adopted what it considered "a broad and liberal construction in favor of the insured"[69] requiring only "actual physical contact"[70] with the insured vehicle to establish that the insured was *upon* the vehicle. A careful consideration of the other quoted terms—in, entering or alighting from, — indicates that this is the only plausible construction to be given to the additional term "upon"; for as stated elsewhere, "It cannot mean that the insured, to be within the meaning of the clause, had to be couched on the roof of the car or on the running board or sitting on the hood. It must connote some physical relationship between himself and the car that enlarged the area defined by the words 'entering or alighting' and the word 'in.' "[71]

*B. Able v. Travelers Insurance Company*[72]

This action was commenced to recover benefits allegedly due on a policy of insurance issued by the defendant company to the plaintiff's husband, Lawrence M. Able, insuring against "loss resulting directly and independently of all other causes from accidental bodily injuries"[73] sustained during the term of the

67. 249 S.C. 96, 152 S.E.2d 731 (1967). For a more detailed analysis of this decision *see* 19 S.C.L. REV. 483 (1967).

68. 249 S.C. at 98, 152 S.E.2d at 731 (emphasis added).

69. *Id.* at 99, 152 S.E.2d at 732.

70. *Id.*

71. Wolf v. American Cas. Co., 2 Ill. App. 124, 118 N.E.2d 777, 780 (1954).

72. 248 S.C. 101, 149 S.E.2d 262 (1966).

73. *Id.* at 103, 149 S.E.2d at 262.

policy but specifically excluding "any loss caused or contributed to by disease."[74] Travelers admitted the existence of the policy but denied liability, relying upon the specific exclusion.

The evidence revealed that the insured was a policeman, approximately sixty-two years of age, with a history of high blood pressure or hypertension, for which he had been receiving treatment. During the evening of December 8, 1963, the insured was attempting to effect an arrest when the suspect broke and ran; the insured pursued him on foot for some distance before falling and injuring his hands. Able then proceeded home and aroused his wife who subsequently testified as to his then visible nervous condition which prompted her to take him to the office of the family physician, Dr. Raysor. He was put in the hospital where he died the following morning.

The trial produced a verdict for the defendant from which the plaintiff appealed on the contention that there was a lack of evidentary support of the defense of non-coverage. The court, in affirming, called attention to the testimony of Dr. Raysor to the effect that the exertion and injuries sustained in the attempted arrest merely combined with the insured's pre-existing physical condition to cause his death, and that the basic cause of death was hypertension. The court considered this testimony in light of the phrase "directly and independently of all other causes" and concluded that the policy provision involved was sufficient to exclude liability.

### *C. Cooper v. John Hancock Mutual Life Insurance Co.*[75]

Albert S. Cooper incurred hospital and surgical expenses in the treatment of an inguinal hernia for which he sought to recover from the defendant insurance company with which he had a policy of insurance providing for hospital and surgical operation benefits. The policy in question extended coverage to "(1) an accidental bodily injury which does not arise out of and in the course of employment, or (2) disease for which the employee is not entitled to a benefit under any Workmen's Compensation Law or Act."[76]

The plaintiff alleged that the hernia was neither an accidental injury arising out of and in the course of his employment nor a

74. *Id.*
75. 248 S.C. 534, 151 S.E.2d 668 (1966).
76. *Id.* at 536, 151 S.E.2d at 668.

disease for which he was entitled to benefits under the Workmen's Compensation Law. The insurer denied these allegations contending that the hernia was an accidental injury arising out of and in the course of Cooper's employment.

Cooper had previously filed for and been denied benefits under the South Carolina Workmen's Compensation Law, the South Carolina Industrial Commission ruling that he "did not receive an injury by accident arising out of and in the course of his employment within the meaning of the terms and provisions of the South Carolina Workmen's Compensation Act."[77] There was also uncontradicted expert testimony presented in the trial of this cause to the effect that Cooper's hernia was "a disease within the meaning of the terms of the policy here involved"[78] so as to entitle him to benefits.

The defendant appealed from this determination that the hernia was not caused by any single happening or event. The supreme court concluded, however, that the hernia was in fact a disease, thus obviating the necessity of determining its cause, and that since no benefits were forthcoming under the Workmen's Compensation Law, Cooper was entitled to the benefits set out in the policy issued by the defendant insurer.

*D. Harper v. Banker's Life and Casualty Co.*[79]

The insured, Mrs. Samuel D. Harper, after having been released from a Florence, South Carolina, hospital to which she had been admitted for surgery and subsequent treatment of cancer, continued to take medicine and drugs prescribed by the attending physician and procured by her from drug stores in the area. During this period she had in full force and effect a policy of insurance issued by the defendant insurance company whereby it agreed to pay certain medical expenses including:

> *1.* HOSPITAL CARE—*Hospital board and room, and miscellaneous hospital expenses, while hospital-confined or as an out-patient; including drugs, medicines . . .*.[80]

The defendant paid the claims for all expenses except that for drugs incurred after the insured's discharge from the hospital. In this regard Banker's challenged the insured's qualification as

77. *Id.* at 536, 151 S.E.2d at 668-69.
78. *Id.* at 538, 151 S.E.2d at 669.
79. 248 S.C. 468, 151 S.E.2d 98 (1966).
80. *Id.* at 470, 151 S.E.2d at 99.

an out-patient, relying upon the stipulated fact that "in the Florence area the only patients that are designated as out-patients by the hospital are those who are treated in the emergency clinic and never admitted to the hospital."[81] The lower court found for the plaintiff, ordering the insurer to pay the cost of all drugs and medicines necessarily and actually used in the treatment of the insured for a covered disease.

The supreme court rejected this position in ruling that "[e]very patient who has been discharged from a hospital is not necessarily an out-patient of the hospital simply because his condition requires further treatment."[82] It went on to note that, in light of the stipulated facts, the insured in this situation did not qualify as an out-patient and was, therefore, not entitled to recover for expenses incurred in the procurement of drugs and medicines subsequent to her discharge from the hospital.

### *E. Harleysville Mutual Casualty Company v. Nationwide Mutual Insurance Company*[83]

Waymon R. Hairston was insured under a policy of liability insurance issued by the plaintiff. This policy was in full force and effect on March 28, 1965, when Hairston was involved in an accident while operating, without permission, an automobile owned by the parents of a friend. This action was for a declaratory judgment absolving the plaintiff of any liability for such recovery as might subsequently be rendered against Hairston as result of injuries or damages sustained by other parties involved in the accident. Although not so indicated in the reported decision, apparently Nationwide had issued a policy containing the requisite uninsured motorist coverage to one or more of the injured parties.

In denying liability Harleysville relied upon a unique interpretation of a policy provision which must be set out in full to be appreciated:

> Persons Insured. The following are insureds under Part I:
> (a) With respect to the owned automobile,
> (1) the named insured and any resident of the same household,
> (2) any other person using such automobile, provided the actual use thereof is with the permission of the named insured;
> (b) With respect to a non-owned automobile,
> (1) the named insured,

81. *Id.* at 471, 151 S.E.2d at 100.
82. *Id.*
83. 248 S.C. 398, 150 S.E.2d 233 (1966).

(2) any relative, but only with respect to a private passenger automobile or trailer, provided the actual use thereof is with the permission of the owner;
(c) Any other person or organization legally responsible for the use of
(1) an owned automobile, or
(2) a non-owned automobile, if such automobile is not owned or hired by such person or organization,
provided the actual use thereof is by a person who is an insured under (a) or (b) above with respect to such owned automobile or non-owned automobile.[84]

The plaintiff's contention was that the permissive use proviso of part (b) beginning with the word "provided" should apply to parts (b)(1) as well as (b)(2) because it begins, not on the same margin as the word "any" above it, but all the way out to the margin at the beginning of (b) under the word "with". Thus, it argued that Hairston was not insured since he was operating the vehicle without permission of its owner.

The court considered this contention, conceding the validity of the argument when the quoted provision was scrutinized out of context with particular attention being focused on the margin in question. It concluded, however, "the device, in context, was inadequate for this purpose. In the printed policy, the location of the word 'provided' on the margin is so inconspicuous as to escape the attention of any save the most diligent and observant."[85] Decisions interpreting similar policy provisions differently were considered by the court, but it was pointed out that in each of these situations the spacing emphasized the use of the device, thereby rendering it conspicuous, in sharp contrast to the printed material in this policy.

### *F. Patterson v. Aetna Life Insurance Company*[86]

The plaintiff's son, a cerebral palsy victim as the result of natal injuries, was insured under a group health insurance policy. The child was a patient at the Asheville Orthopedic Hospital, Inc., Asheville, North Carolina, for a period of more than one year. During this time he received physical therapy, occupational therapy, and speech therapy. The plaintiff, having personally borne the expenses of this treatment, sought reimbursement from the insurer. The defendant denied liability for these expenses challenging the qualifications of Asheville Orthopedic as a "hospital" within the following policy provisions:

84. *Id.* at 400-01, 150 S.E.2d at 234.
85. *Id.* at 401-02, 150 S.E.2d at 234.
86. 248 S.C. 374, 149 S.E.2d 915 (1966).

> The term "hospital" means only an institution which meets fully *every one* of the following tests, namely, (a) it is primarily engaged in providing—for compensation from its patients and on an inpatient basis—diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of physicians, and (b) it continuously provides twenty-four hour a day nursing service by registered graduate nurses, and (c) is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.[87]

This contest was grounded solely on the failure of Asheville Orthopedic to provide surgical facilities. The court concluded that the hospital in question possessed no surgical or operating facilities nor did it have any contractual relationship with a neighboring institution enabling it to share the latter's facilities. These factors were considered in light of the following test:

> [I]n order to qualify, an institution must be primarily engaged in providing facilities for surgical *and* medical treatment of injured and sick persons under the supervision of a staff of physicians.[88]

This decision gave rise to the determination that "to provide facilities for medical treatment, but none for surgery, is to meet the test only in part, which is insufficient for qualification as a hospital under the explicit language of the contract."[89]

Thus, the court resolved this issue by ruling that the language of the policy clearly and unambiguously excluded protection in this instance.

### *G. Mutual Savings & Loan Association v. Monarch Insurance Company*[90]

In 1953 Louise Easterling executed a mortgage on a dwelling to the plaintiff, Mutual Savings & Loan Association at which time she procured a policy of fire insurance from the defendant, naming the mortgagee-plaintiff beneficiary. This policy contained the following provisions:

87. *Id.* at 376, 149 S.E.2d at 916 (emphasis added).
88. *Id.* at 377, 149 S.E.2d at 917.
89. *Id.*
90. 248 S.C. 272, 149 S.E.2d 633 (1966).

> Provided also, that the mortgagee (or trustee) shall notify this Company of any change of ownership or occupancy or increase of hazard, which shall come to the knowledge of said mortgagee (or trustee) and, unless permitted by this policy, it shall be noted thereon, and the mortgagee (or trustee) shall, on demand, pay the premium for such increased hazard for the term of the use thereof; otherwise this policy shall be null and void.[91]

In March 1956 Louise Easterling transferred title to the mortgaged property to her husband, Richard, and in 1957 the insurance policy was renewed. When the dwelling in question was destroyed by fire in July of 1961, a demand was made on the insurer for payment pursuant to the policy provisions. The defendant denied liability, asserting that the policy had been violated by the failure of the plaintiff to notify it of the change of ownership of the insured property, thus rendering the policy null and void. In addition, it alleged the existence of a second policy of fire insurance procured by Richard Easterling in May 1961 from Underwriters Insurance Company, maintaining, in the alternative, that if Monarch be found liable, its liability should not exceed that portion of the loss that its coverage bore to the total coverage under both policies.

The plaintiff, in response to these allegations, denied any knowledge, either actual or constructive, of the change of ownership of the insured property and also denied the existence of the second policy purported to have been issued by Underwriters. Upon reference to a Master, these conflicts were resolved in favor of the plaintiff; and from this determination and its subsequent affirmation by the trial court the defendant appealed.

On appeal the Master's findings were allowed to stand, with the court observing that even if the plaintiff could be charged with knowledge of the change of ownership, the

> failure of a mortgagee-beneficiary to notify the insurer of a change of ownership of the mortgaged property, of which the mortgagee has knowledge, does not forfeit the mortgagee's rights under the policy unless the change of ownership is such as to increase the risk, as to which there was no showing before the Master, or unless the policy provides

91. *Id.* at 277, 149 S.E.2d at 635.

> that a change in ownership will render it void, which the policy in issue did not provide . . . .[92]

This conclusion was apparently dictated by the court's determination that

> The obvious purpose of the required notification is to enable the insurer to determine whether the transfer has increased the hazard, and if so, to demand that the mortgagee pay the higher premium called for by the increased hazard, on pain of having the policy declared void.[93]

*H. Dean v. American Fire & Casualty Co.*[94]

American Fire & Casualty issued its policy of insurance to John Dean on November 5, 1965, providing for payment of medical expenses incurred in the treatment of injuries occasioned when "*struck* by an automobile."[95] On June 1, 1965, Dean sustained injury to his finger while attempting to remove a jack from under his automobile. The vehicle fell on the jack and crushed Dean's finger. This injury necessitated the amputation of the finger for which Dean incurred relatively minor medical expenses. In his action to recover these expenses from the insurer, the lower court ruled that the term "through being struck by an automobile" should be construed to cover only those situations in which the insured, as a pedestrian, was struck by an "automobile in movement and propulsion."[96]

The supreme court concluded that to affirm the decision of the lower court would be to interpolate into the policy language an additional stipulation not contemplated by the parties to the contract:

> The provision of the policy here contains no limitation or condition as to how or in what manner an insured must be "struck by an automobile" in order for coverage to be effective. The word "struck" is the past tense of the word "strike" which in its plain, ordinary and popular sense means "to hit with some force"; "to come in collision with"; "to give a blow to"; "to come in contact forcibly". . . .

92. *Id.* at 280, 149 S.E.2d at 637.
93. *Id.* at 281, 149 S.E.2d at 637.
94. 249 S.C. 39, 152 S.E.2d 247 (1967).
95. *Id.* at 40, 152 S.E.2d 248 (emphasis added).
96. *Id.* at 41, 152 S.E.2d at 248.

Here, the falling automobile was the causative force bringing about the appellant's injury. To hold that the appellant was not struck by an automobile would require us to deviate from the plain, ordinary and popular meaning of the words used in the insurance contract.[97]

*I. St. Paul Mercury Insurance Company v. Pennsylvania Lumbermen's Mutual Insurance Company*[98]

This was an action for a declaratory judgment to determine the ownership of a Chevrolet automobile. The facts were that: in 1963 Varndell Gallardo, a minor whose driver's license had been suspended, desired to purchase the Chevrolet; the vehicle was purchased in the name of Eusebio Gallardo, Varndell's father, under an installment contract with the installments being paid by both Varndell and Eusebio; Varndell paid the Highway Department registration fee and a twenty dollar uninsured motorist fee; the Gallardo family regarded the automobile as belonging to Varndell but considered Mrs. Gallardo, Varndell's mother, as the principal user; at the time the automobile was purchased Eusebio had a family combination policy with Lumbermen's which contained an automatic insurance clause which purported to cover any "private passenger, farm or utility automobile *ownership* of which is *acquired by the named insured* during the policy period."[99]

On January 31, 1964, while being driven by Varndell, the automobile in question crashed into a tree causing bodily injury to Andrew Carn and John Delano Garcia resulting in Garcia's subsequent death. At the time of the accident Carn was insured by St. Paul Mercury with its attendant uninsured motorist protection, and Garcia was insured by State Farm Mutual Automobile Insurance Company. Both Carn and Garcia's administrator[s] filed suit against their respective insurance carriers under the uninsured motorist provision of their policies. St. Paul, when notified of the claims against Varndell, denied coverage and declined defense.

The court determined at the outset that Pennsylvania Lumbermen's protection would extend to the vehicle in question if

97. *Id.* at 41-2, 152 S.E.2d at 248-49.
98. 257 F. Supp. 483 (D.S.C. 1966).
99. *Id.* at 485 (emphasis added).

owned by Eusebio Gallardo but not if owned by Varndell.[100] A review of the applicable South Carolina law indicated a prima facie rebuttable presumption of ownership in favor of the individual whose name appears on the certificate of title. The court resolved the factual issue by declaring Eusebio the owner of the automobile. Those elements apparently considered in reaching this conclusion include: (1) the certificate of title and registration bore the name of Eusebio; (2) Mrs. Gallardo was the principal operator of the vehicle and assumed the responsibility for making inquiries as to insurance coverage; (3) Eusebio was primarily obligated to and actually did make many of the installment payments and was also responsible for payment of property taxes on the automobile. Thus, the presumption was sustained on the evidence with little real indication being given as to just which factors were accorded the greatest weight or what additional elements might be determinative in future cases in the absence of one or more of those present here.

Although the court settled the question of ownership against the plaintiff, it proceeded to relieve it of any liability by concluding that Mrs. Gallardo had expressly rejected the coverage available under the automatic insurance clause. "The fact that the acquired automobile is insured automatically for the notice period does not mean that one cannot refuse the coverage at an earlier time because he does not wish to pay for it."[101]

### *J. Nationwide Mutual Insurance Company v. Fleming*[102]

Henry C. Fleming, Jr. owned a 1963 Ford truck which was covered by a one year policy of liability insurance issued by Nationwide on October 16, 1964. The policy contained an automatic insurance clause extending immediate coverage to all newly acquired *additional* vehicles provided the insurer be notified of such acquisition within a period of thirty days there-

100. It may be that the necessity for this determination of the ownership of the automobile could have been obviated had the plaintiff chosen to rely upon the earlier South Carolina case of *Pacific Insurance Company v. Fireman's Fund Insurance Company*, 247 S.C. 282, 147 S.E.2d 273 (1966). When given its most literal construction, that case appears to apply South Carolina Code Sections 46-750.31 and 46-750.32 to an automobile liability insurance policy of this type so as to extend its coverage to the insured, his spouse, "and *all members of the household, whether related or not,* and while driving *an* automobile, *regardless of who owns it.*" Brief for Appellant at 7, *Pacific Ins. Co. v. Fireman's Fund Ins. Co.*, 247 S.C. 283, 147 S.E.2d 273 (1966) (emphasis added).

101. 257 F. Supp. 483, 487-88 (D.S.C. 1966).

102. 257 F. Supp. 267 (D.S.C. 1966).

after. Under the terms of the policy the same coverage would be extended to any *replacement* automobile whether or not the insurer was notified of the acquisition. At the time the policy was issued, Mr. Fleming also had a 1954 Pontiac which was inoperable and upon which there was no insurance protection. On March 16, 1964, Mr. Fleming traded the 1954 Pontiac as down payment on a 1960 Pontiac. Upon purchase Fleming filled out and submitted to the South Carolina Highway Department a certificate of insurance form number 402 certifying that the 1960 Pontiac was covered by Nationwide, specifying the effective date of protection as October 16, 1963. A photostatic copy of this certificate was forwarded by the Highway Department to Nationwide for certification on May 14, 1964. Thereafter, some time in May of 1964, the 1962 Ford truck was repossessed.

On August 30, 1964, Fleming was operating his 1960 Pontiac when it collided with a vehicle, killing its driver Mr. White. Actions were filed against Fleming on behalf of the estate of Mr. White and the injured White children. Nationwide denied coverage of the 1960 Pontiac and brought this action seeking a declaratory judgment absolving it of any liability Fleming might incur. The theory under which Nationwide proceeded was as follows: (1) the 1960 Pontiac could not be considered as a *replacement* for the 1963 Ford truck because of the lapse of time between the acquisition of the former and the disposal of the latter and (2) coverage was never extended to the 1960 Pontiac as an *additional* automobile because the requisite notice of its acquisition was never received within the specified thirty day period.

In considering Nationwide's first contention the court was faced with an apparent lack of South Carolina authority. This necessitated a review of general law and decisions from other jurisdictions. The conclusion, based on a careful and detailed study of these authorities, was that the Pontiac did not qualify as a *replacement* because the Ford truck "was both serviceable and undisposed of at the time of the delivery of the alleged replacement."[103] Although this determination appeared on its face to be in conflict with or at least inconsistent with one earlier decision,[104] the two cases are clearly distinguishable; and the conclusion is justified if not dictated by the law and evidence presented.

103. *Id.* at 267.
104. Nationwide Mut. Ins. Co. v. Mast, 52 Del. 127, 153 A.2d 893 (1959).

With regard to Nationwide's second contention, Fleming asserted that the filing of the certificate of insurance with the Highway Department should constitute notice to the insurer of the acquisition of the Pontiac. This being the only argument presented by Fleming, the court dispatched it by declaring that "filling out a required form for the highway department does not equate with informing the insurer they are committed to provide additional protection."[105] Having so concluded, the necessity for further consideration was obviated by the recent South Carolina decision of *Miller v. Sturvesant Insurance Company*.[106] There the court adopted the general proposition that

> 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, a failure to give notice prior to an accident occurring after the expiration of the designated period precludes coverage of the new automobile.[107]

*K. Seaboard Fire & Marine Insurance Company v. Gibbs*[108]

In November of 1962 Seaboard issued its policy of automobile liability insurance to Daniel Gibbs, thereby agreeing to provide protection on his 1951 Dodge pickup truck. The policy also provided coverage for any non-owned automobile while being driven by Gibbs provided it was not "used in any other business or occupation, except a private passenger automobile operated by the named insured"[109] and provided the vehicle was an "automobile not owned by or furnished or available for the regular use"[110] of the insured. An automobile was specifically defined as "a four wheel land and motor vehicle designed for use principally upon public roads."[111]

Seaboard refused to defend Gibbs in a suit following an accident in which Gibbs was driving a six wheel truck owned by his employer and furnished as transportation for Gibbs and

105. 257 F. Supp. at 267.
106. 242 S.C. 322, 130 S.E.2d 913 (1963).
107. *Id.* at 327, 130 S.E.2d at 916.
108. 265 F. Supp. 623 (D.S.C. 1967).
109. *Id.* at 626.
110. *Id.*
111. *Id.*

others. Seaboard's refusal was based on three grounds: (1) the six wheel truck was not encompassed in the policy definition of "automobile"; (2) that the truck was excluded from coverage as a non-owned vehicle "furnished or available for his regular use"; (3) the accident occurred while the truck was being used as other than a "private passenger automobile operated or occupied by the named insured."

Accordingly, the insurer commenced this action for a declaratory judgment absolving it of liability for any verdict that might be rendered against Gibbs for injuries or damages arising out of the accident.

In ruling on the plaintiff's first contention the court was compelled by the lack of authority in this jurisdiction to resort to decisions from other jurisdictions from which it concluded that

> Under [the] functional view of what is an "automobile" under the terms of the policy, the fact that the vehicle involved had six wheels on two axles, rather than the four-wheel truck on which the policy was written, cannot alone be controlling under the law of insurance.[112]

This issue resolved, foreign authority was again utilized by the court in supporting its holding that the language, "furnished or available for the regular use" of the insured, referred to the furnishing of a vehicle for his continuous, regular and personal use without his having to secure permission from the owner. Since permission to use the truck was granted to Gibbs only on a day-to-day basis and for specific purposes, the policy provision was not enough to preclude protection in this instance.

The plaintiff's third contention was premised on the use of the truck in transporting permanently employed farm laborers to and from work. These individuals were picked up and delivered on the route usually traveled by Gibbs, and, consequently, the transportation was determined to be a mere gratuity rendered them by Gibbs without compensation from his employers. Accordingly, this activity was found to be a mere incident to Gibbs' casual use of the truck and did not constitute an activity in the pursuit of his business or profession.

112. *Id.* at 628.

*L. Bonus Case*

Although the case of *Lee v. Gulf Insurance Company*[113] is more closely related to the substantive law of evidence, it appears to be of particular significance to those concerned with the practice of insurance law.

The plaintiff, Lee, had previously obtained a judgment against one Kirby Dix, the defendant's insured, in an action predicated on the negligence of Dix in the operation of his automobile. Lee then instituted this action to recover that judgment alleging the existence of a liability insurance policy issued by the defendant with Dix as the named insured.

The defendant admitted the existence of the insurance policy but denied liability. In support of its contention of no liability, Gulf sought to introduce into evidence the signed statement of Dix which had been previously obtained by one of its adjusters. When the statement was excluded as hearsay, Gulf attempted to elicit from the adjuster certain statements alleged to have been made to him by Dix. These were also excluded as hearsay. It is from these rulings that Gulf appealed. The whole question was whether or not the exclusion of this evidence by the trial judge constituted error.

The defendant adopted the position that this evidence would have been admissible had Dix been the plaintiff, and that since Lee "stepped into the shoes of" the insured, he is thereby rendered subject to all disabilities and rights accruing to the insured. As the court put it, the insurer's basic contention was that "the same evidence would be rendered admissible regardless of whether the suit be brought by the insured or the injured party."[114]

In resolving this issue, the court used the general South Carolina rule:

> [A]n injured party who brings suit against a liability carrier in order to collect on a judgment previously acquired against an insured is possessed of all rights of the insured and subject to all defenses that exist between the insured and the insurance carrier. *Crook v. State Farm Mutual Automobile Insurance Company*, 231 S.C. 257, 98 S.E.2d 427.[115]

113. 248 S.C. 296, 149 S.E.2d 639 (1966).
114. *Id.* at 298, 149 S.E.2d at 641.
115. *Id.* at 298, 149 S.E.2d at 640-41.

It went on, however, to reject the defendant's argument:

> To say that the respondent had the same substantive rights and is subject to the same defenses as the insured is not to say that the ordinary rules governing the admissibility of evidence should be modified or suspended in a trial adjudicating these substantive rights and defenses.[116]

Accordingly, the lower court ruling was affirmed, apparently in reliance on the case of *Columbia Casualty Company v. Thomas*[117] in which a strikingly similar fact situation was presented.

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116. *Id.* at 298, 149 S.E.2d at 641.
117. 101 F.2d 151 (5th Cir. 1939).