South Carolina Law Review

Volume 14 | Issue 1 Article 13

Fall 1961

Insurance

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Recommended Citation
Wesley M. Walker, Insurance, 14 S. C. L. Rev. 61 (1961-1962).

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INSURANCE

WESLEY M. WALKER*

No substantial change occurred in the law of insurance this year, but several of the decisions are factually interesting and serve to reaffirm basic principles previously announced by our Court. In addition, the Court was called upon during this period to construe and interpret several provisions contained in the standard insurance policy and to rule upon the trial court's application of such policy provisions to the facts involved.

Uninsured Motorist Coverage Provisions

The case of *Childs v. Allstate Ins. Co.*[1] is the most noteworthy case decided by the Supreme Court in this field during the period covered by this survey. Allstate Insurance Company had issued to the plaintiff-respondent its policy of automobile insurance, Section II of which was entitled, "Protection against bodily injury by uninsured automobiles." The policy contained the following specific provision:

> Allstate will pay all sums which the insured shall be legally entitled to recover as damages from the owner or operator of an uninsured automobile because of bodily injury sustained by the insured, caused by accident and arising out of the ownership, maintenance or use of such automobile.

The policy further contained as an exclusion bodily injury of an insured where the insured or his representatives "without the written consent of Allstate, make any settlement with, or prosecute to judgment any action against, any person or organization who may be legally liable therefor." It was also required that upon instituting any legal action for bodily injury against any other person by the insured or his representative, a copy of the summons and complaint should be immediately mailed to Allstate.

The insured was in collision with one Cunningham and suffered certain personal injuries. Upon report of the accident

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1. 237 S. C. 455, 117 S. E. 2d 867 (1961).

Published by Scholar Commons, 2020

the insurer, after investigation, determined that the accident was the fault of the insured and settled with Cunningham his claim against the insured for damage to his automobile by paying him the amount thereof. Upon refusal by the insurer of the insured's claim for the personal injuries which he received in the collision, the insured brought suit against Cunningham and recovered judgment by default in the sum of $1,500.00. For that amount and the costs of the action, this suit against the insurer was instituted.

Prior to the insured's bringing suit against Cunningham, his attorney had corresponded with the Claims Manager for the insurance company and had received a letter from the Claims Manager, stating that:

> . . . our investigation of the accident indicated that Mr. Childs was responsible for this accident, and hence, could not have any claim under the uninsured motorist coverage. As a result of our investigation of the accident, and our determination of the liability as resting on our insured, we have settled the property damage claim of the Cunninghams.

At the time suit was instituted against Cunningham, the insured's attorney wrote to the Claims Manager so advising and enclosing copies of the suit papers. The Claims Manager wrote back calling attention to the provisions of the policy requiring that written consent of the company be secured before such an action could be initiated and further stating that a prosecution to judgment of the action against Cunningham would relieve Allstate of any obligations under the bodily injury benefit insurance protection of the insured's policy. After the insured reduced his claim against Cunningham to judgment, the Claims Manager made written refusal of the insured's claim contending that since the action had been brought without the written consent of the insurer, the insured had violated his policy and brought himself under the exclusion relating thereto. That same defense was used in the trial of the insured's subsequent action against the company, and the exclusion pleaded. The case was submitted to the jury which returned a verdict for the insured from which the insurer appealed.

The Supreme Court affirmed the judgment for the insured stating that since the insurer had independently determined

for itself without any apparent aid that its insured was at fault and legally responsible for the collision with the uninsured driver and had on that account denied liability under the uninsured motorist provision of the policy, it simply was not in position to invoke the provision of the policy requiring that the insured obtain written permission of the company prior to bringing suit. The Court stated that it was not called upon to consider the efficacy and validity of this clause under other circumstances, but that it dealt only with the facts involved in this case, special emphasis being placed upon the correspondence between the parties. Cited as being in point was *Batson v. South Carolina Mut. Ins. Co.*[2] where the defendant insurer denied all liability on a fire insurance policy containing similar provisions and the question for determination was whether the insured could maintain an action without compliance with the policy provisions. Our Court quoted from that case the following:

> This question has been recently considered in *Thompson v. Piedmont Mutual Ins. Co.*, 77 S.C. 486, 58 S.E. 341, and the conclusion reached was that when an insurance company denies all liability and refuses to make an assessment, an action at law is maintainable to recover the amount of damages which the insured would be entitled to recover if the company had performed its part of the contract.[3]

The Court in the *Childs* case was additionally faced with the insurer's contention that the insured was not entitled to bring suit under the policy for failure to comply with its arbitration provision that in the event of disagreement as to whether or not the insured should be legally entitled to recover damages, or as to the amount to which he was entitled, the matters upon which the insurer and insured did not agree should be settled by arbitration in accordance with the rules of the American Arbitration Association. It was alleged that this was a condition precedent to suit. The Court held that the purported agreement for arbitration is unenforceable in South Carolina, stating that

> Such an agreement is upheld when it provides for arbitration of the amount of the loss but that at hand under-

2. 78 S. C. 309, 58 S. E. 936 (1907).
3. *Childs v. Mut. Ins. Co.*, 237 S. C. 455, 463, 117 S. E. 2d 867, 871 (1961).

South Carolina Law Review, Vol. 14, Iss. 1 [2020], Art. 13

takes to require arbitration of the question of liability and is, therefore, not binding upon the parties.[4]

Construction of Policy

In *Stephens v. Cottingham*[5] the Court considered the meaning of an exclusion provision in a vehicle liability policy which said that "coverage under this policy shall be null and void in the event that more than two (2) of the tractors covered are operated at any one time since one (1) of the tractors covered is a spare to be operated only when one of the other tractors is out of service due to mechanical breakdown, repair, or overhaul."

At the time of the accident, one of the insured's tractors was en route to Baltimore and another was returning from there. The insured intended to stop the returning tractor in Laurinburg, North Carolina, to have its motor repaired, and replace it with the third tractor. With this in view he directed an employee to take the third tractor to a filling station to have it serviced; and as this tractor entered the highway it collided with the plaintiff.

The trial judge held that "sending an unloaded tractor to a local filling station to be serviced . . ." would not constitute "an operation under the exclusion clause of the policy."[6] The Supreme Court reversed this holding and ordered judgment for the insurer saying that the clear intent of the provision "was to exclude coverage when all three pieces of equipment were exposed at the same time to the hazard of an accident. A risk of liability exists whenever a tractor is in operation regardless of the purpose for which it is used."[7]

The question before the Court in *Tsalapatas v. Phoenix Ins. Co.*[8] was whether the insured's boat was considered as being "laid up and out of commission" at the time the damage was sustained, in accordance with a warranty to that effect in the policy. The insured had taken the boat from the boathouse to the dock some 300 yards distance to be inspected and repaired, and while proceeding back to the boathouse under its own power it struck an underwater object and sank.

4. *Id.* at 460, 117 S. E. 2d at 869-870.
5. 237 S. C. 108, 115 S. E. 2d 505 (1960).
6. *Id.* at 113, 115 S. E. 2d at 507.
7. *Id.* at 114, 115 S. E. 2d at 507.
8. 236 S. C. 508, 115 S. E. 2d 49 (1960).

The Court refused to accept the insured's argument that the laid-up warranty must be construed in the light of the custom and practice of the particular locality, but held that the warranty had been broken and the insurer was not liable, the reason being that the risk of striking an underwater object while the boat was being operated under its own power was one of the risks sought to obviated by the terms of the warranty.

Fraud and Insurance Contracts

The case of *Kinard v. United Ins. Co.*[9] involved an action for fraudulent and wrongful cancellation of a health, accident and life policy. It was alleged that the insurer in 1947 issued a policy which provided life insurance of $200.00 on the plaintiff's husband, a weekly sick or accident benefit of $10.00, with further provision for waiver of premiums upon total and permanent disability. In 1953, the plaintiff became so disabled and gave repeated notices to the insurer which nevertheless continued to demand payment of premiums until September, 1957, when the custom of calling at plaintiff's home for the collection of premiums was discontinued. The insured died on January 11, 1958, and plaintiff, as beneficiary, filed proof thereof, but the insurer refused payment of the death benefit and informed the plaintiff that the policy had been cancelled in September, 1957. The complaint filed alleged numerous fraudulent acts by the insurer's agent and further contended that the cancellation was fraudulent and with knowledge of the physical condition of the insured which entitled him to a waiver of the premiums. The insurer answered by way of general denial, admitted that it had made some disability claim payments under the policy, but alleged that the policy was cancelled upon the insured's failure and refusal to continue paying the insured's premiums. From a trial court verdict in favor of the beneficiary, the insurer appealed.

The Supreme Court granted a new trial based upon errors of the trial judge in instructing the jury with respect to the burden of proof and form of verdict, but observed that the evidence produced tended to establish the cause of action for fraudulent breach of contract accompanied by fraudulent act or acts and supported the conclusion that the insured was totally and permanently disabled when the policy was can-

9. 237 S. C. 266, 116 S. E. 2d 906 (1960).

celled and that the insurer had breached the long established custom of calling at the home of the insured for collection of the premiums. It was further held that no estoppel arose, as a matter of law, because the physician's statement accompanying one of the claims for disability benefits answered the question ". . . how long from this date will patient be so confined?" with "seven days." In his testimony at the trial the physician had stated that it was his understanding that each claim was for a specific weekly period and that this statement should cover that time; that in his opinion during all of the period of his treatment of the insured, the insured was totally and permanently disabled.

In *Outlaw v. Calhoun Life Ins. Co.*[10] the action was to recover damages for alleged fraud and deceit in inducing the the plaintiff to execute a release in favor of the defendant insurance company. The defendant demurred upon the grounds that the complaint did not state facts sufficient to constitute a cause of action in that it appeared upon the face of the complaint that the plaintiff was able to read and executed the release without reading or informing herself of its contents, at the same time accepting the benefits of the release. The demurrer was overruled and this action was affirmed by the Supreme Court. The Supreme Court stated it would adhere to the rule that one cannot complain of fraud in the misrepresentation of the contents of a written instrument when the truth could have been ascertained by reading the instrument and that one entering into a written contract should read it and avail himself of every opportunity to understand its contents and meaning. However, the Court pointed out that the issue before them was whether or not the complaint stated a cause of action and in the Court's opinion the complaint was sufficient in this respect. Reference to the opinion should be had for a discussion of the Court's interpretation of the complaint and the Court's ruling as to why the complaint stated a cause of action.

In its decision, the Court pointed out the nine elements a pleader must allege in order to state a good cause of action for fraud and deceit.[11] For the convenience of the reader, these elements are set forth as follows:

10. 236 S. C. 272, 113 S. E. 2d 817 (1960).
11. *Id.* at 275, 113 S. E. 2d at 818.

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;
9. His consequent and proximate injury.

Cancellation of Policy

In *McElmurray v. American Fid. Fire Ins. Co.*[12] the plaintiff contended that the policy in question had not been effectively cancelled. The evidence indicated that plaintiff had purchased a trailer under a conditional sales contract, that the seller had prepaid the whole premium on the insurance policy covering the trailer, that notice of cancellation of the policy had been sent to the plaintiff and that the plaintiff had, subsequent to receiving the notice, made two additional installment payments on the contract. The plaintiff argued that a portion of these two payments was insurance premiums and that acceptance by the seller as agent for the insurer constituted a waiver of cancellation.

The Court rejected this argument saying that since the seller had prepaid the whole premium, it became a part of the total indebtedness owed by the plaintiff and the monthly installment payments were applied to the liquidation of the indebtedness and were in no part insurance premiums. The Court also reaffirmed the position that payment or tender of unearned premium is not a condition of cancellation where the policy specifically negates such requirement.

Lienholder's Right to Insurance Proceeds

In the case of *Blackwell v. State Farm Mut. Auto. Ins. Co.*[13] the Court was afforded an opportunity to reaffirm the well settled rule that where a mortgagor is bound by a covenant in the mortgage or otherwise to insure the mortgaged property for the better security of the mortgagee, the mortgagee will have an equitable lien upon the proceeds due on an insurance policy taken out by the mortgagor to the extent of the

12. 236 S. C. 195, 113 S. E. 2d 528 (1960).
13. 237 S. C. 649, 118 S. E. 2d 701 (1961).

mortgagee's interest in the property damaged or destroyed. The plaintiff here had borrowed money from the bank with which to purchase an automobile. The loan was secured by a chattel mortgage which required that the mortgagor should keep the vehicle insured during the term of the mortgage. The loan included the amount of the insurance premium. When the loan was made, the bank immediately applied to the insurer for comprehensive and collision coverages on the automobile and paid the premium. A binder receipt was issued to the bank agreeing to issue the requested policy "with loss payable to the First National Bank of South Carolina." When the original policy was issued, it was delivered to the bank, naming Blackwell as the insured. Under the heading, "Exceptions and Endorsements," there appeared the following: "Finance — First National Bank of South Carolina, Columbia, South Carolina."

The vehicle was subsequently damaged in an accident and the insurer issued its draft under the policy to the bank. Blackwell's Administratrix (Blackwell having subsequently died) instituted suit against the insurer contending that under the policy the loss was payable to Blackwell alone. The lower court directed a verdict for the plaintiff but the Supreme Court reversed this holding stating that is was unnecessary to determine whether the policy provisions had the the same effect as a loss payable clause since the bank was clearly entitled to the proceeds of the policy to the extent of the mortgage indebtedness under its equitable lien on the insurance proceeds. It was further held that had the insurer, with knowledge of the covenant to insure for the benefit of the bank, paid the amount of the loss to Blackwell, the right of the bank to enforce its equitable lien would not have been affected and the bank could have recovered against the insured the amount of the loss.

Subrogation

In *Calvert Fire Ins. Co. v. James*[14] the Supreme Court held that an insurer's right of subrogation was not barred by a release procured from the insured by the tort-feasor,who knew that the insured had already received payment from the insurer. However, the Court pointed out that the doctrine of subrogation is founded in equity and natural justice and must

14. 236 S. C. 431, 114 S. E. 2d 832 (1960).

be applied in each instance according to the dictates of equity and good conscience in the light of the actions and relationship of the parties.

In *Rankin v. Superior Auto. Ins. Co.*[15] the insured had already instituted an action against the driver of the other vehicle when his insurer paid the loss. The insured thereupon executed to his insurer a subrogation agreement in which he pledged all claims for property damages arising out of the collision. Plaintiff, who was attorney for the insured in the action already begun, went ahead and settled with the adverse party for $1,600.00. He then notified the insurer of the settlement and claimed one-third of the amount as an attorney's fee, but the insurer denied that plaintiff was entitled to any part of the settlement. The Supreme Court reversed the lower court's decision for the plaintiff giving for their reason the fact that there was no contract between the parties. The Court held that the insurer could possibly have intervened in the action but that its decision not to do so did not have the effect of authorizing plaintiff to represent its interests. The incidental benefits derived from plaintiff's services did not constitute a foundation for a legal claim.

School Policies

During the survey year, the South Carolina Supreme Court resolved two cases involving school policies, the cases being unrelated except for the general issue involved.

In *Richardson v. Pilot Life Ins. Co.*[16] the insurer had issued a scholastic accident insurance policy providing coverage for bodily injuries caused by accident "directly and *independently of all other causes.*" The plaintiff, a high school boy, sought to recover under said policy for medical expenses resulting from his having slipped and fractured his leg while at school. At the time of the accident the plaintiff was on crutches and had his leg in a cast due to having fractured the same leg some ten days earlier. On trial of the case the defendant insurance company moved for a nonsuit and a directed verdict on the ground that the testimony conclusively showed that the second accident and the resulting medical expense was not an accident "directly and independently of all other causes" as required under the policy. Both mo-

15. 237 S. C. 380, 117 S. E. 2d 525 (1960).
16. 237 S. C. 47, 115 S. E. 2d 500 (1960).

tions were denied and the jury returned a verdict for the plaintiff. On appeal, the Supreme Court affirmed stating that whether the expense of hospitalization and operation would have been incurred had it not been for the second accident was a question of fact for the jury and was properly submitted to them for their determination. The Court commented that the testimony of the physician that the plaintiff had recovered from the first injury allowed the inference that the first injury was not a cause of the second injury.

The case of *Weston v. Nationwide Mut. Ins. Co.*[17] was an action brought for the death of a child who was struck by an insured school bus, seeking damages in the amount of $5,000.00 under the provisions of Section 21-840.2 (2), Code of Laws of South Carolina, (1952). This statute requires that insurance be maintained on State-owned buses and sets forth the benefits provided, including:

> (1) For lawful occupant of any such school bus who suffers personal injuries or death, a death benefit of two thousand dollars. . . .
>
> (2) For any person other than a person riding in a school bus, or a person who qualifies for benefits under Paragraph (1), who suffers personal injuries or death because of the negligent operation of any such school bus, an amount not exceeding five thousand dollars.

It is further provided under this statute that the benefits under Paragraph (1) "shall exist without regard to fault or negligence," but liability under Paragraph (2) is dependent upon negligence.

The insurer's motion for a nonsuit was granted upon the ground that there had been no showing that the deceased was a third party. The question on appeal was whether the trial judge erred in his conclusion that the plaintiff's case came within the provisions of paragraph (1) or whether it fell within the sections of paragraph (2). The Supreme Court held that the matter should have been submitted to the jury for a determination of the questions of fact relating to whether or not the child had been as "occupant of the bus" or "a third person"and that the decision of the trial judge granting the nonsuit should therefore be reversed.

17. 237 S. C. 464, 118 S. E. 2d 67 (1961).

Presumption Against Suicide

The case of *Strawhorne v. Atlantic Coast Life Ins. Co.*[18] involved an action to recover death benefits under a life insurance policy issued by the defendant insurance company on the plaintiff's wife. The policy contained a clause providing that if the insured should die by his or her own hands during the first two years the policy was in force the company should be liable only for a return of premiums paid. The defendant interposed this defense, the insured having died as a result of a gunshot wound within two years after the issuance of the policy, but the jury returned a verdict in favor of the plaintiff for the amount of the death benefits contained in the policy. On appeal, the Supreme Court reversed the decision of the lower court. With regard to the presumption and burden of proof as it relates to suicide, the Court said:

> Where the defense of suicide is interposed by the insurer to defeat recovery under a policy of insurance, the burden is upon the insurer to prove the fact of suicide by the preponderance of the evidence. It is true that where death by violent injury has occurred, unexplained, there is a presumption against suicide, but this is a presumption of law and not of fact. When evidence as to the fact of suicide is introduced, the presumption against suicide vanishes and the question must be resolved under the evidence. *McMillan v. General Amer. Life Ins. Co.*, 194 S.C. 146, 9 S.E.2d 562 (1940).[19]

The Court held that the facts and circumstances surrounding the insured's death led to but one reasonable conclusion, that being that the insured came to her death by her own hands.

18. 238 S. C. 40, 119 S. E. 2d 101 (1961).
19. *Id.* at 43, 119 S. E. 2d at 102.