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Insurance

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Those cases from South Carolina during the preceding year which primarily involved the field of insurance were characterized by some rather unique factual situations as well as by the establishment and reaffirmation of certain important legal principles, the most significant example of which is probably the case of *Sexton* v. *Harleysville Mut. Cas. Co.*[1] In this case the plaintiff's car was stolen and, while stolen, caused certain damage to the property of four people who thereupon instituted suit against the plaintiff and attached his car at the same time. The plaintiff was judicially relieved of personal liability; but a judgment *in rem* was rendered against the auto, and plaintiff paid the property owners 800.00 dollars in settlement to secure a release of his car. The company had agreed to indemnify the plaintiff against loss which he became "legally obligated to pay," and controversy arose as to whether or not he was "legally obligated" to pay the 800.00 dollars to release the car from attachment. The county court held that the company was not liable; the Court of Common Pleas reversed that holding and ruled in the plaintiff's favor; and the Supreme Court again reversed and held for the company.

The court reasoned that, whils a judgment *in personam* creates personal liability, a judgment *in rem* operates only upon the subject property. The auto here was liable, not the owner, and the statutory lien on the auto under Section 45-55 of the 1962 Code did not constitute a judgment against the plaintiff. Since the company agreed to pay only when the plaintiff became legally obligated, and since this was to be determined by whether or not a valid judgment had been rendered against him, its liability did not accrue under the *in rem* judgment.

Mr. Justice Bussey, dissenting, stated that in his opinion the statutory lien created a legal debt or duty on the part of the owner to pay to the extent of the automobile itself or its value at the time of the attachment and that the judgment gave plaintiff the choice of paying or surrendering his auto. Justice Bussey stated that in either event, the plaintiff was legally obligated to pay the equivalent of 800.00 dollars.

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1. 242 S.C. 182, 130 S.E.2d 475 (1963).

Another important decision extended the use of the so-called "loan receipt" theory. The companion cases of *Othella D. Martin* v. *Henry J. McLeod*[2] and *Joseph B. Martin, Jr.* v. *Henry J. McLeod*[3] were instituted by the plaintiffs against a party allegedly responsible for a fire which damaged plaintiff's dwelling and contents therein. The defendant asserted in the Court of Common Pleas that the plaintiffs were not in fact the real parties in interest since they had both been compensated through their insurer for their respective losses, and at best these were actually assignments of causes of action. From judgments in favor of the plaintiffs, the defendant appealed.

The essential issue in each case was whether or not there had been an unconditional payment as compensation for loss, or whether the insurance company and its insureds, by virtue of what is commonly known as a "loan receipt," in effect suspended the right of subrogation and left the title to the causes of action in the two insureds.

In resolving this question in favor of the plaintiffs, the court cited the landmark case of *Luckenbach* v. *W. L. McCahan Sugar Refining Co.*,[4] which upheld the validity of the "loan receipt."

The court went on to say that, although some jurisdictions strictly confined the application of the *Luckenbach* case to situations involving contingent liability on the part of the insurer, South Carolina and the weight of authority do not so limit this principle. The "loan receipt" was thus a lawful device by which subrogation was avoided and under which the plaintiffs in the two cases were entitled to bring the action in their own names.

The opinion rendered in *Gibson* v. *Glens Falls Ins. Co.*[5] is also quite significant although it will probably be controlling only in cases having very similar factual situations. The action was by an insured against an insurer to recover under a policy of manufacturers' and contractors' liability insurance under which the defendant agreed to pay all sums within the policy limits for which the plaintiff became legally obligated to pay due to injury, harm, or loss of property arising out of the plaintiff's business operation, but excluding coverage for injury or destruction of "*property in the care, custody or control of the insured or prop-*

2. 241 S.C. 71, 127 S.E.2d 129 (1962). This case is also noted in the Pleading section at note 22.
3. 241 S.C. 76, 127 S.E.2d 131 (1962).
4. 248 U.S. 139, 63 L. Ed 170 (1918).
5. 241 S.C. 293, 128 S.E.2d 157 (1962). Recent Decision, 15 S.C.L. REV. 722 (1963).

erty as to which the insured for any purpose is exercising physical control."

The plaintiff was a contractor whose employees were cleaning a swimming pool. The employees had left the pool at about four o'clock one afternoon with the intention of finishing the job the following morning. However, when they returned to the site the next day, they discovered that the floor of the pool had risen some 15 inches. Efforts to rectify the situation were only partially successful, and ultimately the owner of the pool brought an action against the plaintiff who was forced to settle the claim and pay attorneys' fees on his own behalf, the defendant insurer at all times denying liability on the basis of the above stated exclusion. In an action by the plaintiff to recover on the policy, the lower court granted the defendant's motion for a directed verdict and the plaintiff appealed.

The sole question was whether the swimming pool in question was in the care, custody or control of the plaintiff at the time of the loss. The court's answer was negative and the judgment was reversed and remanded. The court said that since the plaintiff and its employees had left the pool, all plaintiff had was the right of access to return the following morning and that care, custody and control of property contemplates something stronger than mere right of access.

The remaining cases have been divided into categories depending upon the significant principles or issues involved therein.

CONSTRUCTION OF POLICY

Significant in this category is the case of *Garrett* v. *Pilot Life Ins. Co.*[6] in which plaintiff brought an action on a scholastic accident insurance policy which provided benefits for accidental injuries occurring while

> traveling directly between home and school for the purpose of attending or returning from regularly scheduled classes, but only if such travel occurred within one hour before the commencement of the day's school session or within one hour after dismissal from school.

On the day in question, the plaintiff was dismissed from school early and stopped at the residence of a neighbor who lived between the school and plaintiff's home and who was taking care

6. 241 S.C. 299, 128 S.E.2d 171 (1962).

of plaintiff's younger brother and sister. He drank a glass of lemonade and then a short time later asked the permission of the neighbor to play with a BB gun. Permission was granted and plaintiff was in the act of loading the gun when it was somehow discharged and his eye injured. This accident occurred about forty-five minutes after he had been dismissed from school.

A trial by jury was waived and the case submitted to the court upon an agreed stipulation of facts. The trial judge found that, although the accident occurred within one hour after the plaintiff had been dismissed from school, every stipulated fact indicated a complete abandonment of any intention of traveling home; and, accordingly, the trial judge held that the accident was not covered under the provisions of the policy. Upon appeal, the Supreme Court affirmed, stating that the trial judge had reached a conclusion of which the facts were reasonably susceptible and that his findings of fact were, therefore, binding.

Another interesting case pertaining to policy construction is that of *Barnhill* v. *Bankers Fire & Marine Ins. Co.*[7] in which the plaintiff owned a 36.3 acre farm upon which he resided. He subsequently purchased an adjoining farm of 108.5 acres with a seven room tenant house thereon and gave a mortgage on the combined farms, being a total of 144.8 acres. The mortgagee required the plaintiff to obtain fire insurance on his residence and on the tenant house in the amounts of $8,000 and $500 respectively. Upon the plaintiff's request, the defendant insurance company issued a policy wherein the amounts of coverage on the two buildings were stated as follows: $8,000.00 on one story frame, composition roof main dwelling occupied by owner .... $500.00 on 7 room, comp. frame, tenant dwelling, situated 1200 feet N of main dwelling." The acreage of the farm referred to in the policy was incorrectly entered as 108.5 rather than 144.8.

The tenant house burned and the controversy between the parties arose over the identity of the building referred to in the policy as the "main dwelling, occupied by the owner." The plaintiff contended that, since the acreage in the farm on which the buildings were located was shown in the policy as 108.5 acres and the building which burned was the main dwelling on that tract, the amount of insurance coverage under the policy was 8,000 dollars. On the other hand, the defendant contended that the building which burned was that designated in the policy as a

7. 240 S.C. 325, 125 S.E.2d 889 (1962).

"7 room tenant dwelling" and was only insured for $500.00. The trial court rendered judgment on an $8,000 verdict for the plaintiff, and the defendant appealed.

In reducing the amount of the judgment to $500.00, the Supreme Court noted that there was only one building located on plaintiff's property "occupied by the owner," and that building was not destroyed by fire. There was only one "seven room tenant dwelling," and that was the one destroyed by fire and occupied at the time by a tenant, never by the plaintiff owner. The court pointed out that while the policy refers to the acreage in the farm as 108.5, this was patently an error under all the testimony, as it is conceded that some of the buildings insured were located on the 36.3 acre tract and some on the 108.5 parcel. In this regard, the court said:

> The acreage in the farm is not the subject of the insurance, but the buildings located thereon. The acreage relates solely to the location of the insured property and any misstatement of the acreage in the farm on which the buildings were located was immaterial in this case, since the location and identity of the insured buildings could be clearly ascertained from the other language used in the policy in the light of attendant circumstances.

Linder v. *Firemen's Ins. Co.*[8] was an action by an insured to recover for damage by windstorm to trees on his residential premises. Attached to and made a part of the subject policy was a form which stated that the perils insured against were "all risks of physical loss to the property covered except as otherwise excluded." Under the provision entitled "PROPERTY AND INTERESTS COVERED" the plaintiff's dwelling and certain appurtenances and equipment were included, but trees, shrubs, plants or lawns were excluded "except as provided elsewhere in this form." Under the section entitled "EXTENSIONS OF COVERAGE" certain limited coverage was provided against the loss of trees by fire, lightning, smoke and other enumerated perils which, however, did not include windstorm.

The plaintiff contended that the word "windstorm" could be substituted for the word "fire" under the "EXTENSIONS OF COVERAGE" clause by reason of the language found in the comprehensive perils clause as follows:

8. 240 S.C. 331, 125 S.E.2d 645 (1962). This case is also noted in the Pleading section at note 4.

> In the application of the provisions of *the policy to which this form is attached*, whenever the word fire appears, there should be substituted the peril involved or the loss caused thereby, as the case requires.

The Supreme Court rejected the plaintiff's contention stating that the word "fire" by which respondent would substitute "windstorm" does not appear in the policy to which the form is attached, but appears in a provision of the form itself. The court went on to say:

> It is immaterial that the policy and attached form, together, constitute the contract of insurance. The italicized words in the above quoted provision have a distinct and readily understood meaning, which comports with the manifest intention of the parties, as gathered from the entire contract.

Thus, the court held that the damage to trees by windstorm was not covered by this insurance contract.

In the case of *First Nat'l Bank* v. *Glens Falls Ins. Co.*,[9] an action was instituted by the bank to recover under the terms of the banker's blanket bond for loss sustained on a loan secured by fictitious invoices. The notes given for the loan were properly signed by the borrower, but the unsigned invoices which were attached to the notes and which purported to represent certain accounts receivable were fictitious. The relevant portion of the bond in question provided that the insurance company would indemnify the bank against any loss to the bank's having, in good faith and in the course of business, extended credit on the faith of or otherwise acted upon any securities or written instruments *which proved to have been counterfeited or forged as to the signature of any maker.*

The district court, citing the decision of the Third Circuit in *Fidelity Trust Co. v. American Sur. Co.*,[10] held that the invoices in question were "counterfeit" and that, therefore, the loss was covered under the terms of the bond. On appeal, the Fourth Circuit Court of Appeals reversed the judgment, pointing out that neither the district judge nor the Third Circuit had given adequate consideration to the limitation of the bond which confined the recovery to losses on securities or written instruments which proved to have been counterfeited or forged as to the signature.

9. 304 F.2d 866 (4th Cir. 1962).
10. 268 F.2d 805 (3rd Cir. 1959).

In examining the language set forth in the bond, the court noted that there is no comma after the word "counterfeited" and no other indication that the phrase does not qualify both terms of evil import. The court also referred to other portions of the bond which were found to be positive indication that it is the counterfeited or forged signature to the fraudulent document rather than false statements in the document or the falsity of a document in its entirety which alone gives rise to the liability of the insurer. Since there was no signature at all on the invoices, they were not covered by the bond.

Pennsylvania Threshermen & Farmers Mut. Cas. Ins. Co. v. *Hartford Acc. & Indem. Co.*[11] involved a suit brought to determine the respective liabilities of two insurance companies for damages resulting from a collision between an automobile and a tractor-trailer unit. The tractor was covered by a policy issued by P. T. & F., and the trailer was covered by a policy issued by Hartford. The owner of the trailer had agreed to pay the owner of the tractor a certain sum to haul a cargo of gasoline to a certain destination, and an accident had occurred on the return trip. The district judge held both insurance companies liable and both appealed. The P. T. & F. policy provided as follows:

> Exclusions—This policy does not apply:
>
> (c) Under coverages A and B while the automobile is used for the pulling of any trailer owned or hired by the insured and not covered by like insurance in the company; or while any trailer covered by this policy is used by any automobile owned or hired by the insured and not covered by like insurance in the company . . . .

P. T. & F. contended that the trailer was "hired" by its insured because by its use, the time consumed and costs involved in the transportation and delivery of the gasoline were reduced. It was contended that the mutual benefits accruing to the parties from this arrangement caused the trailer to be hired, thereby excluding the coverage of P. T. & F.

The Fourth Circuit Court of Appeals rejected this contention, noting that no rental or other compensation had been paid for the use of the trailer and affirmed the judgment as to P. T. & F.

11. 310 F.2d 618 (4th Cir. 1962).

The Hartford policy contained the usual omnibus coverage with respect to persons insured but excluded coverage under the following circumstances:

> The insurance with respect to any person or organization other than the named insured does not apply under Division (2) of this insuring agreement.
>
> (a) With respect to an automobile while used with any trailer owned or hired by the insured and not covered by like insurance in the company; or with respect to the trailer while used with any automobile owned or hired by the insured and not covered by like insurance in the company . . . .
>
> (d) With respect to any hired automobile, to the owner or a lessee thereof other than the named insured, or to any agent or employee of such owner of lessee . . . .

The Court of Appeals stated that the owner of the tractor came within the omnibus clause since he was using the trailer with the permission of its owner. The court determined, however, that the tractor had been hired by the owner of the trailer and that this circumstance excluded the tractor owner from coverage under the Hartford policy. The court also concluded that the driver of the tractor trailer unit was not acting as agent or employee of the insured under the Hartford policy and that, therefore, there was no coverage on the part of Hartford.

A difficult question of construction was presented by the case of *Baxley* v. *State Farm Mut. Auto. Liab. Ins. Co.*,[12] which was an action to recover funeral benefits under an automobile liability policy. The policy provided coverage while driving a "temporary substitute automobile" which was defined as "an automobile not owned by the named insured." "Named insured" was defined as including the insured's spouse if residing in the same household. The deceased insured died while driving an automobile owned wholly by his wife. The company denied coverage on the basis that the wife, who was living with her husband in the same household, was thus a named insured, and that, therefore, her automobile could not be construed as a temporary substitute automobile within the terms of the policy, because it was "owned by the named insured."

In affirming the decision of the lower court in favor of the plaintiff, our Supreme Court held as follows:

12. 241 S.C. 332, 128 S.E.2d 165 (1962).

> The definition of "named insured" in the policy, and under the circumstances here involved, simply had the effect of making "the named insured" two people instead of one. Since it is conceded that the Chrysler automobile was not owned by Mr. Baxley, nor by Mr. and Mrs. Baxley jointly, but only by Mrs. Baxley, it was "not owned by the named insured" and was covered as a temporary substitute automobile under the provisions of the policy.

The case of *Hunter* v. *Southern Farm Bureau Cas. Ins. Co.*[13] concerned the construction of an automobile liability policy provision excluding coverage with respect to the "death of any member of the family of the insured residing in the same household." The court held that the decedent came within the exclusion where it was shown that she had lived with the named insured about six years and bore him three children although she was not married to him.

In resolving this question in favor of the defendant insurance company, the court reasoned that the term "family" as here used included "such persons as habitually reside under one roof and form one domestic circle." Since the woman had lived under one roof with insured and had borne him 6 children she was clearly a member of his domestic circle and a member of his family and, as such was excluded from coverage under the policy provision in question.

REPRESENTATIONS

Section 37-161 of the 1962 Code provides that life insurance policies shall be incontestable with respect to false representations after two years from the date of issuance. Section 37-471.5 provides that after two years from the date of issuance of an accident and health policy, no misstatement, *except fraudulent misstatements*, may be used to void the policy.

In the case of *Culbreth* v. *Prudence Life Ins. Co.*,[14] the question was which of the above statutes applied to a policy insuring the plaintiff "for loss of life, limb, sight or time caused by sickness." Our Supreme Court held that Section 37-471.5 applied, thus allowing the insurer to contest the validity of the policy on the ground of fraudulent misstatement. The court quoted the

13. 241 S.C. 446, 129 S.E.2d 59 (1962).
14. 241 S.C. 46, 127 S.E.2d 132 (1962). This case is also noted in the Pleading section at note 17.

following language from the opinion of the Ohio Court of Appeals in *Oglesby-Barnitz Bank & Trust Co.* v. *Clark*:[15]

> Life insurance generally includes the occurrence of death by accident as one of the conditions which call for payment by the company, as well as death from other causes. Accidental death policies include only injuries by accident causing death, and to that extent they each provide insurance of life. Yet, neither of these two kinds of policies is for that reason brought within the same class of policy. In other words, in a policy of life insurance, death is the contingency insured against; and if it be the result of an accident, the accident is but an incidental factor; while in an accidental death policy, the accident causing death is the thing insured against, and the death is but one of the incidents which creates liability.

Using this reasoning, the Supreme Court held that in the instant case the policy was one of insurance against accident and disability.

Atlantic Life Ins. Co. v. *Beckham*[16] was a suit by a life insurer to rescind two policies issued to the decedent. The plaintiff alleged that the application for the policies was made fraudulent by misrepresentations and omissions concerning the decedent's medical history. The Supreme Court reviewed the evidence and affirmed the judgment for the decedent's beneficiary, stating that cases of this nature must of necessity stand on their own peculiar facts and the question had been properly submitted to the jury. The court also reaffirmed the well-established rule that in such cases it is incumbent upon the insurer to show not only that the statements complained of were untrue but, in addition, that their falsity was known to the applicant, that they were material to the risk, and relied on by the insurer, and that they were made with the intent to deceive and defraud the company.

In *Small v. Coastal States Ins. Co.*,[17] the defendant insurance company appealed from a directed verdict on two hospitalization policies in favor of the plaintiff insured. The defendant contended that there were certain false statements in the application amounting to warranties and that, therefore, the defendant was

15. 112 Ohio App. 31, 175 N.E.2d 98 (1959).
16. 240 S.C. 450, 126 S.E.2d 342 (1962).
17. 241 S.C. 344, 128 S.E.2d 175 (1962). This case is also noted in the Agency section at note 5.

absolved of any liability to pay. The statement in question was to the effect that the plaintiff had had no previous stomach trouble when in fact he had been treated for indigestion caused by stomach acids prior to his making the application.

In affirming the judgment for the plaintiff, the court noted that there had been no showing that the plaintiff knowingly falsified the answers with an intent to deceive the company. The court referred to its recent decision in *Atlantic Life Ins. Co.* v. *Beckham*,[18] where it held that the answers to questions regarding health were representations and not warranties, and that the answer, even if false, would not void the policy unless material to the risk, known by the applicant to be false, made with an intent to mislead, and relied upon as a basis for issuance of the policy. In order to deny coverage, the insurer must show all of these.

The case of *Home Fire & Marine Ins. Co.* v. *Tisdale*[19] was a declaratory action in which the insurance company denied coverage under an automobile liability policy on the ground that the policy had been issued in reliance on the truth of a representation which later proved to be false. The insured admitted that the representation made in the application was false but testified that the company's agent knew it was false and had directed the insured to answer in that manner. The agent testified to the contrary. The policy contained the following conditions:

> 14. CHANGES. Notice of any agent or knowledge possessed by any agent or by any other person shall not effect a waiver or a change in the part of this policy or estop the company from asserting any right under the terms of this policy; nor shall the terms of this policy be waived or changed, except by endorsement issued to form a part of this policy.
>
> 17. DECLARATIONS. By acceptance of this policy, the insured named in Item 1 of the declarations, agrees that the statements in the declarations are his agreements and representations, that this policy is issued in reliance upon the truth of such representations, and that this policy embodies all agreements existing between himself and the company or any of its agents relating to this insurance.

Notwithstanding these provisions in the policy, the Fourth Circuit Court of Appeals held that under the well-established

18. 240 S.C. 450, 126 S.E.2d 342 (1962). Noted *supra* note 16.
19. 303 F.2d 348, (4th Cir. 1962).

law in South Carolina, "an insurance company may not set up forfeiture on account of facts known to the agent of the company to be existing at the time of the making of the contract."

The Court of Appeals noted that the South Carolina court has gone even further, declaring that the company is charged not only with notice of what its agent knew, but also with what he could have known once put upon inquiry by facts disclosed to him. The court held that in view of the circumstances, a question of fact as to the agent's knowledge was created and should have been sent to the jury.

SUICIDE

The Supreme Court in the case of *Coleman* v. *Palmetto State Life Ins. Co.*[20] reaffirmed the well-established rules of evidence that where suit is brought on an accidental death policy, the burden of proof is on the beneficiary to show the death of the insured by accident; and when the insurer interposes the defense of suicide, it has the burden to prove suicide by the preponderance of the evidence. There is a presumption against suicide, but the presumption is 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 upon the evidence. Upon reviewing the record, the court concluded that the only reasonable inference was that the insured had committed suicide.

FRAUD AND DECEIT

The case of *Hopkins* v. *Fidelity Ins. Co.*[21] arose under a complaint which alleged that the plaintiff was an illiterate, twenty-six year old woman, who was the mother of two minor children. She had no husband and was entirely dependent for support on the kindness of relations. One of the children was crushed under the wheels of a heavy truck owned by B. L. McCaskill and died within five days. It was further alleged that an agent and adjuster of the defendant company had persuaded plaintiff to accept 2,000.00 dollars for the death of the child under the threat and guise that the defendant owed her nothing and that, if she would not sign the release and take the money, "they would pick up plaintiff's minor brother and put him in bad trouble." It

20. 241 S.C. 384, 128 S.E.2d 699 (1962).
21. 240 S.C. 230, 125 S.E.2d 468 (1962). This case is also noted in the Pleading section at note 6.

was contended that the adjuster, acting as agent of the insurance company, made such representations for the purpose of defrauding the plaintiff of several thousands of dollars which she would have been entitled to for the death of her child, and that by virtue of her executing such release, she thereby forfeited and lost her legal rights to a fair and just monetary value for the death of her child. The defendant demurred to the complaint, alleging that on its face it did not show that any damage was suffered on the part of the plaintiff. The lower court overruled the demurrer, but on appeal the Supreme Court reversed and held that the demurrer should have been sustained upon the ground that the complaint alleged no damages.

The court pointed out that the action was laid in fraud and deceit, the claim of damage being founded upon the alleged loss of plaintiff's right to be adequately compensated monetarily for the death of her child, and that under our Code, the action for wrongful death is vested in the deceased child's personal representative. Her right to compensation was, therefore, not in her own right, but as beneficiary of a statutory cause of action. The court further concluded that it was not alleged that the child had come to its death as a result of the negligent operation of McCaskill's truck and that the mere allegation that the child was fatally injured by the truck did not warrant inference of negligence or indicate that the plaintiff or the personal representative actually had any cause of action.

TRANSGRESSIONS OF AGENT

The defendant in *Allied Mut. Ins. Co.* v. *Roberson*[22] had been, for a number of years, the general agent for the plaintiff for the State of South Carolina, employing in that capacity various sub-agents throughout the state. It became the practice of the sub-agents to remit their premiums to the defendant, who would then deduct his commission and send the balance to the plaintiff. However, the defendant became delinquent in forwarding his monthly balances within the time specified in his contract, and the plaintiff instituted a change whereby the various sub-agents were to remit directly to the company, thus by-passing the defendant. These billing changes and the naming of company adjusters were the only alterations made in the general agency agreement, which the plaintiff at the time had no desire to ter-

22. 306 F.2d 130, (4th Cir. 1962).

minate. However, the defendant refused to turn over the premiums which he had on hand, and the company terminated the agreement and brought suit for the premiums held by the defendant. The defendant responded with a counterclaim for a breach of his agency contract and alleged that he was entitled to renewals after the termination of the agency. The Fourth Circuit Court of Appeals held that there had been no breach of contract since the written agreement between the parties gave no right to the defendant regarding billing procedures. The court also held that in the absence of an express agreement between the parties, and there was none here, an agent is not entitled to renewals after his agency has been properly terminated.

In *McPherson* v. *United Am. Ins. Co.*[23] the South Carolina Supreme Court affirmed the plaintiff's judgment for actual and punitive damages. The court held the defendant company liable for fraudulent conversion where its agent received a full year's premium from the plaintiff but turned over only the amount of a quarterly premium to the company which issued a policy good for three months.

By a rather ingenious argument the defendant contended that there was no conversion of the plaintiff's property since the plaintiff actually received what he paid for. Under the well settled rule that if a policy of insurance is issued, the coverage is for such period of time as could be bought with the amount of premium paid. The court, in rejecting this argument, pointed out that while the plaintiff might have been entitled as a matter of law to treat the policy as valid and in force for the entire year, he was not bound to pursue this remedy. He could elect, as he had done, to sue for conversion or for wrongful cancellation.

The court stated that under the doctrine of respondent superior, the defendant was liable for the wrongful conduct of its agent even though the defendant did not authorize or justify or participate in, or indeed, know of such misconduct, or even if it forbade the acts or disapproved of them.

EXPIRATION OF POLICY

Temptron, Inc. v. *Dixie Fire & Cas. Co.*,[24] involved a rather unique factual situation. Prior to October 1, 1957, Vardry Ram-

23. 242 S.C. 28, 129 S.E.2d 842 (1963). This case is also noted in the Agency section at note 6.
24. 241 S.C. 55, 127 S.E.2d 4 (1962).

seur was prominent in the ownership and management of two close corporations, Ramseur's, Inc. and Ramseur Equipment Company. Vehicles owned by both corporations were insured under the same policy issued by the defendant company. On October 1, 1957, however, Mr. Ramseur sold his interest in Ramseur Equipment Company, and the name was changed to Temptron, Inc. The liability policy expired on April 1, 1958. A renewal policy which again named the vehicles of both corporations was mailed to Mr. Ramseur. Upon receipt of this policy, he notified the agent of defendant that he wanted insurance only for Ramseur's, Inc., and the agent accordingly issued an endorsement dated May 12, 1958.

A vehicle owned by Temptron was responsible for a loss which occurred on May 20, 1958, and the question was whether this loss was covered under the policy issued to Mr. Ramseur. Temptron, the plaintiff, contended that the loss was covered under the renewal policy first sent to Mr. Ramseur, as it listed vehicles owned by both corporations, and since no notice of expiration had been given to Temptron.

Judgment was entered for the defendant insurance company and affirmed on appeal. The Supreme Court held that the defendant owed no duty to the plaintiff to renew the policy or to give notice of expiration. The court said that the renewal policy sent to Mr. Ramseur was no more than an offer by the insurance company to make a new contract, which offer was rejected by Mr. Ramseur who in turn made a counter-proposal. Ramseur was under no obligation to contract for Temptron's insurance, and the contract which was finally made did not afford any coverage to Temptron for the loss on May 20, 1958.