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Insurance

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INSURANCE

There was a slight reduction in the amount of litigation involving insurance contracts and insurance statutes during the preceding survey period. The South Carolina Supreme Court handed down 16 decisions relating to insurance questions; there were no federal cases dealing with issues of South Carolina law in this area.

An unusual number of cases- four - were reported in the course of the survey period which concerned the long debated rule that the mention of insurance in a torts claims case should result in a mistrial because of possible prejudice to the defendant and his liability insurer. The supreme court reversed and remanded one case for a new trial on the above mentioned ground, but the lower court holdings in the other cases were affirmed.

I. Fire Insurance

During the past year, the South Carolina Supreme Court was faced with the case of *Williams v. South Carolina Farm Bureau Mutual Insurance Co.*[1] for the second time. The plaintiffs, Williams and Robinson, were the owners of the "Ocean View Motel," a motel located in Cherry Grove Beach, South Carolina. The plaintiffs leased the motel property to one Hamilton and requested that he obtain an insurance policy covering the property.[2] Pursuant to such request, Hamilton got in touch with the defendant's local agent and purchased a policy. Both the application and the policy, however, showed the insured's name as "Ocean Drive Motel c/o Mack A. Hamilton, Jr., Route 4, Conway, South Carolina." The instruments also showed that Williams held a mortgage on the property, rather than that he was a part owner thereof.[3]

The motel property and its contents were thereafter totally destroyed by fire.[4] The plaintiffs, bringing an action against the

1. 253 S.C. 53, 168 S.E.2d 794 (1969).
2. The motel property was leased to Hamilton during the beach season of 1966 with an option to the lessee to purchase the property, which option, however, the lessee was not able to exercise. In November, 1966, the plaintiffs executed and delivered to Hamilton another lease and option to purchase, the term thereof to run from April 15, 1967, to November 15, 1967, but Hamilton was allowed to take possession prior to commencement of the term of his lease for the purpose of proceeding with certain painting and repairs.
3. The name of the plaintiff, Robinson, did not appear either in the application or the policy.
4. The fire occurred on February 14, 1967. The policy covered the building in the amount of $45,000, and the contents in the amount of $10,000.

defendant-insurer to collect on the policy, alleged *inter alia*, that the defendant, through its agent, had knowledge of the lease and agreement between the plaintiffs and Hamilton, and thereby waived any defect as to the names as stated in the policy.[5] At the initial trial, the defendant company was granted a nonsuit as to the cross-complaint of Hamilton on the grounds that he had no insurable interest; however, the jury returned a verdict in favor of the plaintiffs for the full amount of the policy. On appeal the supreme court reversed and remanded the cause for a new trial because of procedural errors.[6] At the second trial, the plaintiffs again received a jury verdict, and the defendant once again appealed.

On the second appeal, the defendant-appellant contended that the evidence did not support an inference of intention to insure the plaintiffs' property sufficient to raise a jury issue, and that the intent of the parties should have been resolved in its favor as a matter of law. The court reasoned that the crux of the appellant's contention was that Hamilton intended to denominate himself as owner of the insured property and that the minds of Hamilton and the agent met in that regard.[7] Anomalously,

5. Hamilton was named a defendant in the action, the complaint alleging that he had an interest in the policy which was in excess of the interest of the plaintiffs, but no relief was sought against him. Hamilton also served a cross-complaint against the defendant company asserting that he had an interest in the policy; that he, as well as the plaintiffs, was entitled to protection under the policy; and praying that he along with the plaintiffs have judgment against the company for the face amount of the policy. There was apparently no such legal entity as "Ocean View Motel," and consequently, neither the policy nor the application contained any named insured.

6. *See* Williams v. South Carolina Farm Bureau Mut. Ins. Co., 251 S.C. 464, 163 S.E.2d 212 (1968). *See also 1969 Survey of South Carolina Law: Insurance*, 21 S.C.L.REV. 583 (1969).

7. The defendant-appellant relied on the following testimony of Hamilton:

> Q. And you anticipated that sooner or later if your plans worked out that you would be the owner of the property and Mr. Williams would have a mortgage on it, isn't that right?
> A. That's right.
> Q. So when Mr. Williams told you to take out insurance and make him the mortgagee, that was what you were trying to accomplish, isn't that right?
> (Interruption by counsel).
>
> Q. And that's what you meant for the insurance company to do and instructed them?
> A. That's right.
> Q. And that was your intention?
> A. Yes.
> Q. And that is what the insurance did, isn't it?
> A. Yes, sir.

Record at 66.

The defendant conceded, however, that a question of fact arose and was resolved by the jury in favor of the plaintiffs as to whether it, through its

however, the cross-complaint of Hamilton in the original action was dismissed on the defendant's motion for nonsuit upon the ground that Hamilton had no insurable interest. The court thus upheld the lower court's decision and stated that the evidence, as previously,[8] created a jury issue as to whether or not the policy was intended to insure the property owned by the plaintiffs, and that there was no error in the refusal of the trial court to grant the defendant's motion for directed verdict or for judgment *non obstante veredicto.*

The second assertion presented by the defendant-appellant was that the plaintiffs should not be entitled to any interest since there was no proof of loss filed, contrary to the requirement of the policy.[9] The evidence showed that Hamilton, upon instruction by the defendant's agent, went to the defendant company's local office the morning following the fire and signed a loss report or notice of loss. The trial judge concluded that the plaintiffs, because of the applicable statute[10] and the jury finding that Hamilton was acting on behalf of and as agent of the plaintiffs, had complied sufficiently with any requirement as to proof of loss.

In resolving this issue, the supreme court explained that the purpose of the above mentioned statute is to provide a method by

agent, knew at the time it accepted the application and issued the policy that the plaintiffs were the owners of the property. The court concluded that the testimony of Hamilton, as quoted, was not sufficient to override the ambiguities inherent in the company's knowledge of this basic fact of ownership and in its act of issuing the policy in the name of "Ocean View Motel." Moreover, there was the fact of issuance of the policy in that name in contradiction of Hamilton's testimony.

8. On the first appeal the court stated as follows:

> It is sufficient to say, we think, that the evidence was in sharp conflict as to whether the company, through its agent, had full knowledge at the time it accepted the application and issued the policy of the true status of the property with respect to its title and the several interests of the various parties therein. The evidence, we think, raised jury issues as to whether the company intended to issue the policy either to or for the benefit of the plaintiffs, ...

251 S.C. at 469-70, 163 S.E.2d at 214.

9. The parties had agreed that the question of interest would be determined by the trial court.

10. S.C. CODE ANN. § 37-166 (1962) provides as follows:

> When any company under any insurance policy requires a written proof of loss after the notice of such loss has been given by the insured or beneficiary, the company or its representative shall furnish a blank to be used for that purpose. If such forms are not so furnished within twenty days after the receipt of such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proofs of loss written proof covering the occurrence, character and extent of the loss for which claim is made.

which the insured can file proof of loss when the insurer's form is unavailable.[11] In the case at bar the written notice of loss filed with the defendant company by Hamilton covered fully the nature, the scope, and the extent of the loss for which the claim was made, in compliance with the provisions of the statute. Accordingly, the court affirmed the trial judge's ruling that the plaintiffs, by virtue of the statutory provision, were deemed to have complied with the requirements of the policy as to proof of loss.[12]

II. LIFE, ACCIDENT, AND HEALTH INSURANCE

A. *Continuous House-Confining Illness or Accident*

The question of whether an insured must be continuously confined inside the house pursuant to the house confinement provision of his insurance policy appeared in *Price v. United Insurance Company of America.*[13] In that case the plaintiff-insured suffered a heart attack in January, 1961. Subsequent to the attack, the insured performed no work of any kind nor did he attempt to obtain employment. The defendant-insurer paid the plaintiff from the time of the attack until September 22, 1964, when such payments were discontinued on the ground that plaintiff was no longer entitled to benefits under the terms of the policy.

At the trial, the plaintiff testified that most of his time was spent sitting around the house reading and looking at television. He admitted, however, that he went to church almost every Sunday, occasionally drove to the doctor's office, went fishing, and was in the habit of individually driving downtown to get a haircut and to buy his suits.[14] The jury returned a verdict for the plaintiff-insured, and the defendant appealed therefrom.

On appeal, the insurer argued that the trial judge should have directed a verdict in its favor on the ground that the only reasonable inference to be drawn from the whole of the testimony

11. *Accord,* American Mut. Fire Ins. Co. v. Green, 233 S.C. 588, 106 S.E.2d 265 (1958).

12. The policy provided, *inter alia,* that the loss would be payable "sixty days after proof of loss" and ascertainment of the amount of the loss. In the instant case there was from the inception no question as to the amount of the loss and, the statutory equivalent of a proof of loss having been filed with the insurer on the date of the fire, it followed that the trial judge correctly held that the plaintiffs were entitled to interest sixty days after the date of the fire. *See generally* Columbia Real Estate & Trust Co. v. Royal Exch. Assurance, 132 S.C. 427, 128 S.E. 865 (1925); Berry v. Virginia State Ins. Co., 83 S.C. 13, 64 S.E. 859 (1909).

13. 175 S.E.2d 221 (S.C. 1970).

14. Record at 17-19. *See also* Brief for Appellant at 6-7.

was that, as a matter of law, the plaintiff had not proved that he had been continuously confined inside the house under the regular attendance of a physician as contemplated by the terms of the policy. The pertinent portion of the policy relied upon by the appellant read as follows:

> The company will pay . . . if the Insured suffers "Such Sickness"[15] which shall wholly and continuously disable the Insured so as to prevent him from performing every duty pertaining to his occupation and cause him to be confined inside the house under the regular care and attendance of a legally qualified physician or surgeon, during the period of disability . . . .
>
> The term "confined inside the house" is hereby defined as confinement of the Insured continuously inside the house because of "Such Sickness", except that the right of the Insured to recover under the policy shall not be defeated because he visits his physician for treatment or goes to a hospital for treatment when such treatment cannot be administered in the Insured's home.[16]

Reviewing the testimony of the insured, the supreme court stated that the only inference to be drawn from the whole of the evidence was that the plaintiff had not been continuously confined inside the house within the meaning of the policy. The court further declared that the medical attention sought by the plaintiff and rendered by his physician[17] did not, as a matter of law, meet the requirement of the contract.[18] Accordingly, the case was remanded for entry of a judgment in favor of the appellant-insurer.

15. The policy defined "Such Sickness" and insured the plaintiff:
> [A]gainst loss of life, limb, sight or time, resulting . . . through accidental bodily injury, . . . and against loss of time on account of sickness contracted during the term of the policy, hereinafter referred to as "Such Sickness", ...

16. Record at 12.

17. The plaintiff's physician testified that he attended the plaintiff two times during the policy year of September, 1964, and September, 1965. The next policy year the plaintiff was again treated twice, for dizziness and heavy heart beating. During the third policy year the plaintiff did not see his doctor. In the course of the fourth policy year the plaintiff saw his doctor once and had wax removed from his ears.

18. For precedent the court relied upon *Tyler v. United Ins. Co. of America*, 243 S.C. 114, 132 S.E.2d 269 (1963), *citing* 29A AM. JUR. *Insurance* § 1530 (1960), as follows:
> But even under a liberal construction of the house confinement provision, where the insured is able to, and does, leave his house for primarily business or other personal, as contrasted with therapeutic, reasons, it has generally been held that he is thereby precluded from recovering benefits for house-confining illness or accident.

B. *Proof of Accident*

In *Green v. United Insurance Company of America*[19] the plaintiff insured had been employed at a mill in Rock Hill for forty-three years. On the date in question, she worked the third shift, returned to her home, and after retiring was awakened that evening by severe pains in her back and left leg. Her family physician made X-Rays which showed that she had "narrowing of the disc spaces of the fifth lumbar and first sacral vertebra." Thereafter, the plaintiff instituted an action on an accident and health insurance policy issued by the defendant-insurer in which she asked for disability income benefits of $100 a month.

At the trial the plaintiff's family physician testified on cross-examination that there had to be an injury to the plaintiff to cause such a disorder[20]; however, there was no mention made by the plaintiff or by any of her witnesses of any specific happening or event which could have produced such accidental injury.[21] The jury returned a special verdict in plaintiff's favor, upon which a judgment in the amount of $900 was entered.[22] The

The section of the policy relied upon by the appellant-insurer protected plaintiff, *inter alia*, as follows:

> (1) against loss . . . of time resulting directly and independently of all other causes from accidental bodily injury caused by accident occurring while this policy is in force, hereinafter called "such injury"; . . . .

19. 174 S.E.2d 400 (S.C. 1970).

20. The testimony was as follows:

> Q. Let me put it this way, how does a disc normally become narrow when there is no injury?
> A. There has to be an injury, but she couldn't give any specific incident how she hurt it.
> Q. There is nothing anywhere to show that she was in fact injured?
> A. Not from her history, no.

Record at 17.

21. The plaintiff testified herself as follows:

> Q. I believe you told the doctor you didn't injure yourself?
> A. If I did, I don't know when.

Record at 29.

22. The cause was submitted to the jury for its determination as to whether the plaintiff was entitled to recover under either a "confining illness" clause of the policy, or under an "accident" clause thereof. The jury specifically found that the plaintiff had suffered an accidental injury and that she did not suffer an illness entitling her to recover under the "confining illness" clause of the policy. However, it was obvious that the plaintiff was proceeding on the confining illness theory in that nowhere in the complaint was an accident specifically or by implication alleged.

defendant appealed therefrom.

PART FIVE, TOTAL DISABILITY BENEFITS FOR LIFE-ACCIDENT.

If "such injury" causes continuous total disability and total loss of time within twenty days after the date of the accident and requires regular and personal attendance by a licensed physician, surgeon, osteopath or chiropractor, other than the Insured, the Company will pay at the rate of the Monthly Benefit stated in the Policy Schedule for one day or more from the first medical treatment so long as the Insured lives and is disabled, suffers such loss of time and requires such regular and personal attendance.[23]

The appellant-insurer conceded the sufficiency of the evidence to establish total loss of time and continuous total disability requiring regular attendance by a physician. The insurer asserted, however, that there was no evidence from which it could reasonably be inferred that such disability resulted directly and independently of all other causes from accidental bodily injury and that such disability resulted within twenty days after the date of the accident, if such occurred.

In resolving this issue, the court relied upon the fact that neither the word "accident" nor any words descriptive of such an event appeared anywhere in the record, except for the testimony of the family physician with respect to whether there was an "injury."[24]

Accordingly, if the plaintiff is to prevail, the verdict in her favor has to rest solely upon such testimony on the part of the doctor . . . . We give full accord to the doctor's opinion that there had to be "an injury". Such, however, is not at all conclusive. The doctor did not elaborate at all upon what he meant by "an injury." The term "injury" is frequently used simply in the sense of "impairment". An injury is not necessarily of traumatic origin, and even if of traumatic origin, not necessarily of accidental origin. The doctor was not asked and he ventured no opinion as to the origin of the injury or just how recent or how ancient such may or may not have been. Giving full force to his testimony, we are still left in the realm of conjecture and speculation as to the origin and duration of any injury to the disc. To conclude from his very brief reference

23. Record at 11-13. *See also* Brief for Appellant at 4.
24. *See* notes 20 and 22 *supra.*

> to injury that such was of accidental origin and that such occurred within twenty days prior to plaintiff's disability would be indulging in the sheerest of speculation.[25]

In conclusion the court stated that jury verdicts cannot rest upon surmise, speculation, and conjecture. Thus, the decision of the lower court was reversed, and the cause remanded for entry of judgment in favor of the appellant-insurer.

C. *First Monthly Premium Paid by Worthless Check*

The problem of whether a life insurance policy was in force and effect at the time of the death of the insured, where the insured had made the initial premium payment with a worthless check, was answered in the case of *McCormick v. State Capital Life Insurance Co.*[26] In *McCormick* the deceased-insured, George C. McCormick, submitted an application for a life insurance policy to an agent of the defendant and delivered to the agent a check for the initial monthly premium. The agent issued a receipt to the applicant and forwarded the check and application to the home office of the defendant.[27] The check was deposited, and the agent transferred the policy to McCormick.[28] The check was, subsequently, returned to the defendant marked insufficient funds. The agent contacted the applicant; and as a result of such communication, the check was redeposited. It was, however, again returned to the insurer because McCormick did not have on deposit sufficient funds to pay the check. Thereafter, McCormick was killed in an automobile collision, and his parents, the beneficiaries under the policy, brought an action to recover death benefits pursuant to the policy. The trial court granted the defendant's motion for a directed verdict, and the plaintiffs appealed from such ruling.

25. 174 S.E.2d at 402.
26. 253 S.C. 544, 172 S.E.2d 308 (1970).
27. The application contained the provision that any policy issued pursuant thereto would not take effect unless and until it is delivered to the insured and the first premium is paid during his lifetime. The receipt read, "Received from George C. McCormick, twelve dollars and 80/100 cents in cash intended to be the first premium on a proposed insurance policy for $10,000 on the life of George C. McCormick". It also provided that, "This receipt must be for the whole amount of the first premium and such amount must be paid in cash to the Agent; otherwise this receipt is of no force or effect."
28. Attached to the policy was a receipt acknowledging the payment of $12.80 on the policy issued. Endorsed on the reverse side of said receipt was the following: "If check, draft or money order is given in payment of this premium, the receipt shall be valid only if said check, draft or money order is paid upon presentation."

The sole issue on appeal was whether or not the policy was in force and effect at the time of the death of McCormick. The plaintiffs-appellants contended that the lower court erred in refusing to submit to the jury the issue of whether the initial premium of the policy had been paid in cash. The court declared that, in the absence of an express or implied agreement to the contrary, a check does not constitute payment unless it produces payment in cash, the presumption being that the check is accepted on the condition that it shall be paid. It was, moreover, held in *Burns v. Prudence Life Insurance Co.*[29] that the mere giving of a worthless check to the insurer does not effect the payment of a premium. If a worthless check is given for the first premium, the coverage is never effected.[30] The court concluded that it is well settled that, when only one reasonable inference can be drawn from the testimony, the question is no longer one for the jury but one of law for the court.[31] In the case at hand, the only reasonable inference that could be drawn from the testimony was that a check was delivered for the first monthly premium and the check was returned twice because the applicant did not have sufficient funds to pay the check. Consequently, the judgment of the lower court was affirmed, since the check for the payment of the first monthly premium was never paid and the insurance policy was never in effect.

III. AUTOMOBILE INSURANCE

A. *Liability Insurance: Non-Owned Automobile Coverage*

In *Willis v. Fidelity and Casualty Company of New York*[32] Charles R. Russell and his mother resided with Mrs. Russell's father, Guy G. Scruggs, as members of his household. Mr. Scruggs owned an automobile described in a liability insurance policy issued to him by the defendant-insurer.[33] While driving

29. 243 S.C. 515, 134 S.E.2d 769 (1964). *See also,* 14 J. APPLEMAN, INSURANCE LAW AND PRACTICE, § 8144 (1962); *Annot.,* A.L.R.2d 630 (1956).

30. The court also cited *Hare v. Connecticut Mut. Life Ins. Co.,* 114 W. Va. 679, 173 S.E. 772 (1934), where the court held that the fact that the insurer's general agent entered the insured's check on the agent's records as payment, issued a receipt as for cash, and sent his personal check to the insurer did not constitute payment of the premium to the insurer, so as to render it liable where the insured's check was worthless and the insurer, on being so notified, returned the premium to the general agent.

31. *See, e.g.,* Kennedy v. Carter, 249 S.C. 168, 153 S.E.2d 312 (1967).

32. 253 S.C. 91, 169 S.E.2d 282 (1969).

33. The policy in question provided coverage to an insured while driving an automobile not listed in the policy with the following exceptions:

> (b) this insuring agreement does not apply;
> (1) To any automobile owned by or furnished for regular use to either the named insured or a member of the same household . . . .

his mother's uninsured automobile, Charles Russell negligently injured the plaintiff. Thereafter, the plaintiff sued Charles Russell, and obtained a judgment. An action was then instituted against Mr. Scruggs' insurance carrier, the defendant. The plaintiff appealed from an adverse judgment of the circuit court.

The lone issue involved on the appeal was whether the exclusion of an automobile owned by a member of the household of the insured from the "non-owned automobile" coverage of the liability insurance policy was inconsistent with the provisions of the Motor Vehicle Safety Responsibility Act, and, hence, invalid. The facts of the case fell directly within the exclusionary clause of the policy, and there could be no recovery against the defendant-insurer unless the Motor Vehicle Safety Responsibility Act required that liability coverage be furnished to the insured's grandson.

The plaintiff-appellant relied upon sections 46-750.31(2) and 46-750.32 of the Act.[34] The former section defines the term, "insured," while the latter specifies the character and extent of coverage required in automobile liability policies issued in South Carolina. The definition of "insured" was made applicable to uninsured motorist coverage in 1963,[35] and the legislative intention was that the insured, his spouse, and his or her relatives residing in the same household should have the benefit of uninsured motorist coverage at all times.[36] Therefore, Charles

34. S.C. CODE ANN. § 46-750.31(2) (Supp. 1967) provides:
> The term "insured" means the named insured and, while resident of the same household, the spouse of any such named insured and relatives of either, while in a motor vehicle to which the policy applies and a guest in such motor vehicle to which the policy applies or the personal representative of any of the above.

S.C. CODE ANN. § 46-750.32 (Supp. 1967) provides:
> No policy or contract of bodily injury liability insurance or of property damage liability insurance, covering liability arising from the ownership, maintenance or use of any motor vehicle, shall be issued or delivered in this State to the owner of such vehicle, or shall be issued or delivered by an insurer licensed in this State, upon any motor vehicle then principally garaged or principally used in this State, unless it contains a provision insuring the persons defined as insured, against loss from the liability imposed by law for damages arising out of the ownership, maintenance or use of such motor vehicle within the United States of America or the Dominion of Canada, subject to limits exclusive of interest and costs, with respect to each motor vehicle . . . .

35. This was accomplished by Act No. 312 of 1963. *See also* Pacific Ins. Co. v. Firemen's Fund Ins. Co., 247 S.C. 282, 147 S.E.2d 273 (1966).

36. *Accord,* Davidson v. Eastern Fire & Cas. Ins. Co., 245 S.C. 472, 141 S.E.2d 135 (1965).

Russell, while a resident of his grandfather's household, was an insured under the policy in question at all times, by virtue of section 46-750.31(2) of the Act. Any attempt by the insurer to exclude him from the full coverage provided by the policy as required by the statute would have been illegal.[37] The statute, however, merely fixed Charles' status as an insured, and the coverage afforded him by the applicable insuring agreement had to be ascertained from the terms of the policy and the terms of section 46-750.32 of the Act.

The plaintiff-appellant made no assertion that the accident was covered by the terms of the policy, but alternatively, contended that the insurer was required by the Act to furnish liability coverage to Charles while he was operating his mother's uninsured vehicle. In response to this argument the supreme court announced that the contention was supportable only if the Act requires insurance against liability imposed by law for damages arising out of the use by a statutory insured of *any* motor vehicle regardless of ownership. The court then interpreted the Act as only requiring that insurance contracts insure "the persons defined as insured, against loss from the liability imposed by law for damages arising out of the ownership, maintenance or use of *such* motor vehicles . . .," the phrase, "such motor vehicle," meaning those vehicles *described* in liability insurance policies issued in South Carolina. Since the Act did not require the insurer to afford liability coverage with respect to a motor vehicle not described in the policy, that part of the insuring agreement was a voluntary contract as to which the parties were free to choose their own terms.[38] Consequently, no conflict resulted between the controlling exclusionary clause and the Act,[39] and the trial court's judgment in favor of the defendant-insurer was affirmed.

37. *See* Pacific Ins. Co. v. Fireman's Fund Ins. Co., 247 S.C. 282, 147 S.E.2d 273 (1966).

38. The court further proclaimed that the plaintiff's reliance upon the decision in *Pacific Ins. Co. v. Fireman's Fund Ins. Co., id.,* was unjustified. In *Pacific* the tort-feasor was an insured under the statutory definition, although not so under the terms of the policy; however, no exclusionary clause was applicable. Once the tort-feasor was identified as an insured, the rights of the parties were fixed by the terms of the contract, not inconsistent with law, which permitted recovery. The court followed the same course in the present case to the opposite result because an exclusionary provision, not inconsistent with law, was applicable in this case.

39. The court cited the case of *American Motorist Ins. Co. v. Kaplan,* 209 Va. 53, 161 S.E.2d 675 (1968), which involved analogous facts, to support its view.

B. *Validity of Exclusionary Endorsement*

The issue of which liability insurance carrier was to bear the ultimate financial burden of the settlement of certain claims was presented in *Potomac Insurance Co. v. Allstate Insurance Co.*[40] Potomac issued a garage liability policy insuring Williams Chevrolet Company of Florence, South Carolina. While the Company was repairing an automobile belonging to one White, Williams provided White with the unrestricted use of a car owned by Williams and insured by Potomac. White had in effect an automobile liability policy with Allstate which provided that its coverage with respect to a non-owned automobile would be excess coverage in the event that there was other valid and collectible insurance on the non-owned vehicle. While driving Williams' service-car, White was involved in a serious accident. Following the accident both insurers effected a settlement toward the payment of which each insurer contributed equally, but under an agreement whereby each insurer reserved the right to litigate the issue of where the ultimate financial burden lay. Subsequently, Potomac instituted an action to recover its contribution from Allstate, and Allstate counterclaimed for its own contribution. Potomac appealed from an adverse judgment rendered by the lower court without a jury.

On appeal Potomac conceded that its policy covered White but asserted that such coverage was limited by an exclusionary endorsement which limited the omnibus coverage and purportedly afforded coverage to White only under and in accordance with the pertinent portion of the endorsement, to wit:

> (b) any other person, but only if no other valid and collectible automobile liability insurance either primary or excess, with limits of liability at least equal to the minimum limits specified by the financial responsibility law of the state in which the automobile is principally garaged, is available to such person; provided that with respect to Coverage C, such person shall be deemed to be a person for whom insurance is afforded, whether or not there is any other valid and collectible automobile liability insurance.[41]

The lower court found the above quoted provision to be in direct violation of the statutory law of South Carolina and, therefore, held the attempted exclusion, or limitation of cover-

40. 173 S.E.2d 653 (S.C. 1970).
41. Record at 12.

age, void. The South Carolina Supreme Court, per Justice Bussey, stated that the quoted exclusionary endorsement of Potomac could not be sustained in view of the provisions of the South Carolina Financial Responsibility Act. The court cited sections 46-750.31(2)[42] and 46-750.32[43] of the Act and proclaimed that the provisions of these sections must be considered as though they were written in the particular policy involved.[44] The court decided, therefore, that under the facts of the case, White, by virtue of the statutory law, was fully covered by Potomac's policy up to the statutory limits, in spite of the exclusionary endorsement inserted in the policy.[45] Whether the endorsement constituted an attempt to redefine the term, "insured," in contravention of section 46-750.31(2) or sought to afford White only conditional or contingent coverage, as opposed to the full and effective coverage required by the statute, made little difference, since in either event the endorsement was invalid because it was not in accord with the statutory law.[46] Thus, the judgment in favor of Allstate was, accordingly, affirmed.

C. *Uninsured Motorist Insurance*

One of the most interesting cases decided during the survey period was that of *Whitmire v. Nationwide Mutual Insurance Co.*[47] In this case the plaintiff, a passenger, got out of a parked car owned and operated by Raines. The plaintiff began to walk around the rear bumper of the parked car when he heard the noise of an approaching vehicle and at approximately the same time saw it through the rear window and windshield of the Raines car. Realizing that a collision between the two vehicles was imminent, he started running from the scene. The approaching vehicle — operated by Cox, an uninsured motorist — collided with the Raines automobile, and the plaintiff was struck by one of the two vehicles. The Raines automobile was covered by an

42. *See* note 34 *supra.*
43. *Id.*
44. *Accord,* Pacific Ins. Co. v. Fireman's Fund Ins. Co., 247 S.C. 282 147 S.E.2d 273 (1966).
45. The appellant relied upon the North Carolina case of *Allstate Ins. Co. v. Shelby Mut. Ins. Co.,* 269 N.C. 341, 152 S.E.2d 436 (1967), wherein an endorsement to the same effect as Potomac's endorsement was held not to be in contravention of the North Carolina Financial Responsibility Law. However, the court was uncertain from the *Allstate* opinion whether or not the North Carolina Act is, or is not, identical to our Act, in all pertinent particulars. In any event, the court was not persuaded to a contrary result by that decision.
46. For authority in support of its view, the court cited *American Motorists Ins. Co. v. Kaplan,* 209 Va. 53, 161 S.E.2d 675 (1968); and *Hardware Mut. Cas. Co. v. Celina Mut. Ins. Co.,* 209 Va. 60, 161 S.E.2d 680 (1968).
47. 174 S.E.2d 391 (S.C. 1970).

automobile liability policy issued by the defendant, Nationwide, and the defendant, National Grange Insurance Company, had in effect a similar policy insuring the injured plaintiff. Upon the failure of the insurance carriers to pay, the plaintiff initiated an action for declaratory judgment against both to determine their respective liabilities. The lower court, without a jury, held that the plaintiff was an insured under the policy of Nationwide, the insurer of the parked car, and that its policy provided primary coverage for the loss. Judgment was entered against Nationwide for the entire amount, and Nationwide appealed.

The first issue raised by Nationwide on appeal was whether the plaintiff was an insured under its policy. The uninsured motorist endorsement in the policy of Nationwide included in the definition of an insured "any other person while occupying an insured automobile." The word, "occupying," as used in the policy was defined as "in or upon or entering into or alighting from" the insured vehicle. Thus, in order for the plaintiff to qualify as an insured under the policy, he must have been "occupying" the insured parked vehicle at the time of his injury. It was conceded that the plaintiff was not *in* or *upon* or *entering into* the vehicle. The contention was that the plaintiff was *alighting from* the automobile insured by Nationwide and was, therefore, an insured under the policy.

The court, relying upon *McAbee v. Nationwide Mutual Insurance Co.*,[48] proclaimed that the term, "alighting from," was not free from ambiguity and required a broad and liberal construction in favor of the insured. Pursuant to such a construction, the court reasoned that the words "in" and "upon" encompass situations where a person has some physical contact with the vehicle at the time of injury. If the phrase "alighting from" was limited to the physical act of descending from the automobile, it would be meaningless, because a person would still be in contact with the car and within the coverage afforded under the terms "in" and "upon." The court held, therefore, that "alighting from" must extend to a situation where the body is no longer in contact with the vehicle.[49] In the case at

48. 249 S.C. 96, 152 S.E.2d 731 (1967).

49. The court was careful to point out that where the act of *alighting from* is completed is uncertain and must be determined under the facts of each case. Its meaning must be related to the particular use of the automobile and the hazards to be encountered from such use. It is reasonable to conclude that coverage was intended to protect a guest against the hazards from passing automobiles in the vicinity, while the guest, although not "in" or "upon" the vehicle, is still engaged in the completion of the act of getting out of the automobile.

hand, at the time of injury the plaintiff was actually attempting to escape the danger from the oncoming vehicle and had not cleared the rear of the insured automobile. The court thus announced that the lower court had properly concluded that the plaintiff was engaged in "alighting from" the Raines car at the time of his injury, within the meaning of that provision of Nationwide's policy.[50]

Since the plaintiff-respondent qualified as an insured under both the policy of Nationwide and that of Grange, the court also had to decide whether the plaintiff's loss should be paid entirely by Nationwide or pro rata by it and Grange, the plaintiff's insurer. The lower court had relied upon the holding in *Wrenn & Outlaw, Inc. v. Employers' Liability Assurance Corp.*[51] in deciding that Nationwide provided primary coverage for the plaintiff's loss. On appeal Nationwide argued that *Wrenn* was inapplicable, since the policy provisions as construed in that case were included in the general liability provisions of the policy while in the case at bar the provision in question was under the uninsured motorist endorsement. *Nationwide* cited *Vernon v. Harleyville Mutual Casualty Co.*[52] as precedent for its contention that an excess insurance clause is illegal in an uninsured motorist endorsement because its effect is to place a limitation upon the coverage required to be afforded by the uninsured motorist statute. This argument would invalidate the excess insurance clause in both policies; the pro rata provisions under which both companies would contribute to the payment of plaintiff's loss would thus control.

The court decided that *Vernon* did not sustain Nationwide's position because the justices did not construe *Vernon* as holding that "other insurance" clauses are necessarily in conflict with the uninsured motorist statute. The court could find nothing in the statute or the decisions which would require a holding that such "other insurance" provisions conflict with the provisions of the uninsured motorist statute or which would require giving them any different meaning or application than that resulting when such clauses are used in the general liability provisions of a policy.[53] Sustaining the decision of the trial judge, the court

50. *See generally, 12* G. COUCH, CYCLOPEDIA OF INSURANCE LAW §§ 45:158-159 (2d ed. 1964). *See also* Annot., 19 A.L.R.2D 513 (1951).
51. 246 S.C. 97, 142 S.E.2d 741 (1965).
52. 244 S.C. 152, 135 S.E.2d 841 (1964).
53. The court recognized that there were decisions from other jurisdictions in accordance with the proposition that "other insurance" provisions conflict with the respective uninsured motorist statutes; however, the court did not find such decisions persuasive.

held that *Wrenn* involved similar "other insurance" clauses in the general liability provisions of the policy and was controlling in this instance. Thus, the excess insurance clause in Nationwide's policy was inapplicable because the automobile occupied by the plaintiff was owned by the named insured. The pro rata clause in Nationwide's policy would have applied only if the plaintiff had other similar insurance available to him and applicable to the accident. Grange's policy did not, however, provide the plaintiff with other insurance within the meaning of the pro rata clause of Nationwide's policy, because Grange's policy as to non-owned automobiles was expressly declared to be excess and could not, therefore, be other insurance available to the plaintiff and applicable to the accident.

D. *No Action Clause*

The case of *Travelers Indemnity Co. v. Canal Insurance Co.*[54] originated following an automobile collision involving one Sanders and one Wilkes. Under the medical payment coverage of an insurance policy issued to Sanders, the Travelers Indemnity Company made payments to the occupants of the Sanders' vehicle. At the same time, Travelers notified Canal Insurance Company, Wilkes' liability carrier, of its subrogation claim against Wilkes. Canal, however, disregarded this notice, compromised and settled the tort claims asserted against Wilkes by the injured persons, and took from them a release purporting to discharge Wilkes from further liability arising out of the collision. In an action by Travelers against Canal to recover the amount of its subrogation claim, Travelers obtained a favorable judgment from which Canal appealed.[55]

On appeal Canal relied solely upon the standard "no action clause" in its policy which provided that:

> No action shall lie against the company unless, as a condition precedent thereto, the amount of the obligation of the insured to pay shall have been finally determined by either judgment against the insured after

54. 173 S.E.2d 656 (S.C. 1970).

55. In awarding judgment to Travelers, the trial court regarded as controlling the case of *Calvert Fire Ins. Co. v. James,* 236 S.C. 431, 114 S.E.2d 832 (1960). However, that case did not involve the "no action" clause of a liability insurance policy. It was an action by a subrogee insurer against a tort-feasor who had settled with the injured party after notice of the insurer's subrogation claim. The decision stands for the proposition that a release procured by a tort-feasor under these circumstances will not defeat the insurer's right of subrogation.

> actual trial or by written agreement of the insured, the claimant and the company.[56]

In reaching a decision, the court, speaking through Justice Brailsford, cited two recent cases[57] in which it recognized that the policy provision relied upon by Canal makes it a condition precedent to the commencement of an action against the company that the amount of any claim or loss shall first be fixed and rendered certain either by judgment against the insured or by agreement between the parties with the written consent of the company. The court concluded that the failure of Travelers to comply with this condition precedent was a bar to the action on the policy; and, consequently, the trial court's decision was reversed.[58]

E. *Default Judgment*

The question of whether the trial judge abused his discretion in refusing to vacate a personal injury default judgment arose in *Edwards v. Ferguson*.[59] The plaintiff and the defendant—while riding in the defendant's automobile, which was covered by a liability insurance policy issued by State Farm Mutual Automobile Insurance Company—were involved in a one-car collision which resulted in serious personal injuries to both the plaintiff and the defendant. Which of the two persons was driving the vehicle at the time of the accident was disputed, but

56. Brief for Appellant at 6-7. Admittedly, there was no compliance with this condition of the policy in that no judgment had been obtained against Wilkes, and no agreement determining the amount of his liability had been signed by anyone. The compromise settlement was not an admission of liability. Instead, it stipulated that Wilkes had compromised a doubtful and disputed claim but expressly denied liability.

57. *See* Sexton v. Harleysville Mut. Cas. Co., 242 S.C. 182, 130 S.E.2d 475 (1963); Pharr v. Canal Ins. Co., 233 S.C. 266, 104 S.E.2d 394 (1958).

58. Travelers urged that to sustain the defense in this case would empower liability insurers to destroy subrogation rights of other insurers by making private settlements and obtaining general releases. The court stated, however, that this contention was unfounded:

> The principle adopted in Calvert Fire Ins. Co. v. James [*see* note 55 *supra*] adequately protects such rights. A release taken from an injured party in behalf of an alleged tort-feasor by a liability insurance carrier, which in this case [*Travelers*] would be no more effective against a subrogation claim than is a release taken by the tort-feasor himself, which was the *Calvert* case. Nor after such a settlement would a subrogee who had paid less than the injured party's loss be precluded by the rule against splitting a cause of action from suing the tort-feasor in its own name. The rule of reason is that "the indivisibility" rule may not be invoked against the subrogee where the subrogor has parted with all beneficial interest in the right of action.

236 S.C. at 436, 114 S.E.2d at 835.

59. 175 S.E.2d 224 (S.C. 1970).

the highway patrolman's official accident report indicated that the plaintiff was the driver at the time of the accident.[60] The defendant never reported the accident to his insurer, State Farm, and it was not until fourteen months after the wreck that State Farm received a letter from the plaintiff's attorney wherein the plaintiff asserted his claim and requested that the insurer's representative make contact regarding a possible settlement. Such settlement of the case did not materialize, and a copy of the summons and the complaint was received by the defendant's father who was unable to read. The case was not filed in the office of the clerk of court until two days after the time for answering had expired.

At the trial counsel for the plaintiff stated that he had informed State Farm's representative by telephone that a summons, a notice, and a complaint had been served on the defendant the previous day[61]; however, the representative denied any recollection of such conversation. The trial judge found that the summons, the notice, and the complaint had been served on the defendant on the stated day; and judgment was entered against the defendant. The trial court overruled the defendant's motion to set aside the personal injury default judgment, pursuant to section 10-1213 of the South Carolina Code of Laws, on the ground that the judgment was taken through mistake, inadvertence, surprise, or excusable neglect. The defendant appealed from this adverse decision.

On appeal the court found that a prima facie showing of meritorious defense was presented to the lower court, to wit: (1) that the defendant was not driving the vehicle; and (2) that, even if the defendant was driving the vehicle, the plaintiff was guilty of contributory negligence and recklessness. The court, summarizing prior decisions, then stated:

60. The defendant was an alcoholic, and in his statement taken by State Farm's representative, which was made a part of the record, the defendant explained:

> [P]rior to meeting Sarah (the plaintiff), I had drunk about 2 half-pints of whiskey before meeting Sarah, and from the time we left K-Mart until the accident, I had drunk about half of another half-pint I had in my car. Sarah saw me drinking and I was pretty drunk at the time. We left K-Mart in my car and Sarah was driving at the time. I was just about too drunk to drive.

Record at 22.

61. The summons and the complaint were not served upon or given to State Farm until the plaintiff's counsel notified State Farm's representative that the matter was in default and enclosed in the notice copies of the pleadings.

> This court has held that abuse of discretion arises in cases in which:
>
> (1) the judge issuing the order was controlled by some error of law; or (2) where the order, based upon factual, as distinguished from legal, conclusions is without evidentiary support.[62]
>
> We have held that Section 10-1213 should be liberally construed to see that justice is promoted and to strive for disposition of cases on their merits.[63]
>
> In determining whether there has been an abuse of discretion all of the facts and circumstances must be evaluated. If the requirements to vacate a judgment are met the judgment should be opened and the defendant permitted to answer. In order to vacate a judgment there must be a showing (1) that the judgment was taken against the defendant through his mistake, inadvertence, surprise, or excusable neglect, and (2) that there is a showing of prima facie meritorious defense.[64]

After reviewing the entire record of the case, the court was convinced that the trial judge had abused his discretion in failing to vacate the judgment. Accordingly, the judgment was set aside with leave to the defendant to answer so that the issues could be tried on the merits.

F. *Misrepresentations*

In *Ferguson v. Employers Mutual Casualty Co.*[65] the plaintiff, injured in a collision with a truck owned by one Corbett and driven by one Watson, obtained a default judgment against Corbett and Watson in the amount of $7,000 for property damage sustained. The plaintiff then commenced an action against the defendant, Employers Mutual Casualty Company, to enforce the payment of the judgment to the extent of $5,000 under a policy of liability insurance issued by the defendant to Corbett pursuant to the Assigned Risk Plan of North Carolina. The defendant denied that the policy provided coverage and alleged

62. 175 S.E.2d at 226 (S.C. 1970), *quoting from* Brown v. Weathers, 251 S.C. 67, 70, 160 S.E.2d 133, 134 (1968); Holliday v. Holliday, 235 S.C. 246, 251, 111 S.E.2d 205, 208 (1959); Simon v. Flowers, 231 S.C. 545, 550, 99 S.E.2d 391, 393-94 (1957).

63. 175 S.E.2d at 226 (S.C. 1970). *See generally* Gaskins v. California Ins. Co., 195 S.C. 376, 11 S.E.2d 436 (1940).

64. 175 S.E.2d at 226 (S.C. 1970), *quoting from* Rochester v. Holiday Magic, Inc., 253 S.C. 147, 152, 169 S.E.2d 387, 390 (1969); Gaskins v. California Ins. Co., 195 S.C. 376, 379, 11 S.E.2d 436, 437 (1940).

65. 174 S.E.2d 768 (S.C. 1970).

that the policy had been rescinded as of the date of its inception. The defendant further alleged that misrepresentations as to the state of licensing and registering and place of principal garaging of the truck covered in the policy were made in the application for the policy by the insured, Corbett. As a final defense, the defendant asserted that the policy was issued pursuant to the Assigned Risk Plan of North Carolina, that the insured was not a resident of North Carolina at the time of the application for insurance, and that the plan was, therefore, not available to him. The trial court, without a jury, held that the policy was in full force and effect at the time of the collision and that the policy in question provided coverage to Corbett.

On appeal the defendant-appellant urged that it was error for the trial judge to find that Corbett was a resident of North Carolina at the time of the issuance of its policy. The defendant contended instead that the policy in question was void *ab initio* for the reason that it was issued to one not a resident of North Carolina and, hence, to one not entitled to coverage under the North Carolina Assigned Risk Plan. The Assigned Risk Plan provides, *inter alia*:

> The provisions of this article relevant to assignment of risks shall be available to non-residents who are unable to obtain a motor vehicle liability insurance policy with respect only to motor vehicles registered and used in this State.[66]

Considering the meaning of residency within this provision, the Supreme Court of South Carolina stated that a person's actions and intentions as to domicile, not the duration of residency, are the determining factors.[67] Corbett testified that he maintained an office in Tabor City, North Carolina, for the purpose of selling produce, and also owned a peach farm in Spartanburg County, South Carolina; that, during the years 1964-1966, he and his wife lived in a rented house near the Spartanburg farm and supervised the operation of that farm; and that he spent his time between the farm and his Tabor

66. 174 S.E.2d at 769 (S.C. 1970), *quoting from* N.C. CODE ANN. § 20-279.34 (1965).

67. *See e.g.*, Miller v. Miller, 248 S.C. 125, 149 S.E.2d 336 (1966). The court quoted from *Reynolds v. Lloyd Cotton Mills*, 177 N.C. 412, 99 S.E. 240 (1919), as follows:

> To effect a change of residence or domicil, there must be an actual abandonment of the first domicil, coupled with an intention not to return to it, and there must be a new domicil acquired by actual residence in another place or jurisdiction, with the intention of making the last acquired residence a permanent home.

City office, where he continued to handle all of his sales operations. Corbett testified, moreover, that he was a resident of Tabor City, North Carolina, at the time of the application for and the issuance of the liability policy in 1967. The court determined that the question as to Corbett's place of residence was one of fact, and that the trial judge found as a fact that Corbett, at the time of application for and the issuance of the policy, was a resident of North Carolina. The evidence supported the finding, and the appellate court was without authority to disturb the decision. Thus, it followed that the Assigned Risk Plan of North Carolina was applicable to the insured.

The second issue on appeal was whether the insurer had the right to void the policy from its inception on the ground that it had been obtained through misrepresentation by the insured. The appellant argued that the insured misrepresented the state of licensing and registration and the place of principal garaging of the truck in his application for insurance. The appellant further contended that the misrepresentations were material to the risk sought to be insured and that, had proper representations been made, the policy would not have been issued.

Liability insurance policies issued under the Assigned Risk Plan of North Carolina are compulsory.[68] Such policies are also subject to the following statutory provision:

> The liability of the insurance carrier with respect to the insurance required by this article shall become absolute whenever injury or damage covered by said motor vehicle liability policy occurs; said policy may not be cancelled or annulled as to such liability by any agreement between the insurance carrier and the insured *after the occurrence of the injury or damage;* no statement made by the insured or on his behalf and no violation of said policy shall defeat or void said policy.[69]

Relying on this provision and citing the case of *Nationwide Mutual Insurance Co. v. Roberts*,[70] the court explained that the primary purpose of compulsory motor vehicle liability insurance is to compensate innocent victims who have been injured by the negligence of financially irresponsible motorists. Its purpose is not the same as that of ordinary liability insurance which saves harmless the tort-feasor himself. Under compulsory motor

68. *Accord,* Allstate Ins. Co. v. Hale, 270 N.C. 195, 154 S.E.2d 79 (1967).
69. N.C. CODE ANN. § 20-279 21(f)(1) (1965) (emphasis added).
70. 261 N.C. 285, 134 S.E.2d 654 (1954).

vehicle liability insurance policies the injured person's rights against the insurer are not derived through the insured as in the case of voluntary insurance, but are statutory and become absolute on the occurrence of an injury covered by the policy.

In conclusion, the court held that the insurer could not, *after* an accident involving injury and damage to a third party, cancel *ab initio* a policy issued in conformity with the North Carolina Assigned Risk Plan, even though the insured falsely represented in his application material facts as to the state of licensing and registration and the principal place of garaging the vehicle in question.

IV. Liability Insurance on Business Premises

In *Riddle-Duckworth, Inc. v. Sullivan*[71] the plaintiffs, operators of a home and auto appliance business, discussed obtaining liability insurance coverage for the business premises with the defendant, Green, an experienced insurance agent. Green was shown and informed of the uses of an elevator and was specifically requested by the plaintiff, Duckworth, to include it in the liability coverage to be procured. Green subsequently procured and delivered an owners', landlords', and tenants' liability insurance policy to the plaintiff and gave assurances to Duckworth that it afforded full coverage for the business premises, including the elevator. The original policy was issued for a one year period; it was renewed annually thereafter, with Green sending a new policy each year and a bill for the premium. Green assured the plaintiffs each time that the business was fully covered. Duckworth received and read the policy covering 1962 to 1963, and some doubt arose as to whether coverage was afforded for the operation of the elevator. In response to specific inquiry concerning the policy, Green informed Duckworth that the policy provided full coverage for the elevator.

Thereafter, in May 1962, the elevator fell and injured a customer. Duckworth immediately notified Green and asked him to handle the claim; Green assured the plaintiff that he would take care of the matter. Subsequently, the defendant, Sullivan, who was then an adjuster, came to the plaintiffs' place of business and concluded that the policy did not provide coverage for the operation of the elevator.[72] The injured party, mean-

71. 253 S.C. 411, 171 S.E.2d 486 (1969).
72. The action was brought against Sullivan and Green, and the complaint alleged that they were partners doing business as insurance agents under the name of Sullivan-Green Insurance Agency.

while, brought an action against the plaintiffs which resulted in a verdict adverse to the plaintiffs. A suit was then brought by the plaintiffs against the defendants to recover the amount of the judgment; this resulted in a verdict against the defendants for that amount from which verdict the defendants appealed. In affirming the verdict for the plaintiff against the defendant, Green, the court considered four issues of significance.

The first issue resolved by the court was that Sullivan had effectively severed all connections with the defendant insurance agency long before the elevator accident. Thus, the transactions relevant to the procurement of the insurance in question were those between the plaintiffs and the defendant, Green; the lower court was in error in refusing the motion of the defendant, Sullivan, for a directed verdict.

The second issue confronting the court involved the allegation that the defendants were negligent in failing to procure a liability insurance policy for the plaintiff covering loss from the operation of the elevator located on its business premises. The court recognized the general rule that insurance agents are required to exercise due care in procuring insurance and are personally liable for the neglect of that duty.[73] The court further noted that, where an insurance agent undertakes to procure insurance for a member of the public, the law holds the agent to the exercise of good faith, reasonable skill, care, and diligence in performing the obligation.[74] In the instant case Green, a licensed agent, undertook to procure a liability insurance policy covering the plaintiff's elevator. He delivered, however, a policy which, through his own fault and neglect, failed to include coverage for the elevator. The evidence was such as to permit an inference of actionable negligence on the part of Green, and the motion for a directed verdict in his favor was properly denied.

Third, the defendant, assuming negligence on his part, contended that the plaintiff was guilty of contributory negligence in the reading of the policy; that, as a matter of law, this would bar recovery; and that he should have received a directed verdict on that ground. The court stated that the defense of contributory negligence is available to an agent against whom the principal

73. *See, e.g.*, Hinds v. United Ins. Co. of America, 248 S.C. 285, 149 S.E.2d 771 (1966); La Tourette v. McMaster, 104 S.C. 501, 89 S.E. 398 (1916). For additional support of this general principle *see* 43 AM. JUR. 2d INSURANCE §§ 174, 176 (1969); 44 C.J.S. *Insurance* § 172 (1945); 14 J. APPLEMAN, INSURANCE LAW AND PRACTICE §§ 8831, 8841 (1962); Annot., 29 A.L.R.2d 171 (1953).

74. *Id.*

brings an action in tort for negligence.[75] The court explained, however, that, while an insured cannot abandon all care, the rules which require one to inform himself of the terms of his contract and to take precautions for his own protection are less exacting where a person deals with his own insurance agent in the procurement of an insurance contract. In the case at hand the defendant, Green, was a licensed insurance agent and held himself out to the public as knowledgeable in the insurance business; conversely, the plaintiff, while experienced in his own business, was not experienced in the insurance field and had a right to rely upon the expert knowledge of the agent. Accordingly, the court declared that it could not be held, as a matter of law, that the plaintiff should have known from a reading of the policy that the elevator was not covered. From the defendant's own testimony he, an insurance expert, thought until after the loss that the elevator was insured under the general provisions of the policy. Thus, the issue of whether the plaintiff acted with due care in relying upon the defendant in the procurement of the insurance policy and his representation as to the coverage afforded by the policy was an issue of fact, and the lower court acted properly in refusing to direct a verdict on this ground.

The defendant's fourth and final contention was that judgment should have been entered in his favor because the present action was barred by the statute of limitations.[76] The initial transaction between the parties occurred in 1956. The basis of the plaintiff's cause of action was not, however, that the defendant negligently failed to provide the requested coverage in 1956, but that he failed to do so in renewing the policy in 1962. The prior transactions were simply relevant to the issue of whether the defendant undertook to provide the particular coverage in the policy obtained in 1962. The present action was begun in the summer of 1962, just a few months after the 1962 policy was issued and the loss sustained. The court found, therefore, that the action was not barred by the statute of limitations.

75. RESTATEMENT (SECOND) OF AGENCY § 415, comment *b* at 275 (1957). *See also* 44 C.J.S. *Insurance* § 172 (1945).

76. Under section 10-143 of the 1962 Code of Laws, the action was barred unless commenced within six years from the time that the cause of action accrued.

V. EVIDENCE: MENTION OF INSURANCE

As previously stated, the South Carolina Supreme Court heard, in the course of the survey year, four cases in which the issue involved the interjection of the defendant's liability insurance into the case.

In *Keller v. Pearce-Young-Angel Co.*[77] the plaintiff, a passenger in a truck owned and operated by his brother, was injured in a collision with a truck of the defendant. During the course of the trial the plaintiff's brother inadvertently mentioned the liability insurance of the defendant in response to a question which did not seek to solicit such information.[78] The trial judge denied a motion for a mistrial, but strongly admonished the jury to disregard the mention of insurance by the witness. The defendant appealed from an adverse verdict of the trial court.

The defendant asserted on appeal that the trial judge should have granted a mistrial because of the mention of liability insurance. In answering this contention, the court reiterated that, as a general rule, a motion for a mistrial is one addressed to the sound discretion of the trial judge, whose ruling thereon will not be disturbed in the absence of an abuse of discretion amounting to an error of law.[79] The court was of the opinion that the discretion vested in the trial judge had not been abused.

> We are inclined to agree with the statement of the trial judge that now "nearly everybody knows that nearly everybody has got insurance." It is, of course, today a matter of common knowledge that a vast majority of the motoring public is protected by liability insurance. While such knowledge provides neither excuse nor justification for intentionally or deliberately injecting liability insurance into the trial of a case, still

77. 253 S.C. 395, 171 S.E.2d 352 (1969).

78. The testimony of the plaintiff's brother was as follows:

> Q. Did the loss of your truck and the loss of your tools cause you to lose any time or any money in the work on these houses in Lexington until you were able to get a replacement truck and buy this other equipment?
>
> A. I would say that it caused me to lose quite a bit because I didn't have the proper tools to do the work with and I couldn't afford to go out and buy more and I didn't have transportation to get around to these jobs. I mean, I would have to haul lumber and different things like that and I didn't have no truck and I called this insurance adjuster, I imagine it was for Pearce-Young-Angel and he was suppose to come over . . . .

Record at 2.

79. See the cases collected in WEST'S SOUTH CAROLINA DIGEST, *Trial* Key No. 18.

> such knowledge is, we think a matter for consideration in determining the likelihood or probability of prejudice to a litigant as a result of insurance having been inadvertently mentioned.[80]

The burden of proof was upon the appellant to show not only error but also resulting prejudice. The court was not convinced that there was any abuse of discretion on the part of the trial judge, or any resulting prejudice to the appellant; thus, the judgment of the lower court was affirmed.[81]

The second case dealing with the mentioning of liability insurance during the course of the trial was *Walling v. Doe*.[82] This action was instituted when the plaintiff, a passenger, was injured in an automobile-truck collision.[83] In instructing the jury, the trial judge read to them the provisions of a statute relating to the conditions for recovery under the uninsured motorist provisions of a liability insurance policy and told them that all of the conditions of the statute had been met. The trial resulted in a verdict for the plaintiff for both actual and punitive damages, and the defendant appealed therefrom.

The defendant-appellant contended that the jury instruction was prejudicial and entitled him to a new trial. In a very brief opinion the court announced that, as a general rule, it is improper in an action for damages to make known to a jury that there is liability insurance available to pay the amount of any recovery. The jury instruction was here considered to amount to

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80. 253 S.C. at 398, 171 S.E.2d at 354 (1969).

81. As to the inadmissibility of evidence with reference to insurance, the court quoted from *Horsford v. Carolina Glass Co.*, 92 S.C. 236, 75 S.E. 533 (1912):

> The general rule is indisputably established that, when in the course of a trial incompetent statements of witnesses are brought in either from accident or when they might be reasonably, though erroneously, thought by counsel to be competent, the only remedy that the court can afford is to grant a motion to strike out and instruct the jury to disregard the testimony. The injury resulting from the jury having heard the incompetent statement is regrettable, but the trial cannot be stopped because of such accidents and mistakes liable to occur in every trial.

See also Keys v. Winnsboro Granite Co., 76 S.C. 284, 56 S.E. 949 (1906); Hagins v. Aetna Life Ins. Co., 72 S.C. 216, 51 S.E. 683 (1905); State v. Adams, 68 S.C. 421, 47 S.E. 676 (1904); State v. Wideman, 68 S.C. 119, 46 S.E. 769 (1904).

82. 253 S.C. 427, 171 S.E.2d 494 (1969).

83. The driver of the truck left the scene immediately following the collision, and his identity was unknown. The action was then brought against the unknown driver as "John Doe" in accordance with the provisions of the Uninsured Motorist Act, to establish liability for the damages sustained by the plaintiff. *See* S.C. CODE ANN. §§ 46-750.34 to -750.35 (Supp. 1963).

reversible error, and the case was, therefore, reversed and remanded for a new trial.

Another case in this area of insurance law was *Stevens v. McGaha*.[84] In this action three-year-old Gregory Stevens lost the sight of his left eye when it was lacerated by a sharp, jagged corner of the metal handle of a chest-type freezer in the kitchen of his grandfather's home. The trial was commenced and was completed on the same day; however, when court opened the next morning, counsel for the defendant moved for a mistrial because of a newspaper article appearing in the local newspaper. The article in question contained the erroneous statement that "the suit is a 'home policy' type in which the grandfather contends that his insurance protects him in the event of a suit from such an accident."[85] After inquiry, the court ascertained that only two of the jurors had read the article, and they stated that the article would not affect their verdict in the slightest degree. Judgment was entered for the plaintiff; the defendant grandfather appealed.

The grandfather made no claim on appeal that the plaintiff was responsible for the publication, but simply contended, *inter alia*, that the article injected the question of insurance into the case and that the only satisfactory remedy was a mistrial. Answering this assertion, the court emphasized that such was not the law in this state.

> The matter was peculiarly within the discretion of the trial judge, and we are not persuaded that his refusal of the motion was unwise. Clearly no abuse of discretion has been shown.[86]

Thus, the decision of the trial court was affirmed.

Finally, the defendant-appellant in *Riddle-Duckworth, Inc. v. Sullivan*[87] alleged error in the denial of the defendant's motion for a mistrial because of certain testimony referring to liability insurance. The appellant relied upon the testimony of the plaintiffs' manager, Duckworth, as to statements made to him by the defendants after the customer had been injured from the fall of the elevator and while an attempt was being made to have

84. 253 S.C. 378, 170 S.E.2d 758 (1969).
85. *Id.* at 380-81, 170 S.E.2d at 759.
86. *Id.* at 381, 170 S.E.2d at 759.
87. 253 S.C. 411, 171 S.E.2d 486 (1969). For a detailed discussion of this case see SECTION IV. LIABILITY INSURANCE ON BUSINESS PREMISES of this article.

the defendants take care of the loss. The plaintiffs' manager quoted the defendant, Sullivan, as saying, "Don't worry about it. Fred (defendant Green) is protected from errors." He further testified that the defendant, Green, told him, "Don't worry about it. We will take care of it"; and later, "Don't worry about it. I just made an error and I am protected and I will take care of you."

The defendant-appellant argued that the reference in the foregoing testimony to the defendant, Green, as "protected" was highly prejudicial in that the only inference to be drawn therefrom was that the defendant had liability insurance which would pay any judgment awarded against him. The court proclaimed that whether or not a motion for a mistrial is granted rests in the sound discretion of the trial judge and his ruling will not be disturbed unless an abuse of discretion is shown.[88] The court was not persuaded that there was an abuse of discretion by the trial judge in the instant case, and the judgment of the lower court was affirmed.

VI. Insurance License Fees and Taxes: Tax on Reinsurance Premiums

In *Southeastern Fire Insurance Co. v. South Carolina Tax Commission*,[89] Southeastern reinsured contracts of insurance issued by Emerald Fire and Casualty Insurance Company. The South Carolina Tax Commission levied a two percent tax on the reinsurance premiums collected by Southeastern pursuant to section 37-130.2 of the South Carolina Code of Laws of 1962. The tax was paid under protest and a suit instituted to recover the amount of taxes paid. The trial court held that the premiums paid Southeastern by Emerald were not taxable because the contract was one of indemnity and not one of insurance as contemplated by the statute. The Tax Commission appealed from this decision.

The court stated on appeal that the sole question for determination was whether reinsurance contracts came within the scope of section 37-130.2. As to the construction of the statute, the court announced that, if a statute is clear and unambiguous, there is generally no room for construction, and courts must

88. *See, e.g.*, Crocker v. Weathers, 240 S.C. 412, 126 S.E.2d 335 (1962).
89. 253 S.C. 407, 171 S.E.2d 355 (1969).

give the terms of such a statute their literal meaning.[90] If the terms of a statute are susceptible of more than one interpretation, the courts must then construe them to determine the intent of the legislature. The court noted that it has also been held that a tax statute is not to be extended beyond the clear import of its language, and any substantial doubt as to its meaning is to be resolved in favor of the taxpayer.[91] After reiterating the aforementioned guidelines, the court then faced the task of determining if the taxing statute refers to insurance contracts only, or if it refers to both insurance contracts and reinsurance contracts.

Section 37-3 of the Code defines "insurance" as follows: "*Insurance*" is a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies." "Reinsurance" is not defined in the Code. However, there is certainly a difference between insurance and reinsurance. Reinsurance is defined in *American Jurisprudence (Second)* as follows:

> "*Reinsurance*," in the strict sense of the word, may be defined as a contract whereby one party, the reinsurer, agrees to indemnify another, the reinsured, either in whole or in part against loss or liability which the latter may sustain or incur under a separate and original contract of insurance with a third party, the original insured.[92]

The court concluded that one of the purposes of reinsurance is to allow insurers to spread their risk. This is highly desirable, because it helps to assure the stability of the insurer and increases the value of the coverage to individuals. Thus, the legislature, by failing to specify that the taxing statute applies to reinsurance as well as to insurance, may have been attempting to encourage reinsurance. In affirming the trial court's decision as to the non-taxability of the reinsurance premiums, the court stated the following:

> We do not think it was the intent of the legislature that an insured person bear the brunt of more than one two per cent tax. Although the tax is not levied against

90. *See generally* McCollum v. Snipes, 213 S.C. 254, 49 S.E.2d 12 (1948); Home Bldg. & Loan Ass'n v. City of Spartanburg, 185 S.C. 313, 194 S.E. 139 (1937).

91. *See, e.g.*, Coble Dairy Products Corp. v. Livingston, 239 S.C. 401, 123 S.E.2d 301 (1961).

92. 44 AM. JUR. 2D *Insurance* § 1857 (1969).

> the insurer, it is inescapable that the cost of doing insurance business including the payment of taxes levied must be passed on to the consumer.[93]

VII. LEGISLATION

The 1970 General Assembly enacted insurance legislation that may substantially affect South Carolina insurance law and practice. The act applies only to that portion of a policy of automobile insurance providing automobile bodily injury and property damage liability coverage and to the provisions therein relating to uninsured motorists coverage.

The grounds for cancellation of an insurance policy by an insurer represent the most significant change effected by the enactment:

> No insurer shall cancel a policy except for one or the other of the following specified reasons:
>
> (1) Nonpayment of premium; or
>
> (2) The driver's license or motor vehicle registration of the named insured or of any other operator who either resides in the same household or customarily operates an automobile insured under the policy has been under suspension or revocation during the policy period or, if the policy is a renewal, during its policy period or the one hundred eighty days immediately preceding its effective date.[94]

Also included in the legislation is the provision that no cancellation or refusal to renew a policy of automobile insurance by an insurer shall be effective unless the insurer shall deliver or mail, to the named insured at the address shown in the policy, a written notice of the cancellation or refusal to renew. Immediately following the foregoing provision are five mandates that must accompany such notice.[95]

It is further provided that any insured may, within fifteen days of the receipt of notice of cancellation or notice of inten-

93. 253 S.C. at 411, 171 S.E.2d at 357.
94. "An Act Regulating The Writing, Cancellation of Or Refusal to Renew Policies of Automobile Insurance; Imposing Powers and Duties on the Chief Insurance Commissioner Therefor; Providing For Hearings and Providing Penalties For Violations," R1335, April 29, 1970, Section 4.
95. *Id.* at Section 5.

tion not to renew, request in writing that the Insurance Commissioner review such action of the insurer.[96] Section 11 of the act sets forth the penalties and consequences to which the insurer may be subjected for non-compliance with any resulting order or regulation from the Commissioner.

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96. *Id.* at Section 8.