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Insurance Law

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INSURANCE LAW

by

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AS has been true in previous *Surveys*, the insurance cases decided during the current reporting period have been primarily concerned with the interpretation of clauses standard in many insurance policies. Although the decisions often turn on the particular facts of the instant cases, the bases for the holdings seem general enough to be of relevance to all insurance practitioners.

I. AUTOMOBILE AND LIABILITY INSURANCE

Uninsured Motorist Coverage. Uninsured motorist coverage continues to be an area of considerable judicial activity, but the developments during the current reporting period seem less significant than those of previous years. In *American Motorist Insurance Co. v. Briggs*[1] the Texas Supreme Court considered the limits of liability in situations in which more than one policy provides uninsured motorist coverage. While occupying a non-owned automobile for which uninsured motorist coverage was provided by International Insurance Company, Mr. and Mrs. Briggs, who had uninsured motorist protection under an American Motorist Insurance Company policy, were injured by an uninsured motorist. The Briggs settled with International for $5,750 each, and in their suit against American Motorist the jury awarded damages which, after remittitur, amounted to $11,230.39 for Mr. Briggs and $6,115.95 for Mrs. Briggs. Relying on an "other insurance" clause, which made it a secondary insurer for accidents in which the insured was driving a nonowned vehicle, American Motorist urged that International provided primary coverage so that American Motorist was obligated only for damages exceeding International's limits of $10,000 per person and $20,000 per accident. Under this theory, American Motorist would owe Mr. Briggs $1,230.39 and would owe Mrs. Briggs nothing. However, following its earlier decision in *American Liberty Insurance Co. v. Ranzau*,[2] the court held that whenever uninsured motorist coverage exists, the insured has a cause of action on the policy for his actual damages to the extent of the policy limits, regardless of the existence of other insurance. If coverage exists under two or more policies, liability is joint and several to the extent of actual damages, subject to the qualification that no insurer shall pay an amount

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1. 514 S.W.2d 233 (Tex. 1974).

2. 481 S.W.2d 793 (Tex. 1972). In *Ranzau* the court held that the "other insurance" clause contravened statutory minimum insurance requirements reflected in the Texas Motor Vehicle Safety Responsibility Law, TEX. REV. CIV. STAT. ANN. art. 6701h (Supp. 1975-76). 481 S.W.2d at 796-97.

in excess of its policy limits. Therefore, Mr. and Mrs. Briggs were entitled to recover their actual damages from American Motorist, less the amounts previously paid by International; that is, $5,480.39 to Mr. Briggs and $365.95 to Mrs. Briggs.

In *Holter v. Employers Mutual Fire Insurance Co.*[3] the court of civil appeals applied the rule of *Briggs* to a three-car collision. Holter, a passenger seriously injured in an automobile owned and operated by Hyche, sued Wilson and Crew, the drivers of the other two vehicles involved. Holter obtained judgment against Wilson and Crew, jointly and severally, for $31,500 in damages. Allstate, Wilson's insurer, paid $10,000, its policy limits, to Holter. Crew was uninsured. Holter then brought suit against Employers Mutual, which provided his uninsured motorist coverage, and against Vico County Mutual Insurance Company, which provided Hyche's uninsured motorist coverage. Prior to the Texas Supreme Court's decision in *Briggs*, the trial court granted both insurers' motions for summary judgment against the plaintiff. However, the court of civil appeals reversed and rendered, first holding that Employers and Vico were entitled to credit for the $10,000 paid to Holter by Allstate, and then applying the rule of *Briggs*, as follows: "Thus, in this case, the plaintiff's injuries have caused him damages in excess of $20,000, the combined limits of the two policies, and since he has been paid only $10,000, he is entitled to recover another $10,000 under the policies."[4]

Several cases decided during the survey period applied and interpreted the provision, standard in many policies, excluding uninsured motorist coverage if the insured "shall, without written consent of the company, make any settlement with any person or organization who may be legally liable therefor." The Texas Supreme Court recognized the validity of this exclusion by refusing the application for writ of error in *McClelland v. United Services Automobile Ass'n.*[5] The stipulated facts were that McClelland was injured while a passenger in Coulter's automobile, that the collision was proximately caused by the negligence of an uninsured motorist, and that all plaintiffs were damaged in the total amount of $19,000. The Coulter automobile was insured by Allstate under a policy that included uninsured motorist coverage. McClelland, a minor, also had uninsured motorist coverage under a policy issued to her mother by United Services (USAA). All of the plaintiffs settled with Allstate for $9,000 without procuring the written consent of USAA. In the absence of a stipulation that negligence on the part of the driver of the Coulter automobile did not proximately cause the accident, the court of civil appeals held that the settlement caused USAA to lose the valuable right of subrogation against the Coulter driver, and so the policy provision voiding USAA's motorist coverage was enforceable.[6]

Although it was apparently assumed in *McClelland* that a release of the insurer of an automobile in which plaintiffs were passengers is a release of

3. 520 S.W.2d 435 (Tex. Civ. App.—Houston [14th Dist.] 1975, no writ).
4. *Id.* at 438.
5. 525 S.W.2d 271 (Tex. Civ. App.—Beaumont 1975, writ ref'd).
6. The court considered the case to be controlled by Grissom v. Southern Farm Bureau Cas. Ins. Co., 476 S.W.2d 448 (Tex. Civ. App.—Waco 1972, writ ref'd n.r.e.), in which the facts were strikingly similar to those in *McClelland.*

"one who may be legally liable" for plaintiff's injuries, the El Paso court of civil appeals specifically so held in *Castorena v. Employers Casualty Co.*[7] Such a release, without written consent of plaintiff's carrier, voids the uninsured motorist coverage. However, the insurer may waive the exclusion of coverage for settlement without written consent by a prior denial of liability. In *Stephens v. State Farm Mutual Automobile Insurance Co.*[8] the Fifth Circuit was confronted with a situation in which newlyweds riding in the wife's car were in a collision with an uninsured motorist. Mrs. Stephens had uninsured motorist coverage under a policy issued to her in her maiden name by Royal Indemnity Company, while Mr. Stephens' coverage was contained in a policy issued to him by State Farm. In the collision Mrs. Stephens was killed and Mr. Stephens was injured, the damages to each exceeding $20,000. Suit was brought against both Royal Indemnity and State Farm. State Farm denied coverage on the ground that Mr. Stephens was riding in an uninsured owned automobile. Without the consent of State Farm, plaintiff settled with Royal for $20,000. The district court found State Farm liable in the amount of $20,000, and the Fifth Circuit affirmed. Finding no Texas cases on point, the court predicted, based on reason and out-of-state authority, that Texas law would hold that State Farm's denial of coverage waived the consent clause. Apparently, this prediction was accurate, since the court in *McClelland*[9] rejected the plaintiff's reliance on *Stephens* by stating that *Stephens* turned solely on the issue of waiver.

Greene v. Great American Insurance Co.,[10] a case of first impression, held that partial rejection of uninsured motorist coverage is permissible. Great American issued an automobile liability policy, including uninsured motorist coverage, to Mrs. Greene. Attached to the policy and signed by Mrs. Greene was Form 119, which specifically denied coverage if the automobile was driven by Mrs. Greene's son, Oran. While driving his mother's automobile, Oran was injured by an uninsured motorist and sued Great American. The court of civil appeals affirmed summary judgment for the insurer on the ground that the policy clearly did not cover Oran and that the use of Form 119 was not void as against public policy, relying on cases that had approved the use of Form 119 with respect to liability coverage.[11]

Three cases addressed miscellaneous questions of uninsured motorist coverage. Following the Texas rule that an automobile liability insurer is liable for exemplary damages imposed against its insured, the court in *Home Indemnity Co. v. Tyler*[12] held that an uninsured motorist insurer is liable for exemplary damages found against the uninsured motorist. *Agricultural Workers Mutual Auto Insurance Co. v. Baty*[13] held that a motorcycle is not an automobile within the meaning of an owned, but not insured, automobile

7. 526 S.W.2d 680 (Tex. Civ. App.—El Paso 1975, writ ref'd n.r.e.).
8. 508 F.2d 1363 (5th Cir. 1975).
9. *See* notes 5-6 *supra* and accompanying text.
10. 516 S.W.2d 739 (Tex. Civ. App.—Beaumont 1975, writ ref'd n.r.e.).
11. Justice Keith wrote a vigorous dissent to *Greene*, in which he concluded that Form 119 excluded Oran's liability coverage, but did not exclude him from uninsured motorist coverage while driving his mother's automobile. 516 S.W.2d at 743.
12. 522 S.W.2d 594 (Tex. Civ. App.—Houston [14th Dist.] 1975, writ ref'd n.r.e.).
13. 517 S.W.2d 901 (Tex. Civ. App.—Tyler 1974, writ ref'd n.r.e.).

exclusion. Finally, *State Farm County Mutual Insurance Co. v. Landers*[14] recognized the validity of the provision that a hit-and-run automobile is an uninsured motor vehicle if "the insured or someone on his behalf shall have reported the accident within twenty-four hours to a police, peace or judicial officer or to the Commissioner of Motor Vehicles."[15]

Persons Insured. Several opinions dealt with the question of who is insured under a policy. *Melton v. Ranger Insurance Co.*[16] concerned the renter-pilot exclusion of an aircraft liability policy. Melton and his six passengers were killed in an aircraft piloted by him, rented from a flying service, and insured by Ranger Insurance Company. The estate of Melton brought suit against Ranger to collect the amount of the judgment which the estates of the passengers had obtained against it after Ranger had refused to defend. Ranger contended that Melton was not covered because the policy did not apply "to any person operating the aircraft under the terms of any rental agreement or training program which provides any remuneration to the Named Insured for the use of said aircraft."[17] Plaintiff contended that the policy was ambiguous and should, therefore, be construed against the insurer, since the declaratory provisions of the policy, entitled "Purpose(s) of Use" made "rental to pilots" a permitted use of the insured aircraft, thereby impliedly making a renter-pilot an omnibus insured. In affirming summary judgment for defendant, the court found no ambiguity since the declaratory provisions covered the lessor for damage to the aircraft sustained during rental to a pilot, but as the further limitation indicated, such coverage did not extend to the renter-pilot.

In *Government Employees Insurance Co. v. Edelman*[18] Government Employees Insurance (GEICO) had issued a policy to A.H. Edburg, Jr., as named insured, which listed an automobile owned by his son, Andy. At the time of the accident, Ronald Edelman was driving Andy's car with Andy's permission, but there was no evidence that the named insured had given such permission. It was, therefore, held that Edelman was not covered by the policy, which limited persons insured to those using the automobile with the named insured's permission, and GEICO thus had no duty to defend him.

In *Boon v. Premier Insurance Co.*[19] the court found no coverage of the named insured's wife, who was injured while occupying another person's vehicle, since she had filed for divorce and separated from her husband and thus was not a "resident of the same household as the named insured." The court gave a similarly restrictive reading to the coverage provisions in *Gary Safe Co. v. Transport Insurance Co.*,[20] holding that the shipper of a safe via a common carrier was not a "lessee or borrower" of the carrier's delivery

14. 520 S.W.2d 604 (Tex. Civ. App.—Fort Worth 1975, no writ). *See also* note 27 *infra* and accompanying text.
15. *Id.* at 605.
16. 515 S.W.2d 371 (Tex. Civ. App.—Fort Worth 1974, writ ref'd n.r.e.).
17. *Id.* at 372.
18. 524 S.W.2d 546 (Tex. Civ. App.—Beaumont 1975, writ ref'd n.r.e.).
19. 519 S.W.2d 703 (Tex. Civ. App.—Texarkana 1975, no writ).
20. 525 S.W.2d 64 (Tex. Civ. App.—Houston [14th Dist.] 1975, no writ).

truck so as to be covered, under the loading and unloading provision of the carrier's comprehensive liability policy, for an injury to the carrier's employee during the unloading of the safe.

Exclusions. Two courts determined insurance coverage by construing terms used in policy exclusions. *Gustafson v. National Insurance Underwriters*[21] dealt with the term "passenger" in an aircraft liability policy. After riding in a private aircraft, Nancy Bischofs climbed out onto the wing and jumped to the ground. She then raised her left hand to wave to her friends, and the hand was struck by the propeller. Her parents sued the owners of the aircraft, Gustafson and Bailey, for her personal injuries. Gustafson and Bailey called upon the insurer of the aircraft, National Insurance Underwriters, to defend, and it refused. The insureds brought this declaratory judgment action for determination of the insurer's obligation to defend against the Bischofs' lawsuit. The trial court granted the insurer's motion for summary judgment, since the policy excluded coverage of claims by passengers. "Passenger" was defined in the policy to include "any person in, on or entering the aircraft for the purpose of riding or flying therein or alighting therefrom following a ride, flight or attempted flight therein."[22] After reviewing the allegations of the petition, the court of civil appeals affirmed, holding that, as a matter of law, Nancy Bischofs was alighting from the aircraft and thus was a passenger within the policy definition.

The meaning of "commercial automobile" was determinative in *Maryland American General Insurance Co. v. Ramsay.*[23] Ramsay, a civilian employed by the U.S. Navy as an air conditioning mechanic, was operating a Navy pickup truck on a public highway when he was involved in a fatal accident. Mrs. Ramsay sued Maryland American for death benefits under a family combination automobile policy endorsement entitled "Automobile Death Indemnity, Total Disability and Specific Disability Benefits." However, this endorsement excluded "bodily injury or death sustained in the course of his occupation by any person while engaged (1) in duties incident to the operation, loading or unloading of, or as an assistant on, a public or livery conveyance or commercial automobile."[24] Coverage of Ramsay was barred by this exclusion if the Navy pickup was a "commercial automobile," a term undefined in the policy. Both parties moved for summary judgment. The trial court granted plaintiff's motion. The court of civil appeals reversed and rendered judgment for the insurer, holding that although the Navy was not engaged in commerce, Ramsay, whose business it was to install, repair, and service air conditioning equipment for the Navy, was so engaged; therefore, the pickup was a commercial automobile. On October 29, 1975, the Texas Supreme Court granted Ramsay's application for writ of error on the single point that as a matter of law the pickup was not a commercial automobile.

Notice. In two cases Texas courts considered whether coverage had been

21. 517 S.W.2d 414 (Tex. Civ. App.—Eastland 1974, writ ref'd n.r.e.).
22. *Id.* at 415-16.
23. 526 S.W.2d 138 (Tex. Civ. App.—Corpus Christi 1975, writ granted).
24. *Id.* at 139.

voided by the insured's failure to give notice as soon as practicable. *Employers Casualty Co. v. Mireles*[25] held that a delay of over six months was, as a matter of law, failure to give notice as soon as practicable. Employers insured Mireles through the Texas Automobile Insurance Plan, formerly the Texas Assigned Risk Plan. Mireles was involved in a serious automobile accident on May 21, 1972. Employers was first notified of the accident when suit papers were delivered to it on December 4, 1972. There was some evidence that Mireles had given immediate notice of the accident to the insurance agency at which he had applied for insurance. Although finding no Texas cases on point, the court followed the majority rule that an assigned risk broker is the agent of the insured and not of the insurer. Therefore, any notice given to the insurance agency would not constitute notice to Employers Casualty.

In *Employers Casualty Co. v. Scott Electric Co.*[26] a notice thirteen months after the accident was held to be, under the circumstances, as soon as practicable. On October 4, 1968, an explosion of volatile vapors in a barge docked at Rincon Shipyard caused property damage, personal injuries, and death to Rincon employees. Part of Rincon's business was using electrical blowers to blow volatile vapors out of barges. Scott Electric had made service calls regarding Rincon's blowers, cables, and breakers. Within an hour of the accident an employee of Scott went to the scene, and it appeared to him that the electricity had been off just prior to the accident. In the course of various investigations, this employee was interviewed three times about the accident, and never was a suggestion made that the explosion was caused by electricity or that Scott Electric had in any way caused the explosion. On November 5 Scott Electric was served with plaintiff's petition, which alleged that the explosion was caused by improper repair of motors by Scott Electric. On November 7 Scott Electric notified its insurer, Employers Casualty, which refused to defend. After four days of trial plaintiff's suit against Scott Electric and others was settled. Scott Electric then sued Employers Casualty. The court of civil appeals affirmed the trial court judgment for Scott Electric because there was evidence to support the jury finding that notice was given as soon as practicable. Furthermore, the court felt that, under the circumstances, Scott Electric had no duty to give notice to Employers Casualty, since, after investigation, there was no reason to believe that Scott Electric could be liable for damages caused by the explosion.

Venue. In both *State Farm County Mutual Insurance Co. v. Landers*[27] and *Johnson v. Commercial Standard Insurance Co.*[28] the plaintiffs contended that venue was proper in the county in which the cause of action arose.[29] To support venue plaintiffs, therefore, were obliged to prove that they had causes of action against the defendant insurers. The insurers urged that such

25. 520 S.W.2d 516 (Tex. Civ. App.—San Antonio 1975, writ ref'd n.r.e.).
26. 513 S.W.2d 642 (Tex. Civ. App.—Corpus Christi 1974, no writ).
27. 520 S.W.2d 604 (Tex. Civ. App.—Fort Worth 1975, no writ); *see* note 14 *supra* and accompanying text.
28. 521 S.W.2d 957 (Tex. Civ. App.—Eastland 1975, no writ).
29. TEX. REV. CIV. STAT. ANN. art. 1995, § 23 (1964).

proof included the necessity of negating all policy exclusions which might defeat coverage. In both cases the courts of civil appeals affirmed the trial courts' overruling of the insurers' pleas of privilege, holding that the insurers were required specifically to raise the exclusions under rule 54 of the Texas Rules of Civil Procedure, and that the insureds were not required to disprove any policy defenses in order to maintain venue.

Limitations. In *Hastings v. Royal-Globe Insurance Co.*[30] plaintiff, claiming coverage under a policy issued by Royal-Globe to his employer, sought attorneys' fees which he had expended in defending a prior suit. The trial court sustained the insurer's plea in abatement, based on the running of the two-year statute of limitations. The court of civil appeals reversed and remanded, holding that Hasting's cause of action against Royal-Globe, based on a written contract, was governed by the four-year statute of limitations and that limitations began to run when Hastings was sued, not when the accident occurred, so that even the two-year period had not run when the instant suit was filed.[31]

Standing to Sue. *Morris v. Allstate Insurance Co.*[32] dealt with the question of who has standing to complain of an insurer's refusal to defend. This declaratory judgment action was brought by the insured, Copeland. The injured plaintiff, Morris, intervened. The trial court held that the insurer was not obligated to defend because there was no coverage. The insured did not appeal, but the intervenor did. The court of civil appeals held that the injured plaintiff had no standing to complain of the insurer's failure to defend and that, under policy provisions, she had no right of action against the insurer until she had established her claim against the insured by judgment or written agreement. However, the court reversed the portion of the trial court judgment declaring that Allstate was not obligated to pay any judgment that the plaintiff might obtain against the insured, because such was an advisory opinion impermissible even in a declaratory judgment action.

Proof of Policy. *Hartford Accident & Indemnity Co. v. Spain,*[33] an action by Spain against Hartford to collect a judgment obtained against an alleged insured, turned on whether proof of the policy had been made. The accident occurred in 1963, and judgment was obtained against the alleged insured, Loggins, in 1972. Based on a jury finding that Loggins was insured by Hartford at the time of the accident, the trial court entered a judgment for Spain and against Hartford. The court of civil appeals reversed and rendered, concluding that despite the evidence that Hartford agents investigated the accident, there was no evidence to support the jury's finding that Hartford insured Loggins on the date of the accident. The court also held that the insurer had not judicially admitted the existence of a policy in the prior suit against Loggins when Spain tried to join the insurer. At that time Hartford

30. 521 S.W.2d 869 (Tex. Civ. App.—San Antonio 1975, no writ).
31. The court also held that Hastings was not required to establish a cause of action against his employer as a prerequisite to suing Royal. *Id.* at 873.
32. 523 S.W.2d 299 (Tex. Civ. App.—Texarkana 1975, no writ).
33. 520 S.W.2d 853 (Tex. Civ. App.—Tyler 1975, no writ).

filed a general denial and further sought abatement of any direct suit against it as a liability insurer of the alleged tortfeasor. Since these were alternative pleadings, the court held that Hartford had not admitted that it had issued a policy to Loggins. Even if this were treated as a judicial admission, the court concluded that by failing to prove the terms of the policy, Spain had failed to establish a cause of action against Hartford.

Bad Faith Settlement. In *Wood Truck Leasing, Inc. v. American Automobile Insurance Co.*[34] an assigned risk insured sought damages from its insurer for settling claims *within* the policy limits. In a converse application of the Stowers Doctrine,[35] plaintiff contended that it was injured by the settlements because they precipitated higher insurance premiums. The trial court granted the insurer's motion for summary judgment, but the court of civil appeals reversed and remanded. Under the policy, the insurer had the right, absent fraud or bad faith, to make any settlement which it felt expedient; however, the insured's pleadings contained a general allegation of bad faith which was sufficient to defeat the insurer's motion for summary judgment on the pleadings alone.

Professional Liability Insurance. A significant statutory development in the insurance area has been the passage of a special article on rating procedures in the writing of professional liability insurance.[36] Effective until December 31, 1977, the new procedures set out specific factors which are to be considered in the setting of rates for this type of coverage. Perhaps the major section of this statute is that dealing with the filing of claims against a person or hospital covered by professional liability insurance. All such claims for breach of express or implied contract, tort, compensation for medical treatment, or hospitalization are subject to a two-year limitations period notwithstanding provisions to the contrary in any other statute.[37]

II. LIFE, HEALTH, AND ACCIDENT INSURANCE

Fraudulent Representations. Life insurers resisting payment on the ground that the insured made fraudulent representations in applying for the policy did not fare well during the reporting period. In *Johnson v. Prudential Insurance Co. of America*,[38] mentioned in the previous *Survey*,[39] the Texas Supreme Court reversed the court of civil appeals' affirmance of a trial court judgment for the insurer. Mrs. Johnson made statements in her applications for insurance under a group life policy issued by Prudential that misrepresented her prior problems with cancer. However, the policy contained a provision, as required by the Texas Insurance Code, that "no statement made

34. 526 S.W.2d 223 (Tex. Civ. App.—San Antonio 1975, no writ).

35. In G.A. Stowers Furniture Co. v. American Indem. Co., 15 S.W.2d 544 (Tex. Comm'n App. 1929, holding approved), the court held that an insurer is required to exercise ordinary care and prudence in determining whether to accept an offer for settlement within the policy limits.

36. TEX. INS. CODE ANN. art. 5.82 (Supp. 1975).

37. *Id.* § 4.

38. 519 S.W.2d 111 (Tex. 1975).

39. Brin, *Insurance Law, Annual Survey of Texas Law*, 29 SW. L.J. 172, 181 (1975).

by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or to his beneficiary."[40] The insurer did not furnish copies of Mrs. Johnson's statements to her during her life. Her beneficiary was furnished with copies of the statements after the insurer had informed him that it was refusing to pay under the policy. Based on jury findings supportive of the insurer's defense of fraudulent misrepresentation, the trial court entered judgment for the insurer. The determinative question before the Supreme Court of Texas was the admissibility of Mrs. Johnson's statements, because, if they were admissible, the insurer's defense was established. The supreme court rejected a literal interpretation of the statutorily mandated provision quoted above. It found that the objective of the legislature was to require the insurer to provide the insured with copies of his statement so that he could make corrections. Consequently, the court held that the statute and the policy language required an insurer to furnish promptly to an insured copies of his application or other written statements material to the issuance of his coverage. Only if the insured dies immediately and before the insurer has a reasonable opportunity to furnish the statements to him may the insurer comply with the provision by providing statements to the beneficiary. The allegedly deceptive statements made by Mrs. Johnson were therefore inadmissible in the beneficiary's suit against the insurer.

In *Bynum v. Signal Life Insurance Co.*[41] the court of civil appeals reversed and rendered a take-nothing judgment based upon a jury verdict. In his application, the insured denied "any other disease, injury, operation or deformity" and "any other impairment, sickness, [or] injury in [the] past five years."[42] Prior to his application, the insured had some problems with his left eye, which he attributed to an automobile injury. His death was caused by a brain tumor. The jury found that the statements in the insured's application were false, but that he had not intended to deceive the insurer. Consequently, the court held that the insurer had failed to obtain a favorable finding on intent, a necessary element of its defense. Additionally, the court held that the insurer had not relied upon the insured's statements. Prior to issuing its policy, the insurer had the insured examined by its doctor, who reported the eye problem. The court indicated that since the insurer knew that the insured's statements were false, it could not have been misled by them.

Intent also played a role in the outcome of *First Continental Life & Accident Co. v. Bolton.*[43] In an interview with an agent of the insured, Bolton indicated serious prior health problems. The agent completed the application but omitted this information. Bolton signed the application, and the policy was issued with a copy of the complete application attached. The jury found that in the application for insurance, material untrue statements were made, but that Bolton did not know that they were untrue. The jury

40. TEX. INS. CODE ANN. art. 3.50, § 2(3) (1963).
41. 522 S.W.2d 696 (Tex. Civ. App.—Dallas 1975, writ ref'd n.r.e.).
42. *Id.* at 697.
43. 524 S.W.2d 727 (Tex. Civ. App.—Houston [14th Dist.] 1975, writ ref'd n.r.e.).

did not answer special issues inquiring whether the statements were made willfully or whether the insurer relied upon them. Based upon the verdict, the beneficiary was awarded the proceeds of the policy, the statutory penalty, and attorneys' fees. The court of civil appeals reversed and remanded, since under the rule of *Odom v. Insurance Co.*[44] an insured is conclusively presumed to have knowledge of the contents of any application signed by him. Thus, Bolton was charged with knowledge of the incorrect statements in his insurance application. However, the insurer's defense was not established as a matter of law because the jury had not made a finding on the issue of intentional misrepresentation. Consequently, the case was remanded for a new trial.

Beneficiaries. Several cases dealt with beneficiary designations and the procedure for changing beneficiaries. The Corpus Christi court of civil appeals held in *Box v. Southern Farm Bureau Life Insurance Co.*[45] that a court-approved settlement agreement, in which a divorced husband agreed not to change the beneficiaries of his life insurance policy without his former wife's consent, gives the designated beneficiaries a "vested, equitable interest" in the proceeds of the policy. Box was divorced in 1964. In the property settlement agreement approved by the court and made a part of the judgment, he agreed that his existing life insurance policy would be kept in force, that the beneficiaries would be the children of the dissolved marriage, and that the beneficiaries would not be changed without the consent of his ex-wife. In 1968, Box changed the beneficiary designation to "Doris F. Bird, friend," whom he subsequently married. In this interpleader action, the trial court, without a jury, awarded the policy proceeds to the children of the first marriage and denied any recovery to the second wife. Additionally, the court found the insured's estate liable to the children in the amount which the insured had borrowed on the policy prior to his death. The court of civil appeals affirmed.

Sanders v. Great American Reserve Insurance Co.[46] also involved a dispute between an insured's widow and his ex-wife. After he married his second wife, Jessie Mae, Nathaniel Sanders was issued an insurance certificate under a group policy, with his ex-wife, Violet, as the named beneficiary. All premiums on the policy were paid during his marriage to Jessie Mae. Apparently Violet was made beneficiary because the insured was delinquent in his child support payments to the five minor children of his marriage to Violet. In this interpleader action, the trial court awarded the proceeds of the policy to Violet, and granted attorneys' fees to Great American. Violet appealed, complaining that Great American had not been justified in its refusal to pay her, so that it was not entitled to attorneys' fees, but rather Violet was entitled to a penalty and attorneys' fees. The court of civil appeals agreed, and reversed and remanded, holding that an investigation would have revealed that Jessie Mae had no valid claim, so the insurer was not justified

44. 455 S.W.2d 195 (Tex. 1970).
45. 526 S.W.2d 787 (Tex. Civ. App.—Corpus Christi 1975, writ ref'd n.r.e.).
46. 525 S.W.2d 956 (Tex. 1975).

in refusing to pay the proceeds to the named insured, who was also in possession of the certificate. The Texas Supreme Court, however, reversed the court of civil appeals and affirmed the judgment of the trial court. It held that Jessie Mae's claim, given the facts that she was Nathaniel's wife when he took out the certificate of insurance, when all premiums were paid, and when he died, was of possible validity since the policy was purchased with community funds and the purchase could have constituted constructive fraud against Jessie Mae. The supreme court thus concluded that interpleader was properly invoked by Great American, that it was entitled to an award for attorneys' fees, and that the fact that it filed the interpleader action thirty-seven days after the demand for payment was not so unreasonable as to justify the imposition of a statutory penalty.

Gladding v. Prudential Insurance Co. of America[47] found that the insured had substantially complied with the procedure for changing her beneficiary, under a group life insurance policy, from her ex-husband to her parents. Shortly after her divorce in August of 1970, she filled out the form to designate her parents. The form was checked, signed, and forwarded by her supervisor to the New York office of IBM, her employer. The New York office received the form, but returned it for corrections so as to show the full names of the intended beneficiaries. In November, the insured was killed in an automobile accident. After her death, the returned form and a new form, filled out but not signed, were found in the insured's desk. By directed verdict, the trial court awarded the policy proceeds to the parents rather than to the ex-husband. The court of civil appeals affirmed on the theory that the insured had substantially complied with the requirements of the policy for changing beneficiaries.

In *Stewart v. Mutual Benefit Life Insurance Co.*[48] the insureds brought suit to require the insurer to record a requested change in beneficiary. The Stewarts submitted to the company a request that the beneficiary of the policy on Mrs. Stewart's life be designated one-half to Mr. Stewart, if living, otherwise to his estate, and one-half to a testatmentary trust created under Mrs. Stewart's will. Further, the request specified in detail a method of payment, stating that such payment would release the company of liability and that no obligation was placed upon the insurer that the insureds were not legally entitled to impose. After some attempt to negotiate changes in the submitted request, the insurer refused to record the requested change of beneficiary. The policy allows the insured "[f]rom time to time, upon request satisfactory to the Company" to change beneficiaries.[49] The court of civil appeals held that this provision does not require the consent of the company for a change, but simply permits the company to refuse to accept a change of beneficiary if such is contrary to the express conditions of the policy or to the law. Since the Stewarts' request merely reiterated some of the procedures provided in the policy for paying benefits and did not alter the policy, the insurer was required to record the requested change. Since

47. 521 S.W.2d 736 (Tex. Civ. App.—Houston [1st Dist.] 1975, writ ref'd n.r.e.).
48. 522 S.W.2d 257 (Tex. Civ. App.—Amarillo 1975, writ ref'd n.r.e.).
49. *Id.* at 15.

the trial court had granted the insurer's motion for summary judgment and denied the insureds' motion, the court of civil appeals reversed and rendered judgment for the insureds.

Good Health Requirement. In two cases, Texas courts analyzed the interplay between the good health requirement and evidentiary requirements. In *Reliable Life Insurance Co. v. Williams*[50] the Beaumont court of civil appeals held that although a lay witness testified that the insured appeared to be in good health, the medical evidence conclusively established that on the date the policy was issued the insured was suffering from a serious disease which eventually resulted in his death. Consequently, under the provision that the policy becomes effective only if the insured is in good health on the date the policy is issued, the insurer was not liable to pay any benefits. In *National Old Life Insurance Co. v. Garcia*[51] the insured sought disability benefits because of blindness and the insurer raised the good health defense. The jury found that at the time the policy was issued the insured was in good health. Good health was defined in pertinent part to mean "state of health free from any disease or bodily infirmity of substantial nature which . . . materially increases risk to be assumed by the insurance company."[52] At the time the policy was issued, Mr. Garcia was having no vision problems and his eyesight had been tested to be 20/200. The court of civil appeals held that Mr. Garcia's degree of blindness constituted, as a matter of law, a bodily infirmity of a substantial nature which constituted a materially increased insurance risk. Since the infirmity of blindness is measureable as to degree and since such measurement is controlling when applied to the determination of whether the degree of risk is materially increased, this case was found to be distinguishable from *Coxson v. Atlanta Life Insurance Co.*,[53] in which the Texas Supreme Court refused to treat as conclusive expert medical testimony that the insured was not in good health because he was suffering from tuberculosis.

Policy Exclusions. Various exclusions in life and accident policies were found inapplicable to defeat coverage in three cases. *Southwestern Life Insurance Co. v. Rowsey*[54] involved the interpretation of a partial aviation exclusion endorsement in a life insurance policy. Coverage was provided only if death occurred as a result of travel or flight "exclusively as a passenger . . . in a duly registered and certified passenger aircraft being legally operated."[55] Rowsey was killed in the crash of a private aircraft having two tandem seats. The aircraft was registered with the Federal Aviation Administration, which had issued it a "Special Airworthiness Certificate" classifying the airplane as "experimental" for purposes of "Exhibition, Racing and Research & Development." However, the FAA does not classify any planes as "certified passenger aircraft." Since the term was not further defined

50. 514 S.W.2d 768 (Tex. Civ. App.—Beaumont 1974, no writ).
51. 517 S.W.2d 621 (Tex. Civ. App.—Fort Worth 1974, writ ref'd n.r.e.).
52. *Id.* at 624.
53. 142 Tex. 544, 179 S.W.2d 943 (1944).
54. 514 S.W.2d 802 (Tex. Civ. App.—Austin 1974, writ ref'd n.r.e.).
55. *Id.* at 804.

in the policy, it was given its ordinary meaning: an aircraft capable of carrying passengers. Consequently, Mr. Rowsey's death was not excluded by the aviation endorsement, and the court of civil appeals affirmed the trial court's judgment for the plaintiff.

In *Tuttle v. Gamble Alden Life Insurance Co.*[56] the insured was killed by being pinned in his pickup truck when it caught fire. The policy excluded coverage for any loss caused or contributed to by "carbon monoxide gas." Medical testimony indicated that Tuttle died from the inhalation of carbon monoxide gas caused by the fire. Distinguishing cases in which carbon monoxide gas escaped from a faulty gas heater and from a faulty automobile exhaust system, the court reasoned that the carbon monoxide gas in the instant case resulted as a chemical reaction in the natural and probable chain of events following a fire, and death by fire in an automobile is a covered risk under the policy. Consequently, under these circumstances, the carbon monoxide exclusion did not operate to deny coverage.

In *Life Insurance Co. of North America v. Spradlin*[57] the court affirmed a summary judgment for the insured, holding an exclusionary clause to be ambiguous. The insurer had issued an accident policy to Spradlin's employer. The policy excluded coverage for passengers in an aircraft owned or operated by an insured, a member of his household, or the policyholder. Spradlin was killed in the crash of an aircraft owned by his employer's president, an insured under the policy. The trial court granted Mrs. Spradlin's motion for summary judgment. The court of civil appeals, relying on an Eighth Circuit opinion,[58] affirmed, holding the policy exclusion to be ambiguous, and thus subject to an interpretation favorable to the insured.

Conversion Rights. An analysis of conversion rights figured prominently in two cases decided during this reporting period. In *First National Bank v. Protective Life Insurance Co.*[59] the Fifth Circuit considered the availability of conversion options once the policy is allowed to lapse. Robinson purchased a $100,000 life insurance policy in 1965 and subsequently transferred title, in trust, to the First National Bank. Robinson failed to pay the premiums and the policy lapsed. Coverage continued under the automatic operation of the extended term, non-forfeiture provision of the policy. However, the bank tried to exercise the policy's conversion option and the insurer refused to allow conversion. The bank then elected the $10,000 paid-up insurance option under the non-forfeiture provisions. After Robinson died, the bank brought suit for $100,000, claiming that the insurer had breached its contract. The trial court entered judgment for the bank in the amount of $10,000 and the Fifth Circuit affirmed, holding that after the policy lapsed, the conversion options were no longer available.

In *Occidental Life Insurance Co. v. Hurley*[60] the insurer issued a life insurance policy to Mrs. Hurley in 1964. Under a rider, her minor daughter,

56. 385 F. Supp. 1352 (N.D. Tex. 1974).
57. 526 S.W.2d 625 (Tex. Civ. App.—Fort Worth 1975, writ ref'd n.r.e.).
58. Iowa-Des Moines Nat'l Bank v. Insurance Co. of North America, 459 F.2d 650 (8th Cir. 1972).
59. 511 F.2d 731 (5th Cir. 1975).
60. 513 S.W.2d 897 (Tex. Civ. App.—Amarillo 1974, no writ).

Laura, was afforded $1,000 term life and given an option to exchange the policy for five times as much coverage at age twenty-one. In 1970 Laura turned twenty-one and converted the policy. In 1972 less than two years after the issuance of the converted policy, Laura died by suicide. Both the original policy and the converted policy contained a suicide clause that denied coverage if the insured committed suicide within two years of the policy date. In entering judgment for the beneficiary, the trial court held, as a matter of law, that the suicide clause in the converted policy was a continuation of the prior clause in the policy issued to Laura's mother so that the two years began to run when the original policy was issued. The court of civil appeals affirmed, holding that the new policy was issued in accordance with the terms of the exchange rider of the original policy so that the rights and obligations were fixed by the prior contract and simply effectuated by the conversion.

Hospitalization and Medical Policies. Three cases decided miscellaneous questions under hospitalization-medical policies. In *Troy v. Mutual Life Insurance Co.*[61] the insurer was allowed to offset against payment of a claim covered under the policy the amount which it previously and erroneously had paid on a claim that was not covered under the policy. In *Group Hospital Service, Inc. v. State Farm Insurance Co.*[62] the court of civil appeals upheld a hospitalization and medical insurer's right of subrogation against a tortfeasor's liability insurer for the amount of hospital and medical payments made to its insured as a result of the tortfeasor's negligence. In *Zimmerman v. National Home Life Insurance Co.*[63] the court of civil appeals held that although a nursing home had a "hospital" facility nearby and available, it was not a hospital as that term was defined in a hospitalization indemnity policy, so the insured was not entitled to policy benefits during his confinement therein.

Limitations. In *Proctor v. Southland Life Insurance Co.*[64] the insured brought suit for total disability benefits. The insurer raised policy defenses, including the bar of limitations since suit was brought more than three years (the limitation period specified in the policy) after the injury that caused the disability. The trial court granted the insurer's motion for summary judgment. The court of civil appeals reversed, holding that since the disability was continuous, the period of disability would be treated as a single unit and no portion of the insured's cause of action was barred simply because suit was brought more than three years after the inception of the disability.

Accidental Injury. In *Ritchie v. John Hancock Mutual Life Insurance Co.*[65] the court of civil appeals reaffirmed the adage that crime does not pay. The insured sued for his son's medical expenses incurred as a result of a gunshot wound. The son was shot during the commission of a crime to which he

61. 514 S.W.2d 822 (Tex. Civ. App.—Dallas 1974, no writ).
62. 517 S.W.2d 897 (Tex. Civ. App.—Eastland 1974, no writ).
63. 517 S.W.2d 842 (Tex. Civ. App.—Waco 1974, writ ref'd n.r.e.).
64. 522 S.W.2d 261 (Tex. Civ. App.—Fort Worth 1975, writ ref'd n.r.e.).
65. 521 S.W.2d 367 (Tex. Civ. App.—Waco 1975, no writ).

later pleaded guilty. The insurer asserted the defense that the injury was not accidental. The trial court granted the insurer's motion for summary judgment and the court of civil appeals affirmed, holding that under the circumstances the son could reasonably have anticipated his injuries since he had been warned that his pursuer had a gun before he began to run; therefore, his injuries were not accidental.

Credit Life Insurance. American Capitol Insurance Co. v. Karnes County Savings & Loan Ass'n[66] involved the question of whether James Colvin was an eligible borrower when his certificate of insurance was issued. Colvin had an outstanding loan with Karnes County Savings on May 26, 1972, when the insurer issued its master policy to Karnes County Savings. On September 27, 1972, Colvin was issued a certificate under the policy. When he died in 1973, the insurer refused to pay, and suit was brought. In its definition of "elegible borrowers" who were entitled to coverage, the policy included present borrowers with "their present loans not in default on the effective date of this group policy and for exactly seven (7) days thereafter."[67] Karnes County Savings and the executrix of Colvin's estate argued that Colvin qualified under this provision since his loan was not in default on the date the master policy was issued, nor was it in default within seven days thereafter, so that he was eligible to receive a certificate even if it was not issued until several months after the master policy. However, in reversing and remanding the court of civil appeals agreed with the insurer that the policy provision provided for an enrollment period, as allowed by the Texas Insurance Code,[68] of seven days in which present borrowers must be issued certificates. Since Colvin was not issued a certificate within seven days of the issuance of the master policy, he was not an eligible borrower unless he could qualify under some other provision of the policy, which he was unable to do. Karnes County Savings and the executrix of Colvin's estate further argued that the insurer waived any condition precedent by issuing a certificate to Colvin more than seven days after the master policy was issued. At the time the master policy was issued, Colvin had a certificate from a prior insurer which was kept in effect for the short time until his new certificate was issued. Mr. Colvin continued to be charged monthly for credit life insurance. Although waiver cannot create a new and different contract, the court of civil appeals found that the meager summary judgment proof did not rule out waiver as a matter of law and remanded the cause for trial on the merits.

III. FIRE AND CASUALTY INSURANCE

Subrogation. McBroome-Bennett Plumbing, Inc. v. Villa France, Inc.[69] presented the novel question of whether a subcontractor is a co-insured under a builder's risk policy issued to an owner/general contractor. Westchester

66. 526 S.W.2d 688 (Tex. Civ. App.—San Antonio 1975, writ dism'd).
67. *Id.* at 690.
68. TEX. INS. CODE ANN. art. 3.53, § 5 (Supp. 1975-76).
69. 515 S.W.2d 32 (Tex. Civ. App.—Dallas 1974, writ ref'd n.r.e.).

Fire Insurance Company issued a builder's risk policy to Villa France, the owner and general contractor of an apartment house under construction. Subsequently, Villa France hired McBroome-Bennett as a plumbing subcontractor. McBroome-Bennett's employees negligently caused a fire which damaged the apartment building in an amount in excess of $15,000. Westchester paid Villa France for the damage and brought this suit in Villa France's name against McBroome-Bennett. McBroome-Bennett contended that it was an unnamed co-insured party under the policy and counterclaimed for the balance due on its subcontract and for the value of its tools that were destroyed in the fire. Based on stipulated facts, the trial court awarded Westchester the amount of the loss, allowed McBroome-Bennett its counterclaim on the subcontract, but denied McBroome-Bennett's claim for the loss of its tools. Villa France was the only insured named in the policy; however, the policy covered "property of the assured or property for which the assured is liable" at the apartment house complex.[70] McBroome-Bennett contended that it was an unnamed co-insured because it had the following property interests within the coverage of the contract: its tools in the building, its work that was destroyed by the fire for which it had not been paid, and its security interest in the entire project for the balance due under its contract. If McBroome-Bennett was a co-insured under the policy, then Westchester could not assert as a subrogee rights of one insured against another insured. However, the court of civil appeals rejected this argument and affirmed the trial court by holding that McBroome-Bennett was not a co-insured under the policy. The court concluded that the policy insured the subcontractor's property to the extent that Villa France was liable for it, but that the policy did not make the negligent subcontractor a co-insured so as to prevent the insurer from seeking reimbursement for the loss paid to its assured. Justice Guittard dissented, pointing to out-of-state authority that language such as "for which the insured is liable" creates insurance coverage which attaches to the property for the benefit of the unnamed owners, and does not merely indemnify the named assured against liability to the owner.[71]

Insured Risks. Several cases have construed policy terms to determine which risks are included and excluded from coverage under the policy. *Glens Falls Insurance Co. v. Covert*[72] involved a policy insuring Covert's business and premises "against all risk of physical loss or damage." A number of vehicle safety stabilizers owned by Covert fell from a shelf to the floor. These stabilizers were sealed units which could not be inspected for internal damage. Subsequently, the manufacturer of the stabilizers withdrew its warranty and Covert decided not to attempt to sell the stabilizers without the warranty. The trial court, without a jury, entered judgment for Covert, but the court of civil appeals reversed and rendered, holding that there was no evidence that the property in question had suffered physical loss or damage.

Transamerica Insurance Co. v. Raffkind[73] involved the definition of "sur-

70. *Id.* at 35.
71. *Id.* at 41.
72. 526 S.W.2d 222 (Tex. Civ. App.—Beaumont 1975, writ ref'd n.r.e.).
73. 521 S.W.2d 935 (Tex. Civ. App.—Amarillo 1975, no writ).

face water" under a homeowner's policy. Water seeped under plaintiff's house and collected in underground heat and air conditioning ducts so as to cause excessive humidity, which damaged the interior of the house. The policy excluded coverage of loss caused by or resulting from "surface water." Based on a jury verdict, the trial court entered judgment for the insured. The court of civil appeals affirmed, holding that plaintiff's damages were not caused by "surface water" since the water in question had soaked into the soil, thereby losing its character as surface water.

In *Allen v. Manhattan Fire & Marine Insurance Co.*[74] plaintiff's truck was damaged by an "implosion," which the parties defined as an internal collapse followed immediately by an outward rush of air. The policy insured against losses from explosions. The court of civil appeals affirmed the trial court judgment for the insurer, holding that an implosion was not an explosion within the meaning of the policy.

In *Crocker v. Gulf Insurance Co.*[75] the court considered whether a motorcycle was an automobile as defined in a homeowner's policy. Although the court could find no cases construing this term in the context of a homeowner's policy, it concluded that the policy definition of automobile included a motorcycle.[76]

Insurable Interests. In *Hinojosa v. Allstate Insurance Co.*[77] plaintiff brought suit under a homeowner's policy to recover for fire damage. The insurer contended that plaintiff had no insurable interest in the property, attaching as an exhibit to its motion for summary judgment a copy of a deed to the subject property, dated approximately one month prior to the loss, from Hinojosa to a third party. The trial court granted the insurer's motion. The court of civil appeals reversed and remanded, holding that the certified copy of the deed did not establish as a matter of law that plaintiff had no insurable interest in the property in question. There was no provision in the policy invalidating the policy upon change of ownership, so a question of fact was presented as to whether Hinojosa had an insurable interest in the property at the time of the fire.

Liability of Agent. Trinity Universal Insurance Co. v. Fuller[78] involved an insurance agent's liability to his principal for failure to reduce the coverage of a policy. The agent issued a policy to the insured in the amount of $25,000. The insurer subsequently instructed the agent to reduce the amount of coverage to $10,000. The agent failed to do so and the insured suffered damage to its building in the amount of $24,000. The trial court found that the agent was not liable to the insurer, but the court of civil appeals reversed and rendered, holding that the agent breached its contract with

74. 519 S.W.2d 706 (Tex. Civ. App.—El Paso 1975, no writ).
75. 524 S.W.2d 566 (Tex. Civ. App.—Texarkana 1975, no writ).
76. *Compare* Agricultural Workers Mut. Auto Ins. Co. v. Baty, 517 S.W.2d 901 (Tex. Civ. App.—Tyler 1974, writ ref'd n.r.e.), *discussed in* text accompanying note 13 *supra*, in which a motorcycle was held not to be an automobile in the context of an exclusion to a liability policy.
77. 520 S.W.2d 936 (Tex. Civ. App.—Amarillo 1975, no writ).
78. 524 S.W.2d 335 (Tex. Civ. App.—Dallas 1975, writ ref'd n.r.e.).

the insurer and that the insurer's failure to mitigate damages by taking action to cancel or reduce the limits of the policy was no defense.

Proof of Loss. In *Tompkins v. Southern Lloyds Insurance Co.*[79] plaintiff sued for fire damage to his home and household goods, claiming a loss of $19,607.93. The insurer had paid $13,130.89 and admitted that it owed an additional $1,423.00, which the insured had refused to accept, but urged that such was the limit of its liability. The jury found that it would reasonably cost $6,505.09, in addition to the $13,130.89 already paid, to repair the damage to plaintiff's property. After the fire, plaintiff had signed a proof of loss indicating his loss to be $13,130.89. He also signed a statement acknowledging that his supplemental claim would not exceed $1,423.00. The insurer contended that by signing these forms the plaintiff settled all claims under the policy. The trial court agreed and granted defendant's motion for judgment notwithstanding the verdict; however, the court of civil appeals reversed and rendered, holding that a proof of loss is not evidence of the extent of loss and that the forms signed by plaintiff did not constitute releases.

Appraisal. In *Standard Fire Insurance Co. v. Fraiman*[80] the insured sought a declaratory judgment to enforce the appraisal provision of a fire insurance policy. The insured suffered fire loss and had requested the insurer to appoint an appraiser to determine the replacement cost of the damaged property. The insurer refused to do so. The trial court granted the insured's motion for summary judgment and required the insurer to appoint an appraiser. The insurer's primary argument was that the appraisal provided for in the policy was really an arbitration proceeding which, by statute, is unenforceable in Texas,[81] so that the common law principle that an agreement to enter into arbitration may be revoked by either party prior to an award governs. In affirming, the court of civil appeals rejected this argument, holding that the appraisal clause was not a provision for arbitration. Finding no Texas cases which had considered whether the insured may compel an appraisal, the court turned to out-of-state authorities and adopted the majority rule, holding that appraisal provisions in insurance contracts are specifically enforceable by either the insurer or the insured.

79. 515 S.W.2d 395 (Tex. Civ. App.—Eastland 1974, writ ref'd n.r.e.).
80. 514 S.W.2d 343 (Tex. Civ. App.—Houston [14th Dist.] 1974, no writ).
81. TEX. REV. CIV. STAT. ANN. art. 224 (1973).