



January 1979

Insurance Law

Arno W. Krebs Jr.

Recommended Citation

Arno W. Krebs, *Insurance Law*, 33 Sw L.J. 303 (1979)
<https://scholar.smu.edu/smulr/vol33/iss1/11>

This Article is brought to you for free and open access by the Law Journals at SMU Scholar. It has been accepted for inclusion in SMU Law Review by an authorized administrator of SMU Scholar. For more information, please visit <http://digitalrepository.smu.edu>.

INSURANCE LAW

by

Arno W. Krebs, Jr.*

I. LIABILITY INSURANCE

Personal Injury Protection Coverage. During the past year the Texas Supreme Court and the courts of civil appeals had several occasions to interpret the scope of personal injury protection (PIP) coverage provided by automobile liability policies issued in accordance with article 5.06—3 of the Texas Insurance Code.¹ In most of these cases the courts chose not to extend previous interpretations of medical payment and uninsured motorist provisions of automobile liability policies to PIP coverage.

In *Sterling v. United States Fidelity & Guaranty Co.*² the Beaumont court of civil appeals decided two previously unresolved questions concerning PIP coverage. The insured, Sterling, was killed instantly while operating one of two automobiles owned by him, both of which were covered by policies issued by the United States Fidelity & Guaranty Company. The insurer paid for funeral expenses, but refused to pay any benefits for loss of income caused by the death of the insured. While PIP coverage includes the “payment of benefits for loss of income as a result of the accident,”³ the policy approved by the Board of Insurance provides that benefits are to be paid for the insured’s loss of income only while he is living. The *Sterling* court held that the board’s approval of the inclusion of the words “while living” in the policy was consistent with the statute, reasoning that the legislature intended to provide funeral expenses if death resulted and benefits for loss of income if disability resulted.

The court in *Sterling* also answered the more important question whether benefits provided by PIP coverage on two separate cars may be “stacked,” in which case the insured would be allowed to combine the policy limits for each of the cars in determining his maximum recovery. Although medical payment coverage can be aggregated in this fashion,⁴ the court refused to allow stacking of PIP coverage. From a reading of the PIP endorsement, the two or more automobiles provision appearing elsewhere in the policy was clearly inapplicable to PIP coverage; thus, the ambiguity

* B.A., Texas A&M University; LL.B., University of Texas. Attorney at Law, Fulbright & Jaworski, Houston, Texas.

1. TEX. INS. CODE ANN. art. 5.06—3 (Vernon Pam. Supp. 1963-78).

2. 555 S.W.2d 889 (Tex. Civ. App.—Beaumont), *opinion on motion for rehearing*, 564 S.W.2d 779 (Tex. Civ. App.—Beaumont 1977, no writ).

3. TEX. INS. CODE ANN. art. 5.06—3 (Vernon Pam. Supp. 1963-78).

4. *Harlow v. Southern Farm Bureau Cas. Ins. Co.*, 439 S.W.2d 365 (Tex. Civ. App.—Austin 1969, writ ref’d n.r.e.); *Southwestern Fire & Cas. Co. v. Atkins*, 346 S.W.2d 892 (Tex. Civ. App.—Houston 1961, no writ).

that allowed aggregation of medical payments was not present. The statute limited recovery to not in excess of "\$2,500 for all benefits, in the aggregate, for each person."⁵

This common-sense construction of the PIP statute was again applied in *Holyfield v. Members Mutual Insurance Co.*⁶ The insured in *Holyfield* paid separate premiums on two automobiles, but his son was injured while riding a motorcycle upon which no PIP premiums had been paid. The policy excluded recovery for injuries sustained in a vehicle owned by insured which was not an "insured motor vehicle," and defined an "insured motor vehicle" as one upon which a specific premium for personal injury protection was paid.⁷ Since the motorcycle was not described or listed in the policy and no specific premium was charged to insure its operators, the court of appeals affirmed the trial court's denial of coverage. In so doing, the court refused to follow *Western Alliance Insurance Co. v. Dennis*,⁸ in which the Texarkana court reasoned that an exclusion relating to PIP coverage was an unlawful restriction of the coverage provided by the statute. In *Holyfield* the Dallas court stated that although the statute sets forth what type of coverage must be provided,⁹ it neither dictates which vehicles must be covered nor prevents the insurer and the insured from agreeing on coverage of only certain vehicles.¹⁰ The supreme court, in a per curiam opinion refusing *Holyfield's* application for writ of error, expressly disapproved the *Dennis* decision.¹¹

In *Unigard Security Insurance Co. v. Schaefer*¹² the question addressed was whether endorsement 119, which allows the insured to exclude a particular driver from the coverage provided by the main provisions of the policy, also excluded the specified driver from PIP benefits that are provided under endorsement 243.¹³ The court held that endorsement 119 is actually an exclusion and is, thus, not applicable to PIP coverage by virtue of the "conditions" section of endorsement 243.¹⁴ Furthermore, the court stated that even if endorsement 119 was not inapplicable because of the terms of endorsement 243, it would still be insufficient as a partial rejection of PIP coverage. Endorsement 119 is written in broad language, not spe-

5. 564 S.W.2d at 780.

6. 566 S.W.2d 28 (Tex. Civ. App.—Dallas), writ *ref'd n.r.e. per curiam*, 572 S.W.2d 672 (Tex. 1978).

7. Specifically, the policy covered "[a]n automobile described in the policy to which bodily injury liability coverage applies and for which a specific premium charge indicates that personal injury protection is afforded." 566 S.W.2d at 29 (emphasis by the court).

8. 529 S.W.2d 838 (Tex. Civ. App.—Texarkana 1975, no writ).

9. TEX. INS. CODE ANN. art. 5.06—3(a) (Vernon Pam. Supp. 1963-78).

10. The insurer always should be entitled to set out accurately in the policy the risks insured against and to charge a premium based on those risks. Refusing to allow the insurer this freedom would undermine the current method of setting insurance premiums on the basis of the risks insured against.

11. 572 S.W.2d at 673.

12. 572 S.W.2d 303 (Tex. 1978).

13. Endorsement 243 is the PIP form promulgated by the Board of Insurance.

14. This portion of endorsement 243 provides: "'None of the insuring agreements, exclusions or conditions of the policy shall apply to the insurance afforded by this endorsement' (Emphasis added.)" 572 S.W.2d at 306.

cifically mentioning personal injury protection, and as a matter of public policy, PIP coverage is to be provided unless specifically rejected in writing. In this case the court refused to allow the broad exclusion under endorsement 119 to qualify as a specific rejection of the coverage.

The supreme court noted that in *Greene v. Great American Insurance Co.*¹⁵ a 119 endorsement was held effective as a partial rejection of uninsured motorist coverage. The court, however, distinguished this case because of the differences that exist between the uninsured motorist act and the personal injury protection act. Nevertheless, because the two coverages share similar public policy aspects, and require a clear and express rejection of coverage, the court disapproved all language in *Greene* contrary to its holding in *Schaefer*.¹⁶

In *Birdow v. Texas Farmers Insurance Co.*¹⁷ the court of civil appeals held that personal injury protection coverage was not subject to the ten-day grace period that is provided for accident and sickness policies.¹⁸ The plaintiffs had not renewed their automobile liability policy, which included PIP coverage. Three days after the expiration of the policy, an accident occurred. Article 3.70—8 of the Insurance Code¹⁹ provides that nothing in the Act regarding accident and sickness insurance shall affect any policy of liability insurance with or without supplementary expense coverage. The court held that the policy issued containing the personal injury protection endorsement was clearly a liability policy with supplementary expense coverage, and therefore was excluded from the grace period described by article 3.70—3(A)(3).

Uninsured Motorist Coverage. Only two cases interpreting uninsured motorist protection coverage merit inclusion in the *Survey*. In *Burson v. Employers Casualty Co.*²⁰ the court was faced with a question concerning the sufficiency of the evidence introduced by the insured to prove the existence of an insurance contract. Instead of offering the policy itself, the insured introduced only the "insurance renewal certificate," which indicated the dates of coverage, that uninsured motorist coverage was provided, and that a premium had been charged for this coverage. The renewal certificate did not indicate that uninsured motorist coverage had been rejected, and the court held that this was sufficient to prove that such coverage existed. The terms of the insurance contract were supplied by article 5.06—1 of the Texas Insurance Code,²¹ of which the court took judicial notice. The court distinguished *Ranger County Mutual Insurance Co. v. Chrysler Credit*

15. 516 S.W.2d 739 (Tex. Civ. App.—Beaumont 1974, writ ref'd n.r.e.).

16. 572 S.W.2d at 308.

17. 568 S.W.2d 206 (Tex. Civ. App.—Waco 1978, no writ).

18. TEX. INS. CODE ANN. art. 3.70—3(A)(3) (Vernon Pam. Supp. 1963-78) provides: "A grace period of . . . [10] days will be granted for the payment of each premium . . . , during which grace period the policy shall continue in force."

19. *Id.* art. 3.70—8.

20. 558 S.W.2d 547 (Tex. Civ. App.—Fort Worth 1977, no writ).

21. TEX. INS. CODE ANN. art. 5.06—1 (Vernon Pam. Supp. 1963-78).

Corp.,²² in which an insurance binder had been found to be insufficient evidence of insurance coverage. *Ranger* was distinguishable because the insurance binder in that case had, by its own terms, expired prior to the date of the loss.

The form of rejection required to exclude uninsured motorist coverage was considered by the court in *Employers Casualty Co. v. Sloan*.²³ The insured initially had individual policies on his automobiles and trucks. Some of the policies provided for uninsured motorist coverage and some contained written rejections of such coverage. Subsequently, all of the policies were cancelled and a fleet policy was issued covering all of the vehicles. This policy contained no endorsement for uninsured motorist coverage, and no premium was charged for the coverage. The insured did sign an application that listed the automobiles that were covered and the types of coverage provided, but failed to execute a written rejection of the uninsured motorist coverage. The insured, however, had orally rejected the coverage. At the time of the accident a second fleet policy had been issued, which similarly did not contain an endorsement or show a charge for uninsured motorist coverage.

The trial court found that the oral rejection was insufficient because rule 10 of the Board of Insurance requires that uninsured motorist coverage be rejected only in writing.²⁴ The insurer contended that an oral rejection was sufficient because the statute does not require a written rejection²⁵ and the Board of Insurance had no authority to promulgate a rule making such a requirement. The court of civil appeals held that since the Board of Insurance has the authority to promulgate rules so long as such rules are not inconsistent with the statutes,²⁶ it can require a written rejection of coverage even though the statutory provision does not so require. The court added that to hold that this coverage could be excluded by oral rejection would do violence to the spirit of the statute and would invite abuses and litigation such as the case before the court. Therefore, the court also rejected the insurer's contention that the insured waived the written rejection requirement of rule 10. The broad language in this opinion indicates that it will be impossible for an insured to waive the requirement of a written rejection of uninsured motorist coverage.

Conditions. During the survey period the Texas courts were again faced with several cases involving the rights of the insured and the duties of the

22. 501 S.W.2d 295 (Tex. 1973).

23. 565 S.W.2d 580 (Tex. Civ. App.—Austin 1978, writ ref'd n.r.e.).

24. *Id.* at 582.

25. TEX. INS. CODE ANN. art. 5.06—1 (Vernon Pam. Supp. 1963-78) provides in this regard:

(1) The coverages required under this Article shall not be applicable where any insured named in the policy shall reject the coverage; provided that unless the named insured thereafter requests such coverage in writing, such coverage need not be provided in or supplemental to a renewal policy where the named insured has rejected the coverage in connection with a policy previously issued to him by the same insurer.

26. *Id.* art. 5.10 (Vernon 1963).

insurer under a liability policy. In *Weaver v. Hartford Accident & Indemnity Co.*,²⁷ a Texas Supreme Court decision, a judgment creditor brought suit against an automobile liability insurer to recover on a judgment previously obtained against an alleged omnibus insured. It was stipulated that the alleged omnibus insured had failed to comply with the provisions of the policy requiring him to forward suit papers. At issue was whether compliance with this policy provision by the named insured eliminated the necessity of compliance by the omnibus insured.

Busch, an employee of the named insured, was involved in an accident while driving a vehicle owned by his employer. The employer's policy was a standard automobile liability policy covering the named insured and any other person using its automobiles with its permission. In March 1971 Weaver, the injured party, filed suit against Busch seeking damages of \$11,000. Busch was served with process in the office of the plaintiff's attorney, but left the papers there. The suit papers were never forwarded to the insurer and no answer was ever filed. Busch testified that he gave a statement to the insurer during its investigation of the accident stating unequivocally that he was not operating the vehicle with the permission of his employer at the time of the accident.

In September 1971 Weaver filed his first amended petition in which he added the employer as a defendant, alleging that Busch was operating the vehicle in the course and scope of his employment, and increased the ad damnum to over \$200,000. Service was had upon the employer, who promptly forwarded the citation and petition to the insurer, and an answer was filed on the insured's behalf. Busch, however, was never served with the amended petition. Subsequently, the injured plaintiff nonsuited the employer and obtained a default judgment against Busch for an amount in excess of the \$100,000 policy limit.

This suit ensued against the insurer on the basis of the default judgment against Busch. At trial the jury found that Busch was operating the vehicle with the permission of the employer, thereby making him an insured. Judgment was rendered for Weaver in the sum of \$100,000. The court of civil appeals reversed and rendered,²⁸ and the supreme court affirmed, holding that since Busch had failed to comply with policy conditions, had stated he was not a permissive user, and had never been served with the amended petition, Hartford was under no duty to defend him voluntarily.²⁹ The supreme court distinguished *Employers Casualty Co. v. Glens Falls Insurance Co.*,³⁰ wherein the court held that timely notice of the accident by the named insured fully satisfied the policy provision requiring notice, making it unnecessary for the omnibus insured to give additional notice. Since the rationale for the notice requirement is to enable the insurer to investigate the circumstances of the accident promptly, while the

27. 570 S.W.2d 367 (Tex. 1978).

28. 556 S.W.2d 117 (Tex. Civ. App.—Beaumont 1977).

29. 570 S.W.2d at 370.

30. 484 S.W.2d 570 (Tex. 1972).

evidence is still fresh, no purpose would be served by requiring the omnibus insured to give additional notice of the same accident. The court stated that a different purpose underlies the requirement that the insured immediately forward suit papers: papers are forwarded to advise the insurer that the insured has been served with process and that the insurer is expected to file a timely answer.³¹ The need for the additional notice of service was evident in the instant case, as Busch was never served with the amended petition that raised the damage plea by almost \$200,000.³²

A vigorous dissenting opinion was written by Justice McGee, with a concurring dissenting opinion by Chief Justice Greenhill. Justice McGee stated that the main purpose of the provision requiring forwarding of suit papers is to make certain that the insurer has the right to control the litigation and defend the suit on the merits, a purpose that is fulfilled when the named insured forwards the papers. It is not clear whether Justice McGee would require the insurer to defend an "omnibus insured" who had not been served merely because the named insured had been served and had forwarded the suit papers to the insurer. Under such circumstances, however, he clearly would require the insurer to defend an omnibus insured who had been served but who had failed to forward the suit papers.

The approach advocated by the dissent would force the insurance company to defend someone who, for reasons known only to the defendant, has failed to forward suit papers. Such a person may have no intention of becoming involved in the lawsuit or of cooperating with either the insurance company or its lawyers. As was stated by the majority, requiring the insurer to defend an alleged omnibus insured who had failed to forward suit papers would place upon the insurer the duty of determining whether such an insured has been served.³³ Further, it might well require the insurer to defend an uncooperative and hostile client.

The decision in *Insurance Company of North America v. ASARCO, Inc.*³⁴ illustrates the difficulty that court and juries have construing the notice provisions in liability policies. An alleged incident occurred on or about October 17, 1973, when William Priebe, an employee of an independent contractor working on the ASARCO premises, allegedly was injured as a result of exposure to chemical fumes. ASARCO's policy provided that "[i]n the event of an occurrence, written notice . . . shall be given by or for the Insured to the Company . . . as soon as practicable."³⁵ Priebe filed suit in October 1974, and ASARCO immediately notified INA, its insurer. This was the first notice INA had received of the occurrence. On November 12, INA advised defense counsel that Lindsey &

31. An additional purpose is to enable the insurer to control the litigation and interpose a defense. 570 S.W.2d at 369.

32. *Id.* at 370. New citation is necessary for a party who has not appeared when the plaintiff, by amended petition, seeks a more onerous judgment than that originally prayed for. *E.g.*, *Sanchez v. Texas Indus., Inc.*, 485 S.W.2d 385 (Tex. Civ. App.—Waco 1972, writ ref'd n.r.e.).

33. 570 S.W.2d at 369.

34. 562 S.W.2d 557 (Tex. Civ. App.—Corpus Christi 1978, writ ref'd n.r.e.).

35. *Id.* at 558.

Newsom would investigate both the accident and possible coverage problems caused by the insured's late notice.

On November 18, the investigator from Lindsey & Newsom visited ASARCO's plant, contacted Hudson, the plant personnel and safety director, and asked to see the information that ASARCO had in Priebe's file. The investigator did not advise Hudson that he was investigating both the accident and the late notice question. Hudson gave the investigator the Priebe file, which included a November 5, 1973, letter from the plant physician to Hudson regarding "a medical-legal problem" arising from the injury allegedly suffered by Priebe.³⁶ After receiving the letter, Hudson had notified the plant manager of its contents and had placed the letter in a folder labeled "William Priebe." This folder had been deposited in the general information file. Upon reading this letter, the investigator did not ask Hudson why a copy of the letter had not been sent to INA. He then toured the ASARCO premises, took several pictures, and left. Approximately two months later the investigator sent a reservation of rights letter to ASARCO, and two weeks after that INA informed ASARCO that it would no longer defend the Priebe suit.

Hudson first became aware that Priebe was actually making a claim against ASARCO on November 18, 1974, when the investigator so informed him. Hudson assumed that the investigator was representing ASARCO's interests and testified that had he known that the investigator was representing another party, INA, he would have given different answers to the questions asked him.³⁷ He further indicated he would not have made his file fully available to the investigator.

It was undisputed that at the time in question Priebe was working at the ASARCO plant. Although several ASARCO employees were working in the same area, none of them reported any incident or unusual occurrence such as Priebe had described to the doctor. An ASARCO employee who supervised the area testified that he would have been in a position to know whether an accident had occurred and that it would not have occurred in the routine, ordinary course of business of the operations at the plant.

The jury found that: (1) ASARCO had given notice as soon as practicable; (2) although INA did not waive the notice provision, it did lead ASARCO to believe that it would not insist upon compliance; and (3) ASARCO relied upon INA's conduct to the extent that it believed that INA would defend the suit without insisting upon compliance with the notice provision.³⁸ The court of civil appeals affirmed, using a questionable line of analysis. The court stated that it was uncontroverted that Priebe

36. *Id.* at 559 n.1. This letter related to a telephone call from Dr. Brown regarding apparent injuries to Priebe caused by his inhaling green gas on the ASARCO premises. Dr. Brown questioned the man's injuries, and according to the letter, thought that he was probably a hysterical, malingering type of individual.

37. *Id.* at 561. There is no indication whether Hudson was asked what answers he would have changed and how he would have changed them, nor whether he could have done so and still truthfully answered the investigator's question.

38. *Id.* at 559.

was an employee of a third party and not under the control of ASARCO. Further, it was conclusively established that no such occurrence had been reported by Priebe or any ASARCO employees to any ASARCO personnel. The "only inkling of such an occurrence"³⁹ stemmed from Dr. Brown's having told the company doctor what Priebe had told him. The letter from the company doctor to the personnel and safety director was determined to be insufficient to put the insured on notice of an event that should have been reported to the insurer.

The court in ASARCO recognized neither the realities of the case nor the realities of our litigious society. There is no evidence that ASARCO made any type of investigation to determine whether an occurrence had taken place that could have resulted in Priebe's alleged injuries.⁴⁰ ASARCO failed to act, even though the company doctor had stated that the problem "might represent a medical-legal problem."⁴¹ Liability insurance is purchased to protect the purchaser from losses caused by his negligent conduct. It is not the insured's decision whether suit will be brought against it; therefore, the insured should not be allowed to make a determination as to what claims or possible claims should or should not be reported to the insurer. Undoubtedly it was questionable whether the incident alleged in ASARCO had occurred. Nevertheless, as those in the legal community recognize, an incident such as the one reported by Priebe frequently results in suits and even judgments.⁴² Once an insured is aware of an incident, or an alleged incident, it should become incumbent upon the insured to give notice to the insurer. It should not be left to the discretion of the insured to determine whether the claim is frivolous, whether there is no liability, or whether the incident did not occur.⁴³ This should be left to the insurer in its investigative and handling capacity, and if suit is filed and litigated, to the trier of fact.

In *Western Casualty & Surety Co. v. Newell Manufacturing Co.*⁴⁴ the insurer defended the insured in spite of the insured's failure to give notice of the accident, raising a question as to who would pay the settlement subsequently agreed to by the insured. The insurer had notified the insured by letter that it had accepted the citation and petition in the suit "under a strict reservation of rights,"⁴⁵ as the insured had failed to give notice of the

39. *Id.* at 561.

40. In *Dunn v. Travelers Indem. Co.*, 123 F.2d 710 (5th Cir. 1941) (interpreting Texas law), the court held an investigation of the alleged incident included not only interviewing all eyewitnesses, but also determining from the claimant himself what he was claiming and what he intended to do.

41. 562 S.W.2d at 559 n.1.

42. 2 R. LONG, *LAW OF LIABILITY INSURANCE* § 13.11, at 13-25 (1978); *see, e.g.*, *Gonzales v. Caterpillar Tractor Co.*, 571 S.W.2d 867 (Tex. 1978). It is extremely doubtful that Caterpillar Tractor Company personnel would have believed that a claim would have arisen when someone slipped off the steps of one of their caterpillars after entering and exiting the unit numerous times. Yet this occurred and resulted in a judgment in excess of \$250,000.

43. 2 R. LONG, *supra* note 42, § 13.12, at 13-27.

44. 566 S.W.2d 74 (Tex. Civ. App.—San Antonio 1978, writ *ref'd n.r.e.*).

45. This letter in part provided:

If at any time we determine that there has been a contractual violation of the

accident. The matter was set for trial, and counsel retained by the insurer appeared on behalf of the insured. After the jury was selected, the counsel for plaintiff offered to settle the matter. At that time the insurer and insured entered into a written agreement whereby the suit would be settled without the insurer's waiving any of its rights under the prior reservation of rights letter. It was also agreed that the insurer's payment of the settlement would not be deemed a waiver, estoppel, or forfeiture of any other rights of the insurer secured by the reservation of rights letter. In the subsequent action to determine which company was responsible for the payment of the settlement, the trial court granted a summary judgment on behalf of the insured, and the court of civil appeals affirmed.

In determining the validity of the reservation of rights the court was faced with a question of first impression in Texas.⁴⁶ Although the insured did not sign the reservation of rights letter, the insurer's offer to defend under the reservation of rights was not rejected. The consent of the insured was inferred from his conduct after receiving notice of the insurer's offer. If, with knowledge of the offer, the insured stands by, expresses no objections, and allows the insurer to defend the action, under the ordinary rules of contract law the consent of the insured is implied. If, on the other hand, the insured refuses to accept the offer of defense under such conditions and so notifies the insurer, the insurer must make a decision either to defend the action or to withdraw.

Even though the court held that the insured's conduct amounted to an acceptance of the terms of the reservation of rights letter, the ambiguities within that letter caused the court to affirm the judgment in favor of the insured. The court stated that the only right clearly retained by the insurer was the right to withdraw from the defense of the suit upon proper notice; the insurer had no right to disclaim liability once the liability of the insured had been established. Because of the ambiguities within the reservation of rights letter, this case should not be considered as authority concerning the rights of the insured or the insurer when there has been a properly drawn reservation of rights letter. When a case is settled out of court the insurer and the insured should be able to reserve their rights to determine who is responsible for the payment of the settlement.⁴⁷

policy conditions, we reserve the right to withdraw upon proper notice to you. Further, we will instigate our initial investigation at once but our investigation is conducted under this reservation afore mentioned [*sic*] and any actions that we may take, either by way of investigation or by way of defense of the pending litigation, shall not be deemed an estoppel of the rights afore mentioned [*sic*]. Further, we must advise that we are requesting your complete cooperation during the investigation that we will hereinafter conduct. . . . Pending further notification from us in writing we will do any and all things to investigate and to protect your interests in accordance with the contractual obligation of the insurance policy.

Id. at 75.

46. The traditional agreement used is a nonwaiver agreement that is executed by both the insurer and the insured.

47. The initial election to defend does not obligate the insurer to furnish a complete and continuing defense. *Consolidated Underwriters v. Loyd W. Richardson Constr. Corp.*, 444

Coverage. In *Ridgway v. Gulf Life Insurance Co.*⁴⁸ judgment creditors brought a garnishment proceeding against the judgment debtor's primary liability carrier, Gulf Insurance Company. The prior judgment had been rendered in a suit involving Holcombe, as driver of a truck, and Barry Trucking Company, Holcombe's employer.⁴⁹ Gulf impleaded Ranger Insurance Company, the umbrella liability carrier for the judgment debtor, demanding that Ranger pay the remaining unpaid portions of the judgment. Gulf argued that its policy covered only Barry, and Ranger, as the umbrella carrier, covered Holcombe; thus, Gulf contended, Ranger should bear ultimate financial responsibility.⁵⁰

In rejecting this argument, the court held that even assuming *arguendo* that Gulf's policy did not cover Holcombe, Gulf's theory completely ignored the scope of Ranger's umbrella liability policy. Ranger's umbrella policy provided that the insured was obligated to obtain comprehensive automobile liability insurance for bodily injury to the limits of \$100,000 as underlying coverage. If the insured failed to carry such insurance, Ranger would be liable only as if the insured had carried it, that is, Ranger would only be liable to the extent that damages exceeded \$100,000.⁵¹

The court, however, found that Holcombe was in fact an "insured" under Gulf's policy. Even though the policy excluded the owner of a hired automobile from coverage,⁵² the main provision of the policy did insure "any person while using an owned automobile or a hired automobile with the permission of the named insured";⁵³ here Barry was the named insured. The court rejected Gulf's contention that the endorsement excluding the owner of a hired automobile excluded Holcombe from coverage. The exclusion was interpreted as eliminating coverage of the owner of a leased vehicle for some condition of the vehicle that might give rise to liability to a third party; it did not apply when the owner negligently operated the vehicle. The court stated that "when the terms of an insurance

S.W.2d 781 (Tex. Civ. App.—Beaumont 1969, writ ref'd n.r.e.). Nevertheless, where the proceedings have gone so far that the interests of the insurer and the insured conflict, and the insured would be prejudiced by the insurer's withdrawal, it has been held that the latter cannot withdraw, even though its rights have been properly preserved. 7A J. APPLEMAN, INSURANCE LAW & PRACTICE § 4694, at 549 (1962).

48. 578 F.2d 1026 (5th Cir. 1978).

49. As the court sets out, the truck that was involved in the accident was owned by Holcombe and leased to Barry Trucking Company for use in its trucking business. Barry then hired Holcombe to drive the truck. This is apparently a common arrangement in the trucking business. *Id.* at 1028 n.1.

50. *Id.* at 1030.

51. *Id.* The court also rejected Gulf's argument that as Holcombe did not procure the underlying insurance, Holcombe was protected by another clause in the Ranger policy that provided a retained limit of \$25,000 for losses not covered by underlying insurance; *i.e.*, for certain losses not covered by underlying insurance, the insurer would pay all expenses incurred over \$25,000. "This construction would reduce Ranger's policy to gibberish." *Id.* The court stated that the \$25,000 retained limit clause was included to provide coverage to the insured for less common losses not typically covered by liability insurance. These would include, for example, professional liability, advertiser's liability, blanket contractual liability, world-wide operations liability, and personal injury liability. *Id.*

52. *Id.* at 1031.

53. *Id.*

contract are capable of two or more constructions and under one a recovery is allowable and under the other it is denied, the construction which permits recovery will be given the policy."⁵⁴ Thus, summary judgment was denied Gulf and granted in part for Ranger.

II. PROPERTY INSURANCE

In *Delta Lloyds Insurance Co. v. Southwest Savings Association*⁵⁵ the rights of a mortgagee, Southwest Savings, who had become the owner of property after it was insured, were in question. Delta issued a fire policy with a vandalism endorsement to the original owner. After the issuance of the policy, the mortgagee purchased the property at a foreclosure sale for the amount of the unpaid mortgage. Thereafter a vandalism loss occurred and the insurer denied liability. The jury found the cost of repair to be \$60,000, but found that the mortgagee's failure to protect the property after purchase had caused the loss. On appeal Delta asserted that Southwest could not recover as mortgagee because its purchase of the property had extinguished its mortgage interest prior to the loss and had changed its status to that of an owner. Recovery as an owner was also precluded, however, because Southwest had failed to protect the property as required by the policy. Southwest, on the other hand, contended that its foreclosure should not affect its right to recovery as mortgagee, and that, as the mortgagee, it had no duty to protect the property against loss.⁵⁶

The court held that Southwest's interest at the time of the loss was that of an owner of the property. The court also disagreed with Southwest's contention that since the policy only required the named insured to protect the property, Southwest, as the mortgagee and new owner, had no such

54. *Id.* (quoting *Kelley v. American Ins. Co.*, 160 Tex. 71, 325 S.W.2d 370 (1959)).

The court, following Texas precedent, held that it does not offend public policy for the insurer to be obligated for punitive damages. *Id.* at 1029; *see* *Home Indem. Co. v. Tyler*, 522 S.W.2d 594 (Tex. Civ. App.—Houston [14th Dist.] 1975, writ ref'd n.r.e.) (exemplary damages recoverable under uninsured motorist policy); *Dairyland County Mut. Ins. Co. v. Wallgren*, 477 S.W.2d 341 (Tex. Civ. App.—Fort Worth 1972, writ ref'd n.r.e.) (exemplary damages recoverable under automobile liability policy). The court did note, however, that although the majority of states permit the insured to recover punitive damages under an automobile liability policy, some states hold that such a recovery violates public policy. *E.g.*, *American Sur. Co. v. Gold*, 375 F.2d 523 (10th Cir. 1966) (interpreting Kansas law); *Northwestern Nat'l Cas. Co. v. McNulty*, 307 F.2d 432 (5th Cir. 1962) (interpreting Florida law).

55. 559 S.W.2d 372 (Tex. Civ. App.—Dallas 1977, writ ref'd n.r.e.).

56. The relevant portions of the standard union mortgage clause provided:

This policy, as to the interest of the mortgagee only therein, shall not be invalidated by any act or neglect of the mortgagor or owner of the within described property, nor by any foreclosure or other proceedings or notice of sale relating to the property, nor by any change in the title or ownership of the property, . . . PROVIDED that the mortgagee shall notify this Company of any change of ownership or increase of hazard which shall come to the knowledge of said mortgagee, . . .

Failure upon the part of the mortgagee to comply with any of the foregoing obligations shall render the insurance under this policy null and void as to the interest of the mortgagee.

Id. at 374.

duty. The court held that by becoming the owner of the property, the mortgagee assumes the owner's obligations under the policy, including the obligation to protect the property.

The effect that "other insurance" clauses contained in two fire insurance policies had on a mortgagee was before the court in *United States Fire Insurance Co. v. Stricklin*.⁵⁷ Property covered by two separate policies with similar terms was damaged, and Stricklin, a third-lien mortgagee, sued each carrier, United States Fire and Houston General, in separate actions. Each of the policies contained an "other insurance" clause that was essentially a pro rata clause.⁵⁸ The trial court failed to give effect to the other insurance clause in the United States Fire policy. The court of civil appeals, however, reversed and remanded, holding that the Houston General policy was "other insurance" with respect to the fire. Stricklin argued that the Houston General policy was not other insurance with respect to him because he was named in the United States Fire policy as a mortgagee-payee, but was not so named in the second policy; as to Houston General, Stricklin based his claim to recovery merely on his equitable rights to the proceeds as the mortgagee. Thus, Stricklin contended that he should be able to sue United States Fire for the entire amount, and assign his rights on the Houston General policy to United States Fire. The court, however, agreed with United States Fire's position that Stricklin's interests under both policies were the same because of an assignment of the second-lien mortgagee's rights, thus making nonexistent the distinction urged by Stricklin. In so doing, the court recognized the validity of pro rata clauses.⁵⁹

The court further held that the insured's rights were not governed by *St. Paul Fire & Marine Insurance Co. v. Crutchfield*,⁶⁰ wherein the court held that a mortgagee of property covered by two policies was not bound by an apportionment clause in one of the policies and could recover its entire loss from either insurer, subject to the policy limits. The *Crutchfield* court recognized, however, that the second policy could constitute other insurance, thereby requiring apportionment, if the mortgagee ratified the second policy. The *Stricklin* court held that by asserting a claim against the second insurer, Stricklin had ratified the second policy as a matter of law.

The court further held that the other insurance clause of the second policy did not violate Texas Insurance Code article 6.15.⁶¹ The court stated

57. 556 S.W.2d 575 (Tex. Civ. App.—Dallas 1977), writ *ref'd n.r.e. per curiam*, 565 S.W.2d 43 (Tex. 1978).

58. The clause provided that if at the time of the loss other insurance was available to cover the loss upon the same terms as contained in the instant policy, the company's liability would be limited to the proportion of the loss that the limit of liability under the instant policy bore to the total amount of insurance covering the property. 556 S.W.2d at 578.

59. Their validity in liability insurance policies had previously been recognized in *Traders & Gen. Ins. Co. v. Hicks Rubber Co.*, 140 Tex. 586, 169 S.W.2d 142 (1943), and *Employers Cas. Co. v. Transport Ins. Co.*, 444 S.W.2d 606 (Tex. 1969).

60. 162 Tex. 586, 350 S.W.2d 534 (1961).

61. TEX. INS. CODE ANN. art. 6.15 (Vernon 1963). The relevant portions of this statute provide:

The interest of a mortgagee . . . under any fire insurance contract . . . shall

that even though the act of the owner in obtaining the second policy could not make Stricklin subject to an apportionment or other insurance clause, Stricklin's own act of bringing suit against the second company served as a ratification of that policy and validated the clause. The supreme court in a per curiam opinion ruled on damage and evidence points, but specifically reserved the question of the effect of the mortgagee protection provided by article 6.15.⁶²

Misrepresentation. In *Ranger Insurance Co. v. Bowie*⁶³ a pilot fraudulently obtained a medical certificate from the Federal Aviation Administration (FAA) and used the certificate to procure a property insurance policy on his plane. Suit was brought by the insured pilot's widow to recover for damage to the aircraft caused by a crash in which the insured pilot was killed. The policy provided for coverage only when the aircraft was being piloted by one having valid pilot and medical certificates.⁶⁴ The policy also contained a fraud or misrepresentation provision that provided that the policy was void if the insured concealed or misrepresented any material facts or circumstances concerning the insurance or the subject thereof, or if the insured engaged in any fraud, attempted fraud, or false swearing "touching any matter related to this insurance or the subject thereof."⁶⁵

It was undisputed that the pilot filed a false written application to obtain his medical certificate. In the application he stated that he had never had heart trouble when in fact he had already suffered a heart attack and was taking medication for his heart condition. It was further stipulated that these representations were material to and actually contributed to the accident involved. Furthermore, testimony established that if the FAA had known of the insured's true condition, it would not have issued the certificate and the company would not have issued the policy.

The plaintiff contended that since the insured's certificates had not been amended or cancelled by the FAA, the plane was being operated by a pilot holding a valid and effective medical certificate for purposes of the insurance policy provision. The company contended that when the insured represented to it that only pilots holding valid and effective medical certificates would operate the aircraft, he necessarily represented that he would properly comply with all the requirements for the certificate. Further, the company argued that the policy was void under the fraud provi-

not be invalidated by any act or neglect of the mortgagor or owner of said described property or the happening of any condition beyond his control, and any stipulation and any contract in conflict herewith shall be null and void.

62. 565 S.W.2d 43 (Tex. 1978).

63. 574 S.W.2d 540 (Tex.), *rev'g* 563 S.W.2d 394 (Tex. Civ. App.—Eastland 1978).

64. The insurance policy contained the following clause: "7. PILOT CLAUSE: Only the following pilot or pilots *holding valid and effective pilot and medical certificates* with rating as required by the Federal Aviation Administration for flight involved will operate the aircraft in flight." 574 S.W.2d at 541 (emphasis added by the court).

65. 563 S.W.2d at 395.

sion because the medical certificate had been fraudulently obtained, which constituted fraud "touching" a matter material to the policy.

The court of civil appeals reversed the trial court judgment for the company and rendered judgment for the plaintiff, stating that the broad language used in the fraud provision of the insured's policy was limited by article 21.16 of the Insurance Code.⁶⁶ The court held that this article referred only to statements made in the application or in the contract of insurance; it did not cover statements made to obtain a medical certificate. The court added that there was no express language in the policy excluding coverage in the event the person piloting the aircraft made a false statement to the FAA to procure a medical certificate. Further, the court noted that to be material to the risk, a misrepresentation must induce the insurance company to assume the risk,⁶⁷ a circumstance not present in this case. The stipulation that the false representation was material to the issuance of the medical certificate was not evidence that it was material to the issuance of the policy.

The supreme court reversed the judgment of the court of civil appeals and affirmed the judgment of the trial court. The court did not consider the misrepresentation issue discussed by the court of civil appeals, but instead addressed the question whether the pilot insured satisfied the policy provision requiring a "valid" FAA medical certificate. The court emphasized that the term "valid" has been held to mean legally sufficient and incapable of being rightfully overthrown or set aside.⁶⁸ In the instant case the medical certificate was capable of being set aside because it was obtained only through the misrepresentations of the insured. The mere fact that the certificate had not been cancelled by the FAA did not make it valid, and therefore, under the terms of the policy, the flight upon which this plane was damaged was excluded from coverage.

III. LIFE, HEALTH, AND ACCIDENT INSURANCE

Misrepresentations. In *Robinson v. Reliable Life Insurance Co.*⁶⁹ the supreme court considered

66. TEX. INS. CODE ANN. art. 21.16 (Vernon 1963) (emphasis added) provides: Any provision in any contract or policy of insurance issued or contracted for in this State which provides that the answers or statements made in the application for such contract or in the contract of insurance, if untrue or false, shall render the contract or policy void or voidable, shall be of no effect, and shall not constitute any defense to any suit brought upon such contract, unless it be shown upon the trial thereof that the matter or thing misrepresented was material to the risk *or* actually contributed to the contingency or event on which said policy became due and payable, and whether it was material and so contributed to the contingency or event on which said policy became due and payable, and whether it was material and so contributed in any case shall be a question of fact to be determined by the court or jury trying such case.

67. *E.g.*, *Westchester Fire Ins. Co. v. English*, 543 S.W.2d 407 (Tex. Civ. App.—Waco 1976, no writ); *Harrington v. Aetna Cas. & Sur. Co.*, 489 S.W.2d 171 (Tex. Civ. App.—Waco 1972, writ ref'd n.r.e.).

68. *Edwards v. O'Neal*, 28 S.W.2d 569, 572 (Tex. Civ. App.—Fort Worth 1930, writ *dism'd*).

69. 569 S.W.2d 28 (Tex. 1978).

whether an insurer, in order to avoid liability on a policy of life insurance on the ground of false representations in the application for insurance, must establish both that the misrepresentation was material to the risk undertaken by the insurer *and* that the condition about which the misrepresentation was made contributed to the death of the insured.⁷⁰

The court of civil appeals held that under article 21.16⁷¹ proof of a misrepresentation material to the risk without proof that the condition misrepresented contributed to the loss was sufficient to avoid liability.⁷² The supreme court affirmed.

The misrepresentations were that the insured had not been treated by a doctor within the last five years, had not had any injury, illness, or operation in the past five years, and had never been hospitalized. In fact, he had been afflicted with sickle cell anemia for several years, was under the treatment of a doctor, and had been hospitalized less than two years before the application was submitted. The only evidence as to the cause of death was the death certificate, which stated that there were no signs of violence and that death apparently resulted from natural causes. It was uncontroverted that a prudent insurer would not issue a policy of life insurance on someone afflicted with sickle cell anemia.

Article 21.16 states that a misrepresentation material to the risk "or" actually contributing to the event that made the policy due and payable renders the policy voidable. The court stated there were several Texas cases that apparently held that the representation is not material if it does not contribute to the loss.⁷³ On the other hand, there were other cases that recognized that there is a difference between whether a condition is relevant to the risk assumed by the insurance company and whether it actually causes the loss sustained by the insured.⁷⁴ The plaintiff beneficiary contended that the court should substitute "and" for "or" in the statute, but the court refused to do so, holding that "under Article 21.16 the materiality to the risk must be viewed as of the time of the issuance of the policy rather than at the time the loss occurred."⁷⁵ The controlling question, therefore, was whether the insurer would have assumed the risk if the truth had been known. The uncontroverted facts showed the answer to be in the

70. *Id.* at 28 (emphasis by the court).

71. TEX. INS. CODE ANN. art. 21.16 (Vernon 1963). The text of this article is set forth in note 66 *supra*.

72. *Robinson v. Reliable Life Ins. Co.*, 554 S.W.2d 231 (Tex. Civ. App.—Dallas 1977).

73. *Southern Life & Health Ins. Co. v. Grafton*, 414 S.W.2d 214 (Tex. Civ. App.—Tyler 1967, writ ref'd n.r.e.); *Trinity Reserve Life Ins. Co. v. Hicks*, 297 S.W.2d 345 (Tex. Civ. App.—Dallas 1956, no writ); *National Life & Accident Co. v. Dickinson*, 115 S.W.2d 1180 (Tex. Civ. App.—El Paso 1938, writ dism'd). These cases confuse the requirements by assuming that a representation is not material to the risk if the statement does not contribute to the loss.

74. *Fidelity Union Fire Ins. Co. v. Pruitt*, 23 S.W.2d 681 (Tex. Comm'n App. 1930, holding approved); *Jackson v. National Life & Accident Ins. Co.*, 161 S.W.2d 536 (Tex. Civ. App.—Dallas 1942, writ ref'd w.o.m.).

75. 569 S.W.2d at 30. The court followed *Bettes v. Stonewall Ins. Co.*, 480 F.2d 92 (5th Cir.), *cert. denied*, 414 U.S. 1007 (1973), which expressly held that "or" in art. 21.16 is disjunctive and not conjunctive.

negative. The court also overruled the plaintiff's contention that the policy should not be cancelled because the insured, a sixteen-year-old boy, did not sign the application. The evidence established that the father, who was the beneficiary, dealt with the agent, paid the premiums, and accepted delivery of the policy with the application attached. Under such circumstances, the father must be held to have ratified any false statements in the application.

Insurability. In *Scarborough v. Aetna Life Insurance Co.*⁷⁶ the supreme court interpreted a "continuing treatment" exclusion contained in a group life insurance policy. The exclusion encompassed any expenses incurred by the insured or his family during the first twelve months the insurance was in force for any condition that had necessitated treatment during the three-month period immediately preceding the effective date of the policy. This exclusion defined treatment of a condition as "receiving either medical services or prescribed drugs or medicines."⁷⁷

The policy became effective on June 16. The insured's wife, Mrs. Scarborough, had gone to a gynecologist on June 6 for an annual physical examination, which revealed abdominal adhesions, abnormal ovarian function, and enlarged ovaries. Nothing on that examination revealed that surgery was necessary, but the doctor requested that Mrs. Scarborough return on June 17 for further examination. Although this second examination showed that she had improved, the doctor's written report concluded with a recommendation of an ovarian excision. Mrs. Scarborough subsequently developed abdominal pains, and on June 30 she went to the hospital at the direction of her physician. A third examination verified the previous condition, and surgery was performed the next day.

The jury found that during the three-month period preceding June 16 Mrs. Scarborough did not receive treatment relating to the surgery subsequently performed. The trial court, therefore, awarded the insured's wife recovery of the surgical expenses. On appeal the company contended that since the June 6 examination revealed the condition that necessitated the surgery, that examination was a medical service constituting treatment of a condition under the continuing treatment exclusion. The court of civil appeals reversed and rendered judgment for the company,⁷⁸ relying on *Provident Life & Accident Insurance Co. v. Hutson*,⁷⁹ which defined medical treatment to include not only an operation or prescription of drugs to relieve or cure a patient's condition, but also a preliminary examination given for the purpose of diagnosing an ailment or infirmity.⁸⁰

The supreme court reversed the court of civil appeals, holding that the

76. 572 S.W.2d 282 (Tex. 1978).

77. *Id.* at 283.

78. *Aetna Life Ins. Co. v. Scarborough*, 556 S.W.2d 109 (Tex. Civ. App.—Beaumont 1977).

79. 305 S.W.2d 837 (Tex. Civ. App.—Beaumont 1957, writ ref'd n.r.e.).

80. *See also* *International Travelers Ass'n v. Yates*, 29 S.W.2d 980 (Tex. Comm'n App. 1930, judgment adopted).

exclusion was only applicable if the insured had received treatment for a known condition within the three months preceding the effective date of the policy; a routine physical examination that uncovered a condition subsequently resulting in surgery would not trigger the application of the exclusion. The court distinguished *Hutson* because in that case the medical examination was given for the purpose of diagnosing an ailment, whereas in the instant case the ailment was found during a routine physical examination.

*United Savings Life Insurance Co. v. Coulson*⁸¹ concerned an insurance policy's "good health" clause, which prevented the policy from becoming effective if at the time the policy was delivered the insured was afflicted with a disease that increased the risk under the policy. The insured, a life insurance agent, applied for a policy with his own company. The company rejected him as a standard risk and offered a rated up policy. At that time he did not accept the policy. Subsequently, the insured again applied for a policy with his company, knowing that he would not be accepted as a standard risk due to his high blood pressure. The company again mailed him a rated up policy. Shortly thereafter, he was diagnosed as having heart trouble, and his doctor prescribed nitroglycerin. The insured mailed the premium check, which was dated July 6, on July 5,⁸² at which time the company was unaware of his change of condition. He died on July 6.

The jury found that although there was not a sufficient change in the insured's condition from the date the application was submitted to the date the rated up policy was mailed to affect his insurability, there was such a change from the date the application was submitted to the date he finally mailed the premium. The jury further found that the insured was aware of the change in his condition, knew that it affected his insurability, and realized that it would have medical significance to the underwriting department of his company. Based upon these jury findings, the court of civil appeals reversed the trial court's judgment for the plaintiff and rendered judgment for the insurance company.

In *Dickson v. Minnesota Mutual Life Insurance Co.*⁸³ the court construed the credit life insurance coverage carried by a teachers' credit union. Mrs. Dickson was diagnosed in October of 1972 as having cancer of the colon, and from that time until her death on February 7, 1973, she was on temporary leave of absence from her teaching duties. On January 30, 1973, Mr. and Mrs. Dickson obtained a loan from her credit union in order to purchase a vehicle. Under an agreement with the insurance company, when a member borrowed from the credit union he was automatically covered by insurance for the unpaid balance, provided that he was under the age of seventy and was physically able to perform, or within a reasonable time might be expected to resume, the usual duties of his livelihood. On

81. 560 S.W.2d 211 (Tex. Civ. App.—Amarillo 1977, writ ref'd n.r.e.).

82. Under the policy provisions the mailing of the premium by the insured was an acceptance of the policy, and the policy became effective upon that date. *Id.* at 213.

83. 562 S.W.2d 925 (Tex. Civ. App.—Tyler 1978, no writ).

February 1, the insured's physician examined her and found a large recurrence of cancer. Her pain was so severe that morphine was required, and seven days later she died.

Incredibly, the jury found that the deceased was physically able to perform, or within a reasonable time might have been expected to resume, the usual duties of her livelihood as a school teacher. The trial court entered judgment notwithstanding the verdict and the court of civil appeals affirmed. The court reviewed the evidence, which included lay testimony that in January the deceased was looking fine and was excited about coming back to work. Friends stated that they did not observe anything that would lead them to believe she would be unable to return to work. The insured's husband testified that in his opinion his wife had been making continual improvement, and based upon his observations, he believed that she would return to work.

The court stated that there were no Texas cases involving a similar eligibility clause regarding ability to work, but held that principles of law governing the interpretation of good health clauses were equally applicable in this case. The court stated that although lay testimony may create an issue of fact as to good health, despite uncontroverted medical testimony to the contrary, in the instant case the lay testimony was based solely on observations of physical appearance and light activity. Such evidence was not of sufficient probative value to support the jury's finding. The medical testimony, which showed that the deceased was in a serious state of health and that death was imminent, should have determined the outcome of the case.

*Boone v. United Founders Life Insurance Co.*⁸⁴ was an action instituted to recover under a policy insuring against the entire, irrevocable loss of sight in one eye. In this case two ophthalmologists testified by deposition. The first testified regarding the possibility of a corneal transplant, and stated that due to the surgical risk, the insured did not appear to be interested in the surgery. The second ophthalmologist testified that the chances of improving vision through a corneal transplant were probably greater than fifty percent, but that this opinion should probably be given by the doctor who was going to do the procedure. The trial court held that the loss of sight was not irrevocable because a reasonably prudent person would have submitted to proper medical treatment to seek recovery of the loss of sight, but the court of civil appeals reversed and remanded. The court stated that the evidence at best indicated only the possibility of a successful corneal transplant. The court noted that it was well established that expert medical testimony must be based on "reasonable medical probability" as opposed to mere "possibility," since many outcomes are at least "possible" in the area of medicine.⁸⁵

The court was also faced with the plaintiff's contention that even if a successful corneal transplant was performed, he would still be entitled to recover under the terms of the policy because he would no longer have his

84. 565 S.W.2d 380 (Tex. Civ. App.—Fort Worth 1978, writ ref'd n.r.e.).

85. *Otis Elevator Co. v. Wood*, 436 S.W.2d 324, 331 (Tex. 1968).

sight, but would be seeing out of someone else's eye. The court agreed after noting that this was a case of first impression in Texas. The court followed the Utah case of *Knuckles v. Metropolitan Life Insurance Co.*,⁸⁶ which held that once the sight is completely destroyed, the insured should not be required at his own expense to test the possibilities of recovering his sight since, under the same policy provision, a person who lost his hand or foot would not be required to incur similar expenses. Based on the foregoing, the court held that the trial court's finding that the loss of sight was not irrevocable was against the great weight and preponderance of the evidence. It would be interesting to see whether this court would declare that someone who had had a heart transplant was legally dead and, therefore, able to recover death benefits under a life insurance policy.

The last case to be discussed involving insurability and coverage is *Northwestern National Life Insurance Co. v. Glenn*.⁸⁷ In that case the insured brought suit for benefits under an employee group health and accident policy that was in effect for one year. It contained a provision that in the case of an insured who was totally disabled on the policy termination date, an extension of coverage would be granted for an additional three months or until the cessation of the total disability, whichever occurred first. During the policy period the insured became totally disabled, and her disability continued beyond the termination of the policy. The insurer provided benefits for three months after the policy's termination date. The trial court entered judgment for the insured for additional benefits based upon *Maryland Casualty Co. v. Thomas*,⁸⁸ which held that medical expenses were "incurred" as of the date of the injury that necessitated medical services, whether or not the services were actually rendered and paid for at that time. The court of civil appeals reversed and rendered, holding that since the insured had not contracted for medical care to be paid antecedent to the date coverage terminated, the expenses were not incurred while the policy was in force. The court disagreed with the *Thomas* holding as to when expenses were incurred and distinguished the case on the grounds that in *Thomas* the medical treatment was provided under a price contracted for prior to the policy's termination.

Beneficiaries. In *Odle v. Williamson*⁸⁹ the question was whether the insured had substantially complied with the method for changing beneficiaries provided in the policy. The insured died in an accident approximately a year after a divorce from the named beneficiary. The policy provided that a change of beneficiary would not be binding until written notice of the change was received by the company. The daughter, who brought the suit, testified that she thought her father had made her the beneficiary. After his death she found a letter from the Exxon Travel Club, through whom her father had obtained the policy, which stated:

86. 25 Utah 2d 319, 480 P.2d 745 (1971).

87. 568 S.W.2d 693 (Tex. Civ. App.—Fort Worth 1978, writ ref'd n.r.e.).

88. 289 S.W.2d 652 (Tex. Civ. App.—Amarillo 1956, writ ref'd n.r.e.).

89. 570 S.W.2d 188 (Tex. Civ. App.—Tyler 1978, no writ).

"The enclosed form may be used to change your class of membership. Your daughter may be covered under your membership as long as she meets the eligibility requirements defined in the attached memorandum."⁹⁰ It was her impression that this letter concerned changing the beneficiary on the policy, though there was other testimony indicating that the purpose of the letter was to advise the insured that his daughter could obtain coverage under the policy. The granddaughter of the insured testified that she saw her grandfather write a letter to Exxon requesting that the beneficiary on the policy be changed from his ex-wife to the plaintiff. She further saw him include it in his monthly gas payment to Exxon. She, however, did not see him deposit the letter in the mail. She further testified that he received a change of beneficiary form and that she saw him fill out the form changing the beneficiary. She also saw him stamp and address the envelope to Exxon and place the beneficiary form therein. Again, however, she did not see him place the letter in the mail, although he told her that he intended to do so. There was no evidence showing that the letter indicating a desire to change the beneficiary was ever received by Exxon or the insurer.

The court stated that when a policy defines the method of changing the beneficiary, such change is not accomplished until there has been substantial compliance with that method.⁹¹ This is accomplished when the insured has done all that he can reasonably do to effect the change.⁹² In the instant case, the mailing of the letter would have been substantial compliance; however, there was no evidence that anyone ever mailed the letter or that the insured ever told anyone to do so. Based thereon, the court reversed the trial court judgment for the insured's daughter and rendered judgment for the appellant.

In *Allstate Insurance Co. v. Mooney*⁹³ the company contended that a policy on the life of the insured had lapsed for nonpayment of premiums and that the insured had failed to timely accept a late payment offer to reinstate the policy. The policy required monthly premiums to be paid on or before the first day of the month or within a grace period of thirty-one days thereafter. The Mooneys failed to pay the premium for May 1 by June 1, the last day of the grace period. On June 4 Allstate sent a late payment offer stating that the policy would be reinstated if all past due premiums were received by June 25, provided that the insured was living when payment was received. On June 28 the premium payment was mailed in order to reinstate the policy. The insured died on June 30, and Allstate received the premiums on July 1. On July 3 Allstate, having knowledge that the insured had died, sent the beneficiary a claimant state-

90. *Id.* at 190.

91. The court cited *Scherer v. Wahlstrom*, 318 S.W.2d 456, 458 (Tex. Civ. App.—Fort Worth 1958, writ ref'd), in support of this proposition.

92. *Tips v. Security Life & Accident Co.*, 144 Tex. 461, 464, 191 S.W.2d 470, 471 (1945); *Witt v. Citizens Nat'l Bank*, 440 S.W.2d 112, 114 (Tex. Civ. App.—Waco 1969, no writ).

93. 562 S.W.2d 950 (Tex. Civ. App.—Amarillo 1978, writ ref'd n.r.e.).

ment form, a medical authorization form, and a letter requesting a certified copy of the death certificate. On July 10 Allstate returned the premium.

The beneficiary claimed that Allstate waived the termination of the policy by forwarding a late payment offer, by cashing her check, and by forwarding her the requested death claim data. Allstate claimed that the policy terminated by its own terms on June 1, that the late payment offer expired on June 25, and further that the insured died before Allstate received the premium. The court held that after the insured died, there was no subject matter to which the provisions of the lapsed policy could attach. A life insurance policy must be in effect at the time of the insured's death or else no liability exists;⁹⁴ conduct by the insurer after the insured's death cannot reinstate the policy. As a result, Allstate did not waive the termination of the lapsed policy by cashing the premium check and furnishing proof of death forms after the insured's death.

IV. INSURANCE AGENTS, ADJUSTERS, AND OTHER PERSONNEL

Several cases were decided during the past year concerning actions of insurance agents and adjusters and the effects their conduct had on the rights of insured. In *Mandola v. Mariotti*⁹⁵ the court of civil appeals reversed a summary judgment on the ground that a fact issue was raised concerning whether the representations of the claims adjuster tolled the statute of limitations. The personal injury action was filed more than two years after the date of the accident; consequently, the defendant filed a motion for summary judgment based upon the statute of limitations. The plaintiff's affidavit stated that the adjuster contacted her shortly after the accident and advised her that she did not need an attorney because the company would take care of the damages. The plaintiff stated that the adjuster paid medical bills as they accrued and periodically reassured her that the company would pay the damages. After the statute of limitations had run, the adjuster informed the plaintiff that the company was no longer responsible for her damages because she had failed to file a timely action.

The attached affidavit of the claims adjuster stated that she discussed the matter with the plaintiff and paid several medical bills, but did not suggest that the company was waiving the right to defend the claim fully or that suit need not be filed within two years. In an attached affidavit the insured defendant stated that he did not tell the plaintiff that either he or the insurance company was waiving the right to defend the claim fully.

The court, following established law,⁹⁶ stated that a party who misrepresents a material fact that induces the plaintiff to postpone filing suit may be estopped from asserting the statute of limitations. Further, this estoppel

94. *Grand Lodge Colored Knights of Pythias v. Preston*, 91 S.W.2d 496 (Tex. Civ. App.—Beaumont 1936, writ ref'd).

95. 557 S.W.2d 350 (Tex. Civ. App.—Houston [1st Dist.] 1977, writ ref'd n.r.e.).

96. *Ladd v. Knowles*, 505 S.W.2d 662 (Tex. Civ. App.—Amarillo 1974, writ ref'd n.r.e.); *Lanpar Co. v. Stanfield*, 474 S.W.2d 753 (Tex. Civ. App.—Waco 1971, writ ref'd n.r.e.).

may arise due to the acts of an agent or representative or a party.⁹⁷ The court held that although statements made by an adjuster or agent admitting liability without the insured's knowledge ordinarily are not admissions of the insured,⁹⁸ an adjuster's statements could estop the insured from asserting the statute of limitations.⁹⁹ The conflicting factual averments in this case necessitated a trial on the merits.

In *Preferred Risk Mutual Insurance Co. v. Rabun*¹⁰⁰ the insurer brought a declaratory judgment action to establish that there was no valid automobile liability insurance policy in effect at the time of the accident. The policy had been cancelled by the company on June 9, and the insured had received a notice of premium due and a subsequent cancellation notice. The insured and his insurance agent, who was a local recording agent as defined by article 21.14 of the Texas Insurance Code,¹⁰¹ were close friends. On the evening of July 19 the agent called the insured to obtain his wife's services as a babysitter. During this telephone conversation a discussion ensued regarding reinstatement of the policy, and the agent told the insured that although his schedule would not permit a meeting for actual payment of premium by the insured until July 24, the insured should not worry because everything was fine.¹⁰²

The accident occurred the day before the meeting to pay the premium. The insured's wife went to the agent's home, informed him of the accident, completed a reinstatement form, and paid the required premium. At the agent's request, both the form and the check were backdated to serve as a memorandum of the telephone conversation of July 19. The agent testified that this was done solely to enable the company to consider whether the conversation of July 19 was sufficient to provide coverage. The company declined to pay the damages. Evidence revealed that on previous occasions the agent had sold insurance to the insured pursuant to oral agreements. The agent would meet with the insured later and submit a policy dated as of the date of the oral binder. The agent had also orally reinstated policies for the insured, in which case he would pick up premiums at the insured's home subsequent to their conversation.

The agent's contract with the company expressly provided that an automobile policy was not to be reinstated by oral binder. The agent, however, testified that he was not sure as to his authority because he had not read the provision in his contract. The trial court entered judgment for the insured and the company appealed, contending that it was not bound be-

97. *General Ins. Co. of America v. United States*, 406 F.2d 442 (5th Cir.), *cert. denied*, 396 U.S. 902 (1969); *Koudsi v. Mathiws*, 147 S.W.2d 585 (Tex. Civ. App.—El Paso 1940, no writ).

98. *Kuehne v. Denson*, 148 Tex. 54, 59, 219 S.W.2d 1006, 1009 (1949).

99. *G.A. Stowers Furniture Co. v. American Indem. Co.*, 15 S.W.2d 544 (Tex. Comm'n App. 1929, holding approved).

100. 561 S.W.2d 239 (Tex. Civ. App.—Austin 1978, writ *dism'd*).

101. TEX. INS. CODE ANN. art. 21.14 (Vernon 1963). Under this article a local recording agent is authorized to solicit business and to write, sign, execute, and deliver policies of insurance, and to bind companies on insurance risks.

102. 561 S.W.2d at 241.

cause the specified mode of reinstatement had not been followed, and further, that since the premium had not been paid, an oral binder could not be effective. The court followed the principles set out in *Bailey v. Sovereign Camp*,¹⁰³ which followed the majority rule for dealing with the renewal of lapsed policies. *Bailey* held that in order for a waiver of the insured's forfeiture to occur, the insurer must have knowledge of the facts constituting the forfeiture of the certificate, the forfeiture must be complete and absolute, and there must be some unequivocal act on the part of the insurer that recognizes the continuance of the policy, or that is wholly inconsistent with its forfeiture.¹⁰⁴ In the instant case the question was whether there was an unequivocal act on the part of the insurer that recognized the continuance of the policy. The agent had reinstated the policy by an oral binder, just as he had done on other occasions. Since the agent was a local recording agent, he had the power to waive stipulations and conditions of the policy and to bind his principal. The court, therefore, found that the policy was in existence on the date of the accident.

In *Trinity Universal Insurance Co. v. Burnette*¹⁰⁵ the court had before it a policy that provided that it would be automatically renewed at expiration unless either the company mailed written notice to the insured of its intention to decline renewal at least thirty days in advance of the expiration date or the insured advised the company that he did not want the policy to be renewed. At the time of the policy's expiration, the insurance agent's records incorrectly indicated that the policy had been renewed. Since the insurance company had not received a renewal request, it assumed that the insurance agent had written the policy through another company; consequently, it did not renew the insured's policy.

The court held that the insurance company was only required to give notice to the insured if it intended to decline renewal. Since in this case the company had intended to renew the policy, it had no duty to give notice of nonrenewal and could not be found negligent for having failed to do so. Since the company had not given notice of nonrenewal, however, the policy was renewed as a matter of law. The court further found that under the agency contract between the company and the agent, the agent had a contractual duty to service the company's policies, to renew them, replace them, or to notify policy holders if they were not to be renewed. Since the agent had breached this duty, he was required to indemnify the company for its loss. The agent claimed that he was entitled to indemnification under State Board of Insurance regulation 8a.¹⁰⁶ The court stated that this regulation was enacted for the protection of policyholders and not

103. 116 Tex. 160, 286 S.W. 456 (1926).

104. *Id.* at 166, 286 S.W. at 457.

105. 560 S.W.2d 440 (Tex. Civ. App.—Beaumont 1977, no writ).

106. *Id.* at 443. This regulation provides that a policy must be renewed at expiration, at the option of the policyholder, unless the company mails written notice to the policyholder of its intention to decline renewal at least 30 days in advance of the policy expiration date. The company may comply by having its agent notify the policyholder. Nevertheless, the responsibility of giving notice to the insured remains with the company if the agent fails to carry out its instructions to notify the insured. *Id.* at 441 n.2.

for the protection of negligent agents. As a result, the agent's claim was denied.

V. DECEPTIVE TRADE PRACTICES AND THE INSURANCE CODE

In *Mobile County Mutual Insurance Co. v. Jewell*¹⁰⁷ the court held that article 21.21, section 16 of the Insurance Code¹⁰⁸ and the Texas Deceptive Trade Practices Act (DTPA)¹⁰⁹ do not apply to county mutual insurance companies. County mutual insurance companies are controlled by chapter 17 of the Texas Insurance Code, article 17.22 of which provides that those companies are exempt from the operation of all insurance laws of the state except as chapter 17 otherwise provides.¹¹⁰ Since none of the articles in chapter 17 provide for coverage of county mutual insurance companies under article 21.21, the court of civil appeals stated that county mutual insurance companies were exempt from its provisions, and the supreme court agreed. The supreme court noted that private persons who deal with county mutuals are not afforded the same protection against unfair and deceptive insurance practices that is afforded to persons who deal with other types of insurance companies and directed the attention of the legislature to this discrepancy.

*Ceshker v. Bankers Commercial Life Insurance Co.*¹¹¹ significantly broadened the right of consumers to bring action under article 21.21. The plaintiff brought suit to recover damages allegedly incurred as the result of his reliance upon the insurance company's alleged deceptive advertising. The company had circulated an advertisement as a newspaper supplement announcing a Medicare Companion Service Policy that contained a detachable application for said policy. Several weeks later the company placed a second advertisement in the same newspaper announcing a Hospital Cash Income Policy that also contained a detachable application. It was undisputed that the advertisements and applications differed in appearance, color, and content. Subsequently, the company received a completed application from the prospective insured for the hospital policy, and a policy was issued. In September the carrier received a claim form for

107. 555 S.W.2d 903 (Tex. Civ. App.—El Paso 1977), *writ ref'd n.r.e. per curiam*, 566 S.W.2d 295 (Tex. 1978).

108. TEX. INS. CODE ANN. art. 21.21, § 16 (Vernon Pam. Supp. 1963-78 provides: Relief Available to Injured Parties.—(a) Any person who has been injured by another's engaging in any of the practices declared in Section 4 of this Article or in rules or regulations lawfully adopted by the Board under this Article to be unfair methods of competition and unfair and deceptive acts or practices in the business of insurance or in any practice defined by Section 17.46 of the Business & Commerce Code, as amended, as an unlawful deceptive trade practice may maintain an action against the company or companies engaging in such acts or practices.

(b) In a suit filed under this section, any plaintiff who prevails may obtain:

(1) three times the amount of actual damages plus court costs and attorneys' fees reasonable in relation to the amount of work expended.

109. TEX. BUS. & COM. CODE ANN. §§ 17.41-.63 (Vernon Supp. 1978-79).

110. TEX. INS. CODE ANN. art. 17.22 (Vernon 1963).

111. 558 S.W.2d 102 (Tex. Civ. App.—Tyler 1977), *writ ref'd n.r.e. per curiam*, 568 S.W.2d 128 (Tex. 1978).

medical treatment received by the insured that undisputedly was not covered by the hospital policy. The plaintiff alleged that he had relied upon the first advertisement in sending in the application attached to the second advertisement. He admitted that he did not pay attention to the form, color, or content of the two advertisements, and did not read anything other than the boldface type in one of them.

The plaintiff brought suit under section 16 of article 21.21.¹¹² The court of civil appeals affirmed the trial court's summary judgment in favor of the company on the ground that the plaintiff had no standing to bring a cause of action under section 16(a) of article 21.21 because he was not a "person" within the terms of section 2 of that article.¹¹³ The court held that one must be engaged in the business of insurance to bring suit under article 21.21 and that the article did not confer a private cause of action upon consumers. The insured also claimed that the summary judgment was improper because a fact issue had been created as to whether he might have recovered under section 17.50 of the DTPA.¹¹⁴ The court stated that a consumer may maintain an action under that section if he had been adversely affected by the use or employment by any person of any act or practice that either has been declared to be unlawful by section 17.46 of the DTPA¹¹⁵ or that is in violation of article 21.21.¹¹⁶ It was undisputed, however, that the insured had applied for the second advertised policy, that the two advertisements were totally different, and that the second policy did not cover the claim. Based on these facts, as a matter of law the insured was not adversely affected; a consumer may not bring an action based on an alleged misrepresentation in an insurance policy that he never purchased.

The supreme court denied writ in a per curiam opinion, stating that although it disapproved of "the holding which construed the [Insurance] Code to limit the term 'person' to one who is engaged in the business of insurance,"¹¹⁷ the judgment of the court of civil appeals was correct for the other reasons stated.

Ceshker was followed in *Royal Globe Insurance Co. v. Bar Consultants, Inc.*¹¹⁸ In that case an insurance policy provided only limited coverage for vandalism and malicious mischief. Immediately after such a loss occurred, the agent and his secretary confirmed that the damage was covered under the policy. After an investigation, the adjuster told the insured that the

112. TEX. INS. CODE ANN. art. 21.21, § 16 (Vernon Pam. Supp. 1963-1978). Section 16 is set forth in note 108 *supra*.

113. Section 2 provides in part: "When used in this Act: (a) 'Person' shall mean any individual, corporation, association, partnership, . . . and any other legal entity engaged in the business of insurance . . ." TEX. INS. CODE ANN. art. 21.21, § 2 (Vernon 1963).

114. TEX. BUS. & COM. CODE ANN. § 17.50 (Vernon Supp. 1978-79).

115. *Id.* § 17.46. This is commonly known as the "laundry list" of violations.

116. Section 17.50(a)(4) of the DTPA authorizes a consumer to bring suit if he has been adversely affected by the use or employment of an act or practice in violation of art. 21.21 or the rules or regulations of the State Board of Insurance issued under art. 21.21. TEX. BUS. & COM. CODE ANN. § 17.50 (Vernon Supp. 1978-79).

117. 568 S.W.2d at 129.

118. 566 S.W.2d 724 (Tex. Civ. App.—Austin 1978, writ granted).

loss was not covered. In the meantime the insured had undertaken repairs based upon the agent's assurances of coverage. The trial court found that the agent's misrepresentations concerning the coverage amounted to a violation of section 17.46(12) of the DTPA,¹¹⁹ and pursuant to article 21.21 of the Insurance Code and section 17.50 of the DTPA the plaintiffs were entitled to treble damages, court costs, and attorneys' fees. The court of civil appeals followed the supreme court's denial of writ in *Ceshker*, and overruled the defendant's contention that plaintiff was not entitled to bring a cause of action under article 21.21. Although the court held that the statements of the agent were misrepresentations in violation of section 7.46(12) of the DTPA, it specifically reserved the question whether the plaintiff was also entitled to pursue a cause of action under that Act.

In granting writ of error,¹²⁰ the supreme court stated that it would consider whether the agent had authority to bind the insurance company by his post-loss statements, and whether the insured was "injured"¹²¹ by the misrepresentations. The court of civil appeals did not consider the first of these questions and only briefly discussed the second, stating that since the insured had acted upon the agent's representations of coverage and had proceeded to repair the premises, he had been injured within the meaning of article 21.21.¹²²

In *National Lloyds Insurance Co. v. McCasland*¹²³ the court was faced with the question whether article 21.35 of the Insurance Code,¹²⁴ which requires attachment of the application to the policy, could be waived by the insured. Although the policy did not contain the application for insurance, the insurer introduced proof that the insured had willfully concealed or misrepresented material facts in the application. No objections were made to the introduction of such testimony, and it was not raised as a ground in the motion for a new trial. In his brief before the court of civil appeals, plaintiff had various no-evidence points of error, but he did not specifically raise article 21.35. In oral argument, however, he raised for the first time the claim that the article rendered all the evidence supporting the

119. This section declares it unlawful to represent "that an agreement confers or involves rights, remedies or obligations which it does not have or involve, or which are prohibited by law." TEX. BUS. & COM. CODE ANN. § 17.46(12) (Vernon Supp. 1978-79).

120. 22 Tex. Sup. Ct. J. 96 (Nov. 23, 1978).

121. To maintain an action under TEX. BUS. & COM. CODE ANN. § 17.50 (Vernon Supp. 1978-79), a consumer must have been adversely affected. To maintain an action under TEX. INS. CODE ANN. art. 21.21, § 16 (Vernon 1963), however, the person must have been injured.

122. After the survey period ended, the supreme court affirmed the court of civil appeals decision. 577 S.W.2d 688 (Tex. 1979). The court held Royal Globe was liable for the deceptive acts of its agents even when Royal Globe neither authorized nor had knowledge that they had occurred. As to injury, the court said: "[t]he injury to Bar Consultants was that it believed it was covered by a policy of insurance from any loss caused by vandalism when it was not so covered." *Id.* at 223.

123. 566 S.W.2d 565 (Tex. 1978).

124. TEX. INS. CODE ANN. art. 21.35 (Vernon 1963) provides in part:

Except as otherwise provided in this code, every contract or policy of insurance issued or contracted for in this State shall be accompanied by a written, photographic or printed copy of the application for such insurance policy or contract, as well as a copy of all questions asked and answers given thereto.

jury verdict inadmissible. The court of civil appeals recognized that the plaintiff had raised article 21.35 for the first time on appeal, but because the statute was viewed as mandatory, the court concluded that the plaintiff's no-evidence objections were sufficient to preserve the complaint.¹²⁵ The supreme court reversed, holding that plaintiff waived this point by not including it in his motion for new trial as required by rules 320, 321, and 322 of the Texas Rules of Civil Procedure.¹²⁶

125. *McCasland v. National Lloyds Ins. Co.*, 553 S.W.2d 6 (Tex. Civ. App.—Waco 1977).

126. TEX. R. CIV. P. 320 stated, at the time of trial, that "each motion for new trial . . . shall specify each ground on which it is founded, and no ground not specified shall be considered." TEX. R. CIV. P. 321 provides:

Each ground of a motion for a new trial . . . shall briefly refer to that part of the ruling of the court, charge given to the jury, or charge refused, admission or rejection of evidence, or other proceedings which are designated to be complained of, in such way as that the point of objection can be clearly identified and understood by the court.

TEX. R. CIV. P. 322 provides that "grounds of objection couched in general terms . . . shall not be considered by the court."

