

January 1982

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Jeff Dykes

Otwy B. Denny Jr.

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### Recommended Citation

Jeff Dykes & Otwy B. Denny, *Insurance Law*, 36 SW L.J. 309 (1982)  
<https://scholar.smu.edu/smulr/vol36/iss1/11>

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# INSURANCE LAW

by

Jeff Dykes\* and Otway B. Denny, Jr.\*\*

## I. LIABILITY INSURANCE

*Personal Injury Protection Coverage.* One case during the survey period focused on the scope of coverage under the personal injury protection coverage. In *Slocum v. United Pacific Insurance Co.*<sup>1</sup> suit was brought by Slocum against his automobile insurer under the personal injury protection clause of his automobile policy. Slocum fractured his hand and sued for lost wages. The evidence showed that the injury occurred on May 23, 1975, some two days before he was to report to work for Burmah Oil Company. The court submitted an issue and instruction based upon language in the policy.<sup>2</sup> The jury answered "we do not" to this issue. Based upon this finding the trial court entered judgment for the insurance company denying recovery to the insured.<sup>3</sup>

The plaintiff on appeal contended that the instructions and policy language were more restrictive in scope than authorized by the legislature<sup>4</sup> and were thus void. The court noted that the plaintiff brought suit on an insurance contract and his pleadings failed to give notice that he was contending that the policy provisions were void. The court ruled that the trial court did not err in using the policy language in its instruction since it was provided for in the policy.<sup>5</sup> In dictum, however, the court said that the phrase "at the time of the accident" should not be construed so narrowly as to deny a recovery to one who had commenced earning income but was injured on a day that he was not working and suggested an instruction that

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\* B.A., M.A., Stanford University; J.D., University of Texas. Attorney at Law, Fulbright & Jaworski, Houston, Texas.

\*\* B.A., Texas A&M University; J.D. Baylor University. Attorney at Law, Fulbright & Jaworski, Houston, Texas.

The authors gratefully acknowledge the assistance of Marc Young, law student, University of Houston School of Law, in the preparation of this Article.

1. 615 S.W.2d 807 (Tex. Civ. App.—Houston [1st Dist.] 1981, writ ref'd n.r.e.).

2. The issue and instruction were as follows:

"Do you find from a preponderance of the evidence that Randy Slocum was an income or wage producer on May 23, 1975, the date of this accident?"

You are instructed that a wage or income producer is defined as a person who at the time of the accident was in an occupational status, where such person was earning or producing income."

*Id.* at 808-09.

3. *Id.* at 808-09.

4. TEX. INS. CODE ANN. art. 5.06—3 (Vernon 1981).

5. 615 S.W.2d at 810.

could be used in those circumstances.<sup>6</sup> Nevertheless, because Slocum had not yet begun work at the time of his accident, he was precluded from recovering under his policy.<sup>7</sup>

*Underinsured Motorist Coverage. American General Fire & Casualty Co. v. Oestreich*<sup>8</sup> involved the construction of article 5.06—1, section 1 of the Texas Insurance Code, which concerns underinsured motorist coverage.<sup>9</sup> The plaintiff and two passengers in her automobile were injured as a result of a collision with an automobile driven by Dowdle and caused by his negligence. Dowdle's liability policy provided coverage of \$10,000 per person and \$20,000 per accident. Although Ms. Oestreich's damages exceeded \$20,000, plaintiffs settled their claim against Dowdle for \$9,750. The remainder of the \$20,000 of Dowdle's insurance was reserved for the two passengers in the plaintiff's vehicle. The underinsured provision of the plaintiff's policy with American General provided for liability of \$10,000 per person and \$20,000 per accident.<sup>10</sup> The carrier contended that the terms of the policy clearly provided that the \$9,750 be subtracted from the \$10,000. Plaintiffs contended that the \$9,750 should be subtracted from the total damages the plaintiffs were entitled to recover from the tortfeasor and that the difference recoverable was up to and including \$10,000.

The court, in interpreting the language in the policy, stated that the word "reduced" contained in section 5<sup>11</sup> modified the phrase "an amount up to the limit specified in the policy," rather than modifying the opening phrase "payment to the insured of all sums which he shall be legally enti-

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6. The instruction suggested was: "You are instructed that one does not have to be at work at the time of the accident to be in an occupational status." *Id.*

7. *Id.*

8. 617 S.W.2d 833 (Tex. Civ. App.—Eastland 1981, no writ).

9. TEX. INS. CODE ANN. art. 5.06—1(1) (Vernon 1981) provides:

No automobile liability insurance (including insurance issued pursuant to an Assigned Risk Plan established under authority of Section 35 of the Texas Motor Vehicle Safety-Responsibility Act), covering liability arising out of the ownership, maintenance, or use of any motor vehicle shall be delivered or issued for delivery in this state unless coverage is provided therein or supplemental thereto, in at least the limits described in the Texas Motor Vehicle Safety-Responsibility Act, under provisions prescribed by the Board, for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured or underinsured motor vehicles because of bodily injury, sickness, or disease, including death, or property damage resulting therefrom.

(footnote omitted).

10. Plaintiff's policy stated in part: "(c) Any amount payable under the terms of this insurance because of bodily injury or property damage sustained in an occurrence by a person who is an insured shall be reduced by . . . (2) the amount recovered or recoverable from the insurer of any underinsured motor vehicle." 617 S.W.2d at 835.

11. TEX. INS. CODE ANN. art. 5.06—1, § 5 (Vernon 1981) reads:

The underinsured motorist coverage shall provide for payment to the insured of all sums which he shall be legally entitled to recover as damages from owners or operators of underinsured motor vehicles because of bodily injury or property damage in an amount up to the limit specified in the policy, reduced by the amount recovered or recoverable from the insurer of the underinsured motor vehicle.

tled to recover."<sup>12</sup> Relying on a Minnesota case construing a similar provision,<sup>13</sup> the court reasoned that the amount paid by the tortfeasor's liability carrier should be deducted from the underinsured motorist coverage. For this reason, the plaintiffs in this matter were entitled to receive \$250.00, the difference between \$9,750 and the \$10,000 underinsured coverage limits.<sup>14</sup>

*Coverage.* *McManus v. Fidelity & Guaranty Underwriters, Inc.*<sup>15</sup> involved construction of a standard Texas homeowner's insurance policy. James McManus's father owned a trail bike of which James was the primary user. James had allowed Craig Wooley to use the bike away from the McManus's premises when Wooley was involved in an accident with Mr. Garcia. Suit was filed against Wooley and James McManus alleging that McManus was guilty of negligent entrustment. Defense was tendered to Fidelity & Guaranty Underwriters, Inc. because James was an insured under the homeowner's policy. The carrier then filed a declaratory judgment action to determine its duty, if any, to defend. The trial court entered judgment finding no duty to defend on behalf of the carrier.

The issue presented to the court of civil appeals was whether the negligent entrustment action arose out of that portion of the policy that stated: "[t]he ownership, maintenance, operation, use, loading or unloading of; . . . a recreational motor vehicle . . . away from the resident premises; . . ." <sup>16</sup> The court noted that although there was no Texas authority on point, other jurisdictions had addressed the question and there existed a split of authority concerning the issue.<sup>17</sup> Some jurisdictions have held that the cause of action is not based upon operation, maintenance, or use but upon the act of negligence and therefore a duty to defend does exist,<sup>18</sup> whereas other courts have held the provision to be clear, requiring no duty to defend.<sup>19</sup>

The court distinguished an earlier negligent entrustment case where the entrustment occurred between insureds.<sup>20</sup> One of the distinguishing fac-

12. *Id.*

13. *Lick v. Dairyland Ins. Co.*, 258 N.W.2d 791 (Minn. 1977).

14. 617 S.W.2d at 835. TEX. INS. CODE ANN. art. 5.06—1, § 2b (Vernon 1981) defines an underinsured motor vehicle as:

an insured motor vehicle on which there is valid and collectible liability insurance coverage with limits of liability for the owner or operator which were originally lower than, or have been reduced by payment of claims arising from the same accident to, an amount less than the limit of liability stated in the underinsured coverage of the insured's policy.

15. 615 S.W.2d 877 (Tex. Civ. App.—Houston [1st Dist.] 1981, writ granted).

16. *Id.* at 878.

17. *See Cooter v. State Farm Fire & Cas. Co.*, 344 So. 2d 496 (Ala. 1977); *McDonald v. Home Ins. Co.*, 97 N.J. Super. 501, 235 A.2d 480 (App. Div. 1967).

18. *See McDonald v. Home Ins. Co.*, 97 N.J. Super. 501, 235 A.2d 480 (App. Div. 1967); *Lalomia v. Bankers & Shippers Ins. Co.*, 35 A.D.2d 114, 312 N.Y.S.2d 1018 (1970).

19. *See Cooter v. State Farm Fire & Cas. Co.*, 344 So. 2d 496 (Ala. 1977); *State Farm Fire & Cas. Co. v. McGlawin*, 84 Ill. App. 3d 107, 404 N.E.2d 1122 (1980).

20. *See Federal Ins. v. Forristal*, 401 S.W.2d 285 (Tex. Civ. App.—Beaumont 1966, writ ref'd n.r.e.).

tors was that the negligent act complained of was the permission to use the bike as opposed to the use of the bike itself.<sup>21</sup> The court of civil appeals resolved the issue in favor of the insured as follows:

Does then the exclusion of "ownership, maintenance, operation, use, loading or unloading" encompass the negligent entrustment allegation against the insured under the fact situation involved in this case? We think it does not. The cause of action of negligent entrustment is a separate and distinct cause of action, and in our case involves the *permission to use* not the *use* of the vehicle. The third-party, Wooley, was the one alleged to have negligently caused the accident and the insured was not directly involved in the accident. The sole allegation against the insured is negligent entrustment, and such allegation does not involve the "ownership, maintenance, operation, use, loading or unloading" by the insured.<sup>22</sup>

Since in the court's view the negligence was in granting permission to use the bike, the court reversed the lower court finding and held that there was a duty to defend.<sup>23</sup>

*Commercial Standard Insurance Co. v. Hartzog*<sup>24</sup> involved a determination of coverage under a standard truckman gross receipts policy. The Hartzogs were injured when their automobile collided with a Houston Truck Lines (HTL) truck that was on loan to Oilfield Company and being driven by an Oilfield employee. Oilfield and HTL were trucking companies owned by the same individual but which were separate and distinct corporations insured under two different types of policies. Oilfield was insured by Southern County under a standard, family type automobile policy covering specifically scheduled vehicles. HTL was insured by Commercial Standard under a Texas standard truckman-gross receipts, commercial type policy covering all vehicles owned by HTL, none of which were specifically scheduled. The premiums were calculated according to the gross receipts of HTL for shipments made during the policy period rather than on the per vehicle basis under the Oilfield policy with Southern County. Suit was instituted by the Hartzogs against the two carriers based upon a personal injury judgment. Payment was denied by both carriers. Southern County contended that Commercial Standard was primarily liable, while Commercial Standard contended an exclusion absolved it of liability.<sup>25</sup> The trial court found that the collision occurred

21. 615 S.W.2d at 879.

22. *Id.* at 881.

23. *Id.*

24. 619 S.W.2d 417 (Tex. Civ. App.—Houston [14th Dist.] 1981, writ filed).

25. The policy provided:

"PERSON INSURED

Each of the following is an insured under this insurance to the extent set forth below:

\* \* \*

(c) Any other person while using an owned automobile . . . with the permission of the named insured, provided his actual operation . . . is within the scope of such permission.

\* \* \*

while the truck was being used over a route the named insured was not authorized by public authority to serve. That court entered judgment that the Hartzogs recover from each of the carriers in amounts proportionate to their respective limits.<sup>26</sup>

Commercial Standard contended on appeal that the exclusion applied while either (1) the automobile was not being used exclusively in the business of the named insured, or (2) the automobile was being used over a route not authorized to be served by federal or public authority. The Hartzogs' position was that the provision in question was ambiguous and required both that the injury occur while the automobile was not being used in the exclusive business of the named insured and that it occur over a route the named insured was authorized to serve by federal or public authority. The court, in interpreting the exclusion, stated that the phrase "not being used" inserted in the Commercial Standard exclusion modified both clauses of the condition.<sup>27</sup> The policy stated in the negative an exclusion provision that has been interpreted in other jurisdictions to provide coverage for others when using the vehicle exclusively in the business of the named insured and over routes authorized by federal or public authority.<sup>28</sup> For this reason, the exclusion applied, and no coverage existed to benefit the Hartzogs.<sup>29</sup>

*Progress Marine v. Foremost Insurance Co.*<sup>30</sup> involved an interpretation of the clause "compulsory by law" in a protection and indemnity policy. Progress Marine, Inc. brought suit against Foremost Insurance Company for expenses incurred in removing the wreck of a jack-up workover barge covered by a policy provided by Foremost. The case turned on whether or not the removal of the rig was "compulsory by law" as provided in the policy.<sup>31</sup> The district court determined that the removal, although prudent on behalf of Progress Marine, was not compulsory by law.<sup>32</sup> The court of appeals noted that interpretations of this clause had reached different results in different jurisdictions across the country.<sup>33</sup> The more restrictive

None of the following is an insured:

(i) any person or organization, or any agent or employee thereof, other than the named insured . . . engaged in the business of transporting property by automobile . . . for others under any of the following conditions:

(1) if the bodily injury or property damage occurs while such automobile is not being used exclusively in the business of the named insured and over a route the named insured is authorized to serve by federal or public authority. . . ."

*Id.* at 418.

26. *Id.*

27. *Id.* at 419.

28. *See St. Louis Fire & Marine Ins. Co. v. Aetna Ins. Co.*, 283 F. Supp. 40 (S.D.W. Va. 1968); *Johnson v. Angerer*, 16 Ohio App. 2d 16, 240 N.E.2d 891 (1968).

29. 619 S.W.2d at 419.

30. 642 F.2d 816 (5th Cir. 1981).

31. The clause in the policy provided reimbursement of "[c]osts or expenses of, or indicated to, the removal of the wreck of a vessel named herein when such removal is compulsory by law." *Id.* at 817.

32. *Id.* at 817-18.

33. *See, e.g., Seaboard Shipping Corp. v. Jocharanne Tugboat Corp.*, 461 F.2d 500 (2d Cir. 1972); *Continental Oil Co. v. Bonanza Corp.*, 511 F. Supp. 62 (S.D. Tex. 1980).

view seemed to require an order by a governmental body to warrant coverage.<sup>34</sup> The court expressed the view that "compulsory by law" should be broader than merely a requirement of a preemptory order by an authoritative governmental agency.<sup>35</sup> Removal based upon an unreasonable apprehension of criminal or civil liability could not be considered compulsory by law to invoke coverage. A fact question, according to the court, existed as to the subjective belief of the insured regarding removal<sup>36</sup> and the resolution of this issue determined whether or not the policy should be invoked and coverage provided.<sup>37</sup>

*Conditions.* *Baker v. Guaranty National Insurance Co.*<sup>38</sup> involved the duty of the insured to forward suit papers. Baker brought suit against Guaranty National Insurance Company based upon a judgment he had obtained earlier against Guaranty's insured, Small. Baker had retained Small to do a termite inspection when he purchased some realty. Small represented that the realty was free of termites. After purchasing the property, Baker learned that the representation was untrue and demanded damages of Small. Guaranty, Small's carrier, investigated the claim and entered into negotiations with Baker regarding settlement, which were unsuccessful. Guaranty requested Small to notify them if suit was filed. Baker did file suit, but Small made a conscious decision not to notify the carrier. On May 8, 1979, judgment was rendered against Small. Guaranty's first notice of the suit and prior judgment was receipt of the suit papers in the above lawsuit. Guaranty denied coverage for failure of the insured to provide notice as required by the policy.<sup>39</sup>

Baker took the position that under section 7A(a)(1) of the Texas Structural Pest Control Act<sup>40</sup> the condition in the insurance policy that required

34. 642 F.2d at 819.

35. *Id.* at 820.

36. The test as stated by the court was: "However, an additional inquiry must be made as to whether the removal was performed as a result of a subjective belief on the part of the insured that such was reasonably necessary to avoid legal consequences of the type contemplated by this policy." *Id.*

37. *Id.*

38. 615 S.W.2d 303 (Tex. Civ. App.—Austin 1981, writ ref'd n.r.e.).

39. Paragraphs 4(b) and 5 of the conditions of the insurance policy stated:

"4(b) If claim is made or suit is brought against the insured, the insured shall immediately forward to the company every demand, notice, summons or other process received by him or his representative.

5. Action Against Company: no action shall lie against the company unless, as a condition precedent thereto, there shall have been full compliance with all of the terms of this policy."

*Id.* at 304.

40. Section 7A(a)(1) of the Texas Structural Pest Control Act provides:

(a) After February 29, 1976, the Board may not issue or renew a Structural Pest Control Business License until the license applicant:

(1) files with the board a policy or contract of insurance approved as sufficient by the Board in an amount of not less than [\$30,000] insuring him against liability for damages . . . occurring as a result of operations performed in the course of the business of structural pest control to premises . . . under his care, custody, or control.

TEX. REV. CIV. STAT. ANN. art. 135b—6, § 7A(a)(1) (Vernon Supp. 1982).

the forwarding of suit papers was unenforceable. Baker contended that the provision required a "no-notice" bond<sup>41</sup> as opposed to a policy of insurance. The court noted that generally a surety on a judgment bond need not be given notice of suit or an opportunity to defend the suit before it is bound by judgment.<sup>42</sup> Provisions in insurance policies that require the insured to provide notice of suit to an insurer, however, were valid and enforceable, and compliance with such provisions by the insured was a condition precedent to coverage by the policy.<sup>43</sup> The court reasoned that the language of the Texas Structural Pest Control Act merely required that the applicant for a license have a policy of insurance not a surety bond, and therefore the notice provision was valid and enforceable.<sup>44</sup> No coverage was provided by the policy because Small had failed to perform the condition precedent.

## II. DECEPTIVE TRADE PRACTICE AND TEXAS INSURANCE CODE

*Springfield v. Aetna Casualty & Surety Insurance Co.*<sup>45</sup> involved a class action suit brought by H.J. Springfield and others against eight automobile insurers. The plaintiffs claimed that they and others had been denied benefits afforded them by article 5.06—3 of the Texas Insurance Code.<sup>46</sup> In addition, they sought damages pursuant to a claim under the Texas Decep-

41. In its opinion in *Howze v. Surety Corp.*, 584 S.W.2d 263 (Tex. 1979), the Texas Supreme Court held that no notice was required when a surety agreed to liability for a specific judgment. The court in *Baker* contrasted such a no-notice bond with a general liability insurance policy such as required by the Structural Pest Control Act. TEX. REV. CIV. STAT. ANN. art. 135b—6, § 7A (Vernon Supp. 1982). The court found that the insurer, unlike a surety under a no-notice bond, must be given notice when insuring for general liability, before being bound by any judgments under the policy. 615 S.W.2d at 305-06.

42. See *Howze v. Surety Corp. of Am.*, 584 S.W.2d 263 (Tex. 1979).

43. See *Weaver v. Hartford Accident & Indem. Co.*, 570 S.W.2d 367 (Tex. 1978).

44. 615 S.W.2d at 306.

45. 620 S.W.2d 557 (Tex. 1981).

46. TEX. INS. CODE ANN. art. 5.06—3(b) (Vernon 1981) provides:

"Personal injury protection" consists of provisions of a motor vehicle liability policy which provide for payment to the name insured in the motor vehicle liability policy and members of the insured's household, any authorized operator or passenger of the named insured's motor vehicle including a guest occupant, up to an amount of \$2,500 for each such person for payment of all reasonable expenses arising from the accident and incurred within three years from the date thereof for necessary medical, surgical, X-ray and dental services, including prosthetic devices, and necessary ambulance, hospital, professional nursing and funeral services, and in a case of an income producer, payment of benefits for loss of income as the result of the accident; and where the person injured in the accident was not an income or wage producer at the time of the accident, payments of benefits must be made in reimbursement of necessary and reasonable expenses incurred for essential services ordinarily performed by the injured person for care and maintenance of the family or family household.

*Id.* art. 5.06—3(e) provides further:

An insurer shall exclude benefits to any insured, or his personal representative, under a policy required by Section 1, when the insured's conduct contributed to the injury he sustained in any of the following ways: (1) [c]lausing injury to himself intentionally[;] (2) [w]hile in the commission of a felony, or while seeking to elude lawful apprehension or arrest by a law enforcement official.



tive Trade Practices Act.<sup>47</sup> Plaintiffs claimed that the defendant insurance companies had illegally limited coverage through use of the State Board of Insurance's prescribed endorsement 243.<sup>48</sup> They alleged a conspiracy between the insurers and the State Board of Insurance, which was made a party after an earlier ruling.<sup>49</sup> The trial court granted summary judgment on behalf of the insurers, and the court of civil appeals affirmed.<sup>50</sup> The plaintiffs' allegation of illegality was that the coverage was limited solely to losses on scheduled vehicles. The court noted that this portion of the complaint was correctly denied under the reasoning of an earlier precedent.<sup>51</sup>

The court observed that insurers are required to use endorsement forms provided by the State Board of Insurance<sup>52</sup> and failure to do so would subject them to action for revocation of their license.<sup>53</sup> The plaintiffs complained that the State Board of Insurance yielded to pressure and defined "benefits for loss of income" in a nonstatutory manner. The definition provided that "benefits for loss of income means eighty (80%) percent of actual income lost because of disability resulting from insured bodily injury which prevents the injured person from performing the substantial duties of his usual occupation."<sup>54</sup> The plaintiffs claimed that an insured should recover his entire loss of income, not merely a percentage of it as provided by the endorsement approved by the State Board of Insurance. The court stated that the Board was empowered to fix the rates based upon the loss of income, but that it was not empowered to restate or limit the statutory benefits.<sup>55</sup>

The court refused the writ, finding that the insurance carriers were not liable for damages for use of the endorsement that the law required them to use.<sup>56</sup> The court specifically pointed out, however, that it did not necessarily approve the holding of the court of civil appeals that because the State Board of Insurance was vested with rate-making power, it therefore carried the greater and distinct power to reduce the coverage offered by

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47. 620 S.W.2d at 558.

48. The Texas Insurance Board, pursuant to legislative authority, may prescribe the form to be used for personal injury protection endorsement. *See* TEX. INS. CODE ANN. art. 5.06—3(f) (Vernon 1981).

49. *See* Allen v. Aetna Cas. & Sur. Ins. Co., 567 S.W.2d 547 (Tex. Civ. App.—Fort Worth 1978, writ ref'd n.r.e.).

50. *Springfield v. Aetna Cas. & Sur. Ins. Co.*, 612 S.W.2d 285 (Tex. Civ. App.—Austin 1981, writ ref'd n.r.e.).

51. *See* Holyfield v. Members Mut. Ins. Co., 572 S.W.2d 672 (Tex. 1978).

52. TEX. INS. CODE ANN. art. 5.06—3(f) (Vernon 1981) provides:

The State Board of Insurance is hereby authorized to prescribe the form, or forms, of insurance policies, including riders and endorsements, to provide the coverage described in this article. The Board shall also prescribe the premium rates under the provisions of this Subchapter A, Chapter 5, Texas Insurance Code. Provided, however, the foregoing provisions relative to forms and rates shall apply only to coverage written to comply with this article; such provisions shall not apply to other accident or health policies even though they promise indemnity against automobile-connected injuries.

53. *See id.* art. 5.06.

54. 620 S.W.2d at 558.

55. *Id.*

56. *Id.*

statute.<sup>57</sup> The court stated that the remedy, if any, for the policyholders would be through the administrative procedures provided in the Texas Insurance Code article 5.11.<sup>58</sup>

*Humphreys v. Fort Worth Lloyds*<sup>59</sup> involved unfair claims practices. Lloyds issued its homeowner's insurance policy to the Humphreyses. While the policy was in force, an automobile driven by Chris Gholston crashed into the Humphreyses' residence. The Humphreyses brought suit against Gholston and subsequently settled with him and his insurance carrier and executed a formal release. The Humphreyses then sued Lloyds, alleging that Lloyds committed certain unlawful and deceptive acts in disclaiming coverage and refusing to negotiate a reasonable settlement of their loss. Lloyds filed special exceptions and an affirmative defense that the Humphreyses failed to state a cause of action. The exceptions were not ruled upon by the trial court. Thereafter Lloyds moved for a summary judgment, arguing that no proper cause of action could be asserted for wrongful claim settlement practices. The trial court granted the motion.

The court of appeals in its original opinion reversing the trial court held that the legislature did not intend to exclude and did not exclude a proper cause of action for wrongful handling of an insurance claim under article 21.21—2.<sup>60</sup> The court withdrew its original opinion, although affirming its reversal of the trial court, and concluded that the question was not properly before the court.<sup>61</sup> In its second opinion the court recognized that the question of whether or not pleadings failed to state a cause of action could not be decided by a summary judgment proceeding in Texas and remanded the case for further proceedings.<sup>62</sup>

*Littlefield v. Hays*<sup>63</sup> involved the question of the constitutionality of article 5.82, section 4 of the Texas Insurance Code.<sup>64</sup> This section provides,

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57. *Id.*; see 612 S.W.2d at 290.

58. 620 S.W.2d at 558-59. TEX. INS. CODE ANN. art. 5.11 (Vernon 1981) provides:  
Hearing on Grievances

Any policyholder or insurer shall have the right to a hearing before the Board on any grievance occasioned by the approval or disapproval by the Board of any classification, rate, rating plan, endorsement or policy form, or any rule or regulation established under the terms hereof, such hearing to be held in conformity with rules prescribed by the Board. Upon receipt of request that such hearing is desired, the Board shall forthwith set a date for the hearing, at the same time notifying all interested parties in writing of the place and date thereof, which date, unless otherwise agreed to by the parties at interest, shall not be less than ten (10) nor more than thirty (30) days after the date of said notice. Any party aggrieved shall have the right to apply to any court of competent jurisdiction to obtain redress.

No hearing shall suspend the operation of any classification, rate, rating plan or policy form unless the Board shall so order.

59. 617 S.W.2d 788 (Tex. Civ. App.—Amarillo 1981, no writ).

60. *Id.* at 790; see TEX. INS. CODE ANN. art. 21.21—2 (Vernon 1981).

61. 617 S.W.2d at 790.

62. See generally *Texas Dep't of Corrections v. Herring*, 513 S.W.2d 6, 10 (Tex. 1974).

63. 609 S.W.2d 627 (Tex. Civ. App.—Amarillo 1980, no writ).

64. 1975 Tex. Gen. Laws, ch. 330, § 1, at 864. This article, enacted by the Texas Legislature in 1975, was repealed by 1977 Tex. Gen. Laws, ch. 817, pt. 4, § 41.03, at 2064, effective Aug. 29, 1977. Similar legislation enacted by the 1977 legislature is found in TEX. REV. CIV.

among others items, a two-year statute of limitation on tort claims against insured doctors.<sup>65</sup> Sandra Littlefield was Dr. Hays's patient and on February 14, 1976, Hays performed surgery for the purpose of removing her ovaries and fallopian tubes. After surgery, Hays told Mrs. Littlefield that he had performed a "full pelvic clean-out." She continued to have pain and was assured by Dr. Hays that all reproductive organs had been removed. Mrs. Littlefield sought other opinions and an ovarian tumor was removed in late October 1976. Her suit was filed on October 23, 1978, more than two years after her last visit with Dr. Hays on March 15, 1976, but less than two years after the tumor was diagnosed and removed. Dr. Hays pleaded that the provisions of article 5.82, section 4 of the Texas Insurance Code applied and obtained a summary judgment. On appeal the court of civil appeals affirmed.<sup>66</sup>

The court noted that article 5.82, section 4 of the Texas Insurance Code applied only to those persons or hospitals covered by professional liability insurance.<sup>67</sup> Moreover, the court recognized that the practical effect upon adults was to abolish the "discovery rule" whereby the statute of limitations does not begin to run on certain medical malpractice claims until the patient's discovery of the negligence.<sup>68</sup> Mrs. Littlefield complained that the provisions of article 5.82, section 4 of the Texas Insurance Code violated the equal rights clause of the Texas Constitution<sup>69</sup> and the equal protection clause of the United States Constitution<sup>70</sup> since it applied only to insured doctors, abolishing the discovery rule as to them but not to those without insurance.

In finding the statute constitutional, the court viewed the statute under the "rational relation test."<sup>71</sup> The purpose of article 5.82, section 4 was to establish standards and procedures for setting insurance rates for a class of health care providers. In light of this group's historical problems with in-

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STAT. ANN. art. 4590i, § 10.01 (Vernon Supp. 1982). Section 10.02 of the article provides that those causes of action arising between the effective dates of arts. 5.82 and 10.01 shall be brought pursuant to art. 5.82. § 10.02. 1975 Tex. Gen. Laws, ch. 330, § 4, at 865, states:

Notwithstanding any other law, no claim against a person or hospital covered by a policy of professional liability insurance covering a person licensed to practice medicine or podiatry or certified to administer anesthesia in this state or a hospital licensed under the Texas Hospital Licensing Law, . . . whether for breach of express or implied contract or tort, for compensation for a medical treatment or hospitalization may be commenced unless the action is filed within two years of the breach or the tort complained of or from the date the medical treatment that is the subject of the claim or the hospitalization for which the claim is made is completed, except that minors under the age of six years shall have until their eighth birthday in which to file, or have filed on their behalf, such claim. Except as herein provided, this section applies to all persons regardless of minority or legal disability.

65. 1975 Tex. Gen. Laws, ch. 330, § 4, at 865.

66. 609 S.W.2d at 630.

67. *Id.*

68. *Id.* at 629; see *Robinson v. Weaver*, 550 S.W.2d 18 (Tex. 1977).

69. TEX. CONST. art. I, § 3.

70. U.S. CONST. amend. XIV.

71. See *Lubbock Poster Co. v. City of Lubbock*, 569 S.W.2d 935 (Tex. Civ. App.—Amarillo 1978, writ ref'd n.r.e.).

insurance, the court found it proper for the legislature to focus on this group and to provide standards for them that differed from standards and procedures provided other insurers and insureds with different problems.<sup>72</sup> Since one of the primary considerations in any insurance rate setting process is the duration of the insurer's exposure to liability, it is within the legislature's power to set an absolute time beyond which the insurer has no exposure.<sup>73</sup> In concluding, the court stated that "an absolute time limit on suits against insureds has a fair and substantial relation to the setting of insurance rate standards and procedures and treats alike all persons who have insurance or use insured entities. The statute is constitutional."<sup>74</sup> Although the court agreed with the plaintiff that the statute abolished the discovery rule for insured doctors and not uninsured doctors, that distinction did not render the statute invalid.<sup>75</sup> The court refused to find a constitutional right to the discovery rule; rather it found that the discovery rule was court-created, and thus could be abolished by the legislature as a necessary incident of regulating insurance rates.<sup>76</sup> Therefore, the court held that Mrs. Littlefield's claim was barred by the statute of limitations.<sup>77</sup>

*Great Commonwealth Life Insurance Co. v. Olton State Bank*<sup>78</sup> involved a suit by a bank (Olton) to recover on a credit life insurance policy issued to one of its customers, J.M. Kendrick. On February 22, 1977, Kendrick signed a promissory master note for the sum of \$90,000, payable to the bank on or before January 15, 1978. The principal of the note was advanced in eleven installments credited to Kendrick's account from February 22 to September 12, 1977. Upon signing the note, the spaces indicating a request for credit life insurance were left blank. At the time, Kendrick had a credit life policy with Pennsylvania Life Insurance Company that expired on July 1, 1977. In January 1976, Great Commonwealth had entered into an agency agreement with the bank authorizing the solicitation of insurance on the lives of debtors of Olton. On the same date, a master policy was issued insuring certain debtors of the bank. The master policy contained language concerning eligible debtors<sup>79</sup> as well as the effective date of coverage.<sup>80</sup> At the expiration of the Pennsylvania policy, Kendrick

72. 609 S.W.2d at 630.

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.*

78. 607 S.W.2d 604 (Tex. Civ. App.—Amarillo 1980, no writ).

79. The policy provided:

"All natural persons of the class defined in the application for this Policy, sixteen (16) years or over, and under the age of sixty-six (66) years at the time of becoming insured hereunder, who are directly liable to pay or repay sums of money to the Creditor over a period not to exceed sixty (60) months and who furnish written and signed evidence of good health and eligible age as required elsewhere in this Policy shall be eligible for insurance hereunder. . . ."

*Id.* at 605-06.

80. The portion of the policy concerning effective dates of coverage stated that "[i]nsurance on any Debtor insured hereunder with respect to a particular debt shall become

requested credit life insurance, and the bank delivered to him a certificate for level term with Great Commonwealth in the amount of \$15,000 effective July 1, 1977, for one year. His bank account was debited for the amount of the annual premium on July 1, 1977. No loan or advance was actually made on that date, but five advances had been made previously and six advances were made thereafter. Kendrick died on September 11, 1977, and the bank sought to collect the \$15,000 from Great Commonwealth. The carrier refused, and this suit was commenced.

The carrier, appealing from an adverse lower court judgment, took the position that the insurance issued to cover Kendrick's continuing line of credit violated article 3.53, section 2 of the Texas Insurance Code.<sup>81</sup> The carrier argued that the definition of credit life insurance applied only when an isolated loan transaction was contemplated as opposed to a general line of credit such as Kendrick had in this case. The court refused to put that limitation on the definition; instead the court held that the phrase "other credit transaction" was broad enough to cover an open line of credit arrangement between debtor and bank.<sup>82</sup> Additionally, the court stated that no specific loan needed to be made on July 1, 1977, since at that time Kendrick was directly liable to the bank and covered under the eligible debtors' provision of the policy.<sup>83</sup>

### III. PROPERTY INSURANCE

*Measure of Damages for "Total Loss" by Fire.* In *Bennett v. Imperial Insurance Co.*<sup>84</sup> the court rejected an attempt to circumvent or modify established rules on the proper measure of recovery for fire loss to real property. Plaintiffs had purchased a dilapidated twenty-six-unit apartment building in a depressed neighborhood in Dallas for \$8,000. At the time of purchase the apartments were not habitable because of deterioration and vandalism, but plaintiffs were under an obligation to the city to bring the building into compliance with building code standards. Plaintiffs purchased a fire policy on the building in the amount of \$120,000. The coverage amount was based upon a per-square-foot replacement cost estimate, without regard to the actual condition of the structure or prevailing market conditions. About three months after the original purchase, without any repairs or remodeling having been undertaken, portions of the building were heavily damaged by fire. Although some portions were substantially untouched by the fire, plaintiff sued for the face amount of the policy, contending that the building was a "total loss" within the meaning of the valued policy

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effective concurrently with the inception of such indebtedness to the Creditor or the effective date of this Policy [2 January 1976], whichever is later . . . ." *Id.* at 606.

81. TEX. INS. CODE ANN. art. 3.53, § 2(B)(1) (Vernon 1981) defines credit life insurance as "insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction."

82. 607 S.W.2d at 606. The court noted that the Minnesota Supreme Court, in construing a similar provision, had held it broad enough to include an open line of credit. *See Blue Earth State Bank v. Crown Life Ins.*, 267 N.W.2d 177 (Minn. 1978).

83. 607 S.W.2d at 606.

84. 606 S.W.2d 7 (Tex. Civ. App.—Dallas 1980, writ ref'd n.r.e.).

law.<sup>85</sup> The jury found that the building was a total loss, but the trial court disregarded this finding as being unsupported by the evidence, and rendered judgment for a partial loss only.<sup>86</sup>

Plaintiffs appealed, contending that the trial court erred in disregarding the jury's finding of total loss because there was evidence (1) that the cost of repair would far exceed the value of the building after repair, so that no prudent owner would undertake restoration and (2) that the reduction in value caused by the fire was substantial.<sup>87</sup> The court of civil appeals affirmed, holding such evidence legally insufficient to support the total loss finding.<sup>88</sup> The court noted that in determining whether a structure was a total loss under the statutory concept, the central question was whether after the fire there remained a substantial remnant that a prudent owner would use in restoring the building to its original condition.<sup>89</sup> Under this standard, it was immaterial whether a prudent owner would in fact elect to restore the building; rather, the question was whether an owner who decided to restore would have a substantial remnant to use as the basis for restoration.<sup>90</sup> The undisputed evidence showed that usable remnants remained after the fire. The court of civil appeals therefore held that there was no evidence to support the jury's finding of total loss, and that the total loss finding was properly disregarded.<sup>91</sup> The court of civil appeals also approved the trial court's charge to the jury on the measure of damages for a partial loss, which was submitted as the difference between the fair market value of the property immediately before the loss and after the loss.<sup>92</sup>

*Proof of Loss.* In *Shelton v. United States Fire Insurance Co.*<sup>93</sup> the court

85. TEX. INS. CODE ANN. art. 6.13 (Vernon 1981), commonly known as the valued policy law, provides:

A fire insurance policy, in case of a total loss by fire of property insured, shall be held and considered to be a liquidated demand against the company for the full amount of such policy. The provisions of this article shall not apply to personal property.

On and after January 1, 1951, the provisions of the preceding paragraph of this article shall be incorporated verbatim in each and every fire insurance policy hereafter issued as coverage on any real property in this State; and it shall be the duty of the Board of Insurance Commissioners, by proper order and procedure, to compel compliance with this statute.

The article mandates payment of the full face amount of the policy whenever there is a total loss by fire to real property, without regard to the actual condition or value of the structure before the loss. See *Royal Ins. Co. v. McIntyre*, 90 Tex. 170, 37 S.W. 1068 (1896); *Superior Fire Ins. Co. v. Roberts*, 84 S.W.2d 810, 811 (Tex. Civ. App.—Dallas 1935, no writ).

86. 606 S.W.2d at 8: The pre-fire fair market value found by the jury was \$28,900. *Id.* at 10. While the jury's post-loss figure was not given in the opinion, all the witnesses had agreed that the post-loss value was "nominal." *Id.* The partial loss measure of damages submitted was the difference in value before and after the fire; one may infer therefore that the trial court's judgment, disregarding prejudgment interest, was slightly less than \$28,900. *Id.* at 11.

87. *Id.* at 10.

88. *Id.* at 12.

89. *Id.* at 10.

90. *Id.*

91. *Id.* at 8.

92. *Id.* at 11.

93. 613 S.W.2d 538 (Tex. Civ. App.—Fort Worth 1981, writ ref'd n.r.e.).

determined whether an adjuster's statements extended the ninety-one-day time period for filing a proof of loss established in a Texas Standard Policy.<sup>94</sup> The plaintiffs purchased fire insurance from two companies upon the contents of a leased building that they ran as a supper club. A loss occurred, and although plaintiffs communicated after the loss with various insurance adjusters, they failed to file a proof of loss within ninety-one days as required by the policy. Plaintiffs contended that statements made by the adjusters operated to extend the ninety-one-day period specified in the policy. After a trial to a jury, the trial court rendered judgment for the defendant insurers because plaintiffs offered no evidence to show compliance with the proof of loss requirement and no evidence that the adjusters were in fact agents of the defendant insurers. The court of civil appeals affirmed, agreeing that plaintiffs had wholly failed to establish any agency-principal relationship between the adjusters and the defendant insurers.<sup>95</sup> The statements of the adjusters themselves were incompetent to establish the alleged agency relationship.<sup>96</sup>

*Homeowners' Policy Theft Coverage.* The current survey period includes two homeowners' policy theft cases. In *Herndon v. Sentry Insurance*<sup>97</sup> plaintiff sued his homeowners' insurer under the "off premises coverage" clause<sup>98</sup> for the value of two stolen rings. Coverage of one ring was con-

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94. The Texas Standard Policy proof of loss provision reads:

Within ninety-one days after the loss, unless such time is extended in writing, the insured shall render to this Company a proof of loss signed and sworn to by the insured. Such proof of loss shall reveal to the best knowledge and belief of the insured the following: the time and cause of the loss; the interest of the insured and all others in the property, including any encumbrances thereon; all contracts of insurance, whether valid or not, covering such property; the actual cash value of each item of property and the amount of loss thereto; and by whom and for what purposes the building was occupied at the time of loss.

In the absence of waiver by the insurer, compliance with this requirement is a condition precedent to the insured's right of recovery. *Commercial Union Assurance Co. v. Preston*, 115 Tex. 351, 357, 282 S.W. 563, 566 (1926). The period within which a proof of loss may be required must be reasonable, and may not be less than 90 days. TEX. REV. CIV. STAT. ANN. art. 5546 (Vernon Supp. 1982).

95. 613 S.W.2d at 539.

96. *Id.*

97. 615 S.W.2d 249 (Tex. Civ. App.—Dallas 1981, writ ref'd n.r.e.).

98. The Texas Homeowners' Policy contains three types of first-party property coverages: (1) Dwelling (Coverage A), (2) Unscheduled Personal Property (Coverage B) and (3) Scheduled Personal Property, if added by endorsement (Coverage C). In *Herndon* the "off premises coverage" provision extended coverage for unscheduled personal property (Coverage B) to personal property anywhere in the world, subject to certain limitations and exclusions so that it was not limited to property located at the insured's dwelling location. The off premises coverage provision read:

"OFF PREMISES COVERAGE—Subject to the provisions and conditions of this policy and the exclusions and limitations therein, Coverage B also covers, as additional insurance, unscheduled personal property (except property usually rented to others) owned, worn or used by the Insured, including members of his family of the same household, anywhere in the world. Such Off Premises Coverage, however, shall be limited to \$1,000 or 10% of the Limit of Liability applicable to Coverage B, whichever is greater . . ."

*Id.* at 250-51. Excluded from unscheduled personal property coverage under the terms of

ceded because it was a specifically scheduled item. The insurer denied coverage for the second ring based on a specific exclusion for unscheduled personal property stolen from any dwelling of the insured other than the one listed on the face of the policy. After purchasing the policy, the insured had moved from one apartment to another without notifying the insurer, so that his dwelling at the time of the loss was not the one reflected on the policy. The trial court rendered judgment for the insurer, enforcing the exclusion as written. The court of civil appeals affirmed, rejecting the insured's contention that the exclusion was ambiguous.<sup>99</sup>

In *Employers Casualty Co. v. Peterson*<sup>100</sup> plaintiffs claimed the theft of scheduled personal property. Plaintiffs had given jewelry to Shay with the intention that Shay would sell it for them. Shay failed to return the jewelry upon demand, and plaintiffs sued their homeowners' insurer, claiming a theft loss. The trial court rendered judgment for plaintiffs upon a jury verdict.<sup>101</sup>

On appeal the insurer challenged the trial court's definition of "control" in submitting to the jury the question of whether the jewelry was under the insured's control at the time of the loss.<sup>102</sup> The court of civil appeals overruled the point, holding that coverage was established as a matter of law and the issue of control was immaterial since the insuring agreement extended to property "owned by or in the custody or control of the insured,"<sup>103</sup> and ownership was undisputed.<sup>104</sup> The insurer also contended that the trial court had erred in excluding evidence of a similar claim made by plaintiffs against another insurance company. The court of civil appeals held the evidence of another similar claim was properly excluded as outside the scope of the pleadings, because the insurer did not plead fraud, scheme, or plan on the part of the insured.<sup>105</sup>

*"Motor Vehicle" and "Vehicle."* In *Nicholson v. First Preferred Insurance Co.*<sup>106</sup> the court was asked to interpret the term "motor vehicle" within the meaning of an exclusion in a Texas Homeowners' Policy. The Nicholsons

the policy was theft of "personal property while on the premises of any dwelling (other than the described dwelling) owned, rented, or occupied by an Insured except while an Insured is temporarily residing therein; . . ." *Id.* at 251.

99. *Id.* at 252.

100. 609 S.W.2d 579 (Tex. Civ. App.—Dallas 1980, no writ).

101. *Id.* at 583.

102. The issue submitted by the trial court and the jury's response were:

"Do you find from a preponderance of the evidence that under the agreement between Fred L. Peterson and Nathan Shay, at the time of Fred L. Peterson's demand for the return of the diamond ring and diamond earrings, such items of jewelry were not under the control of Fred L. Peterson?

Answer, 'They were not under the control' or 'They were under the control.'

ANSWER: 'They were under the control.'"

*Id.* at 587-88.

103. *Id.* at 585.

104. *Id.* at 588.

105. *Id.* at 585.

106. 618 S.W.2d 560 (Tex. Civ. App.—Amarillo 1981, no writ).



suffered a fire at their home and made a claim for damage to the dwelling and its contents, including a dragster race car. The insurer denied the claim, first on the basis that maintenance of the dragster race car voided all coverage because it violated the insured's declaration that no business pursuits were carried on at the dwelling, and secondly, as to the race car in particular, because damage to "motor vehicles" was specifically excluded.<sup>107</sup>

After a trial to the court, judgment was rendered in favor of plaintiffs for all amounts claimed, except the dragster race car.<sup>108</sup> The insured appealed, contending that the dragster was not a "motor vehicle" within the meaning of the insurance policy; rather, the insured argued that a motor vehicle was a machine intended for use upon public roads or highways, and not one intended for racing purposes.<sup>109</sup> The court of civil appeals rejected this argument, holding that the dragster was a "motor vehicle."<sup>110</sup> It approached the issue by reference to two settled principles for interpreting insurance policies that (1) terms not defined are to be given their common and ordinarily accepted meanings<sup>111</sup> and (2) ambiguous terms are to be construed in favor of coverage.<sup>112</sup> Rejecting certain statutory definitions of "motor vehicle" as determinative,<sup>113</sup> the court found the common meaning of the term would include all self-propelled vehicles not operated on stationary rails or tracks.<sup>114</sup> The court noted that this definition was held proper by the Texas Supreme Court in defining the same term as used in the Texas Tort Claims Act.<sup>115</sup> The appellate court also rejected the insurer's cross point relating to business pursuits, stating that no business pursuits had been conclusively established.<sup>116</sup> Accordingly, the trial court's judgment was affirmed.<sup>117</sup>

In *Vetrano v. Aetna Life & Casualty*<sup>118</sup> the insured sued his homeowners' insurer under his unscheduled personal property coverage for a "loss by vehicle." The insured while on a fishing trip had taken with him in the boat several items of personal property. On the first afternoon of the trip, the boat began taking on water and ultimately capsized. The insured sued

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107. The insured's homeowners' policy excluded "motor vehicles" from coverage under the unscheduled personal property provision. *Id.* at 562.

108. *Id.* at 561.

109. *Id.* at 562-63.

110. *Id.* at 563.

111. *Id.* at 562.

112. *Id.*

113. *Id.* at 563. The definition found in TEX. REV. CIV. STAT. ANN. art. 6675a-1(a),(b) & art. 6701d, § 2(a), (b) (Vernon 1977) would extend only to vehicles used "upon a public highway."

114. 609 S.W.2d at 563.

115. 618 S.W.2d at 563. The court has construed "motor vehicle" within the meaning of the Texas Tort Claims Act, TEX. REV. CIV. STAT. ANN. art. 6252-19 (Vernon Supp. 1982) stating that: "[c]ommon usage has made the phrase 'motor vehicle' a generic term for all classes of self-propelled vehicles not operating on stationary rails or tracks." *Slaughter v. Abilene State School*, 561 S.W.2d 789, 792 (Tex. 1977).

116. 618 S.W.2d at 564.

117. *Id.*

118. 612 S.W.2d 689 (Tex. Civ. App.—Houston [14th Dist.] 1981, no writ).

for the value of the personal property lost, claiming he had suffered a "loss by vehicle."<sup>119</sup> Trial to the court resulted in a judgment for the insurer, on the basis that the boat was not a vehicle within the meaning of the policy.<sup>120</sup>

On appeal the insured urged that a boat was a vehicle. The insurer took the opposite position, and further argued that in any event there was no evidence of a loss by vehicle because the boat did not cause the loss. The court of civil appeals held for the insured on both issues,<sup>121</sup> stating that the term, according to its ordinary meaning, was broader than "motor vehicle" or "automobile," and was at a minimum ambiguous as applied to a boat. The term therefore, was construed liberally to include a boat.<sup>122</sup> With respect to the loss itself, the court held that there was some evidence that the loss had been caused by a leak in the boat so as to render it a loss by vehicle, rather than by some other cause.<sup>123</sup> The cause was reversed and remanded for a new trial on the "loss by vehicle" issue.<sup>124</sup>

*Insurable Interest.* In *Reynolds v. Allstate Insurance Co.*<sup>125</sup> the court pushed the concept of insurable interest under Texas law across new frontiers. The Reynoldses bought an undeveloped lot in Vidor, Texas, in 1964. In the same year they contracted with Looney to build a house on the lot and executed a mechanic's and materialman's lien note and a deed of trust in favor of Looney. The house was completed and the Reynoldses took up residence, but failed to make payments on the note. Looney foreclosed in 1970, buying the house himself at foreclosure. After the foreclosure, the Reynoldses continued to live in the house, and began making payments to Looney. The Reynoldses contended at trial that the payments were note payments; Looney, however, contended that they were rent. In 1975 the Reynoldses purchased fire insurance, and four months later the house was destroyed by fire. At the time of the fire the Reynoldses had moved to another residence, and the house where the fire occurred was occupied by another family.

At trial the insurer contended that the Reynoldses had no insurable interest in the house, because they neither lived in the house nor owned it. The Reynoldses contended that they did own the house, on the theory that Looney's foreclosure five years before the fire was void because of certain procedural irregularities. The case was tried to a jury, which in response to special interrogatories found that Looney's foreclosure was void. The trial court rendered judgment on the verdict for plaintiffs for the property

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119. Under the policy, unscheduled personal property was insured against loss by twelve specifically listed perils. One of the insured perils was "loss by . . . aircraft and vehicles." "Vehicles" was not defined in the policy. *Id.* at 691.

120. *Id.*

121. *Id.*

122. *Id.* at 692-93.

123. *Id.* at 693.

124. *Id.*

125. 629 F.2d 1111 (5th Cir. 1980), *aff'd in part and rev'd in part on rehearing*, 633 F.2d 1208 (1981).

damage and also for attorney's fees.<sup>126</sup>

On appeal the insurer contended that it was error to permit the Reynoldses to attack collaterally Looney's foreclosure, five years after it occurred, for the purpose of establishing their legal title and hence their insurable interest. The Fifth Circuit disagreed, upholding the trial court's position.<sup>127</sup> It observed that under Texas law collateral attacks are permitted upon void titles, as distinguished from titles that are only voidable.<sup>128</sup> The court also held that because insurable interest had been asserted as a defense on the basis of Looney's foreclosure, the Reynoldses must be given an opportunity to show proof that the foreclosure was void.<sup>129</sup> The court observed that Looney would not be bound by the judgment rendered in the case and his title therefore would be unaffected.<sup>130</sup>

Although the Fifth Circuit, in its original opinion, approved awarding attorney's fees in a suit on an insurance contract,<sup>131</sup> it reluctantly reversed its position on rehearing, recognizing that suits against insurance companies upon policies are excluded by the literal language of the statute from the scope of article 2226.<sup>132</sup>

*Reynolds*, a diversity case, was not based upon direct precedent from Texas courts, and the question therefore arises whether *Reynolds* represents an accurate interpretation or prediction of Texas law. The most closely analogous Texas case relied upon by the *Reynolds* court was *Maryland Casualty Co. v. Davenport*,<sup>133</sup> in which the insurer sought unsuccessfully to deny plaintiff's insurable interest on the basis of a prior foreclosure. *Davenport* held for the plaintiff on the insurable interest question, but not on the basis of the challenge to the foreclosure.<sup>134</sup> The court specifically avoided adjudication of the validity of the foreclosure or of its underlying lien,<sup>135</sup> and relied instead on the facts that plaintiff (1) had bought and paid for the property in good faith, (2) had taken possession of it, and (3) had contracted to rent it to another and, but for the fire, would

126. 629 F.2d at 1112.

127. *Id.*

128. *Id.* at 1115.

129. *Id.*

130. *Id.*

131. *Id.* at 1116-18.

132. 633 F.2d at 1208-09. TEX. REV. CIV. STAT. ANN. art. 2226 (Vernon Supp. 1982) contains the following exclusion:

The provisions hereof shall not apply to contracts of insurers issued by insurers subject to the provisions of the Unfair Claim Settlement Practices Act (Article 21.21—2, Insurance Code), nor shall it apply to contracts of any insurer subject to the provisions of Article 3.62, Insurance Code, or to Chapter 387, Acts of the 55th Legislature, Regular Session, 1957, as amended (Article 3.62—1, Vernon's Texas Insurance Code), or to Article 21.21, Insurance Code, as amended, or to Chapter 9, Insurance Code, as amended, and each such article or chapter shall be and remain in full force and effect.

See also *Standard Fire Ins. Co. v. Fraiman*, 588 S.W.2d 681 (Tex. Civ. App.—Houston [14th Dist.] 1979, no writ).

133. 323 S.W.2d 615 (Tex. Civ. App.—Amarillo 1959, no writ).

134. *Id.* at 617.

135. *Id.* at 617-18.

have received a pecuniary benefit in the form of rent payments.<sup>136</sup> Although factually similar in some respects, *Davenport* clearly does not support the reasoning or the holding of *Reynolds*.

*Reynolds* embodies questionable public policy for three reasons. First, because it permits a collateral attack on a land title without joinder of the record title holder,<sup>137</sup> it undermines the integrity of the adversary process. The party with the greatest stake in the title question and the greatest knowledge of the foreclosure facts is not called upon, under *Reynolds* to participate in the trial or defend his record title. As a practical matter, it is much easier to prevail against a party on any issue if that party is not present to defend himself, or has no real interest in doing so. In the absence of the record title holder, the adversarial nature of the trial of issues relating to foreclosure is subverted.

Secondly, the *Reynolds* holding creates an obvious risk of inconsistent adjudications. A court might first hold a foreclosure void in the claimant's suit against the insurance company, and then, in a second suit, hold it valid in a suit by the claimant against the record title holder. Clearly, if the record title holder (former lien holder) prevails against the claimant (former mortgagor) and defeats the challenge to the foreclosure, then the claimant should be held to have no insurable interest, and should not be permitted to recover insurance proceeds. The *Reynolds* rule, however, permits the insured to recover against the insurance company, while losing the battle, or never undertaking the battle on the same issue against the record title holder.

Thirdly, the *Reynolds* holding tends to increase the moral hazard to the property by creating an incentive for the claimant to produce an intentional loss. If a claimant's only means, or easiest means, to realize a benefit from the property is through insurance, then he is given a financial motive to produce the loss. Why should the claimant, having neither possession nor record title, initiate a judicial battle against the record title holder, when a claim against an insurer, who is a stranger to the title dispute, offers the prospect of a prompt resolution of all problems through a large cash payment?

*McClellan v. Scardello Ford, Inc.*<sup>138</sup> illustrates that in order to recover upon an insurance policy, not only must the plaintiff have an insurable interest in the property, but also the insurance policy must cover the plaintiff's interest. McClellan was to pay Scardello in cash for a truck when it was delivered in Dalhart, Texas. Scardello located a truck in Tennessee and arranged for it to be driven to Dalhart. En route, the driver became ill and was forced to delay his trip by three or four days, during which time Scardello's travel insurance expired. In order to shift the expense of addi-

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136. *Id.* at 616-17.

137. The *Reynolds* opinion contains no indication whether the insurer objected to the failure to join Looney, the record title holder, as could have been done under FED. R. CIV. P. 12(b)(7). The opinion does allude to the possibility of joining the absent party. 629 F.2d at 1115 n.7.

138. 619 S.W.2d 593 (Tex. Civ. App.—Amarillo 1981, no writ).

tional insurance to McClellan, Scardello contacted not his own insurance company, but Farm Bureau, McClellan's insurer. Farm Bureau agreed to add an endorsement covering the truck, and McClellan was informed of the arrangement, to which he assented. After the driver recovered from his illness and continued his journey toward Dalhart, the truck caught fire and was destroyed. McClellan refused to sign a document reflecting his ownership of the truck and made no claim to Farm Bureau for the loss. Scardello did submit such a claim, but it was rejected by Farm Bureau. The case was submitted to the trial court upon depositions, and judgment was rendered in favor of Scardello against both McClellan and Farm Bureau for the value of the truck.

On appeal Scardello conceded that McClellan had not accepted the risk of loss on the truck at the time of the fire, and abandoned his suit as to McClellan.<sup>139</sup> Farm Bureau urged that its policy only protected McClellan's interest, if any, in the truck and not that of Scardello. The appellate court agreed and held that Scardello, as a stranger to the insurance contract, could not assert rights under the policy;<sup>140</sup> the trial court's judgment therefore was reversed, and a take-nothing judgment was rendered in favor of Farm Bureau.<sup>141</sup>

*Insurers' Subrogation Rights.* Three cases in the survey period deal with insurers' subrogation rights. In *Cloyd v. Champion Home Builders Co.*<sup>142</sup> the insurer paid for a fire loss to Cloyd's mobile home and then, as subrogee, brought a breach of warranty suit against the manufacturer. The trial court granted the manufacturer summary judgment based on a general release that Cloyd had executed in the manufacturer's favor.<sup>143</sup> The release was undated, and there was no summary judgment evidence to show the date of its execution. On appeal the subrogated insurer contended that the trial court had erred in placing upon it, as plaintiff, the burden of showing the manufacturer's knowledge or awareness of the subrogation claim at the time the release was taken from Cloyd. The court of appeals disagreed, holding that the release on its face barred the suit, and to avoid its effect, the plaintiff-insurer had the burden of proving that the defendant had notice of the subrogation claim at the time the release was taken.<sup>144</sup> In the absence of such evidence in the record, summary judgment for defendant was affirmed.<sup>145</sup>

In *Landsdowne-Moody Co. v. St. Clair*<sup>146</sup> Landsdowne-Moody, the insured, leased a tractor to St. Clair. The tractor was stolen, allegedly through St. Clair's negligence. The insurer paid to Landsdowne-Moody a

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139. *Id.* at 596.

140. *Id.* at 597.

141. *Id.*

142. 615 S.W.2d 269 (Tex. Civ. App.—Dallas 1981, writ ref'd n.r.e.).

143. *Id.* at 270.

144. *Id.* at 271-72.

145. *Id.* at 271.

146. 613 S.W.2d 792 (Tex. Civ. App.—Houston [14th Dist.] 1981, no writ).

portion of its loss under a policy of insurance, and brought a subrogation action against St. Clair. During the pendency of the subrogation action, Landsdowne-Moody brought a separate, parallel action against St. Clair for the amount of its loss, over and above the amount covered by insurance. In the latter case, Landsdowne-Moody was awarded judgment for \$361 as the amount of its uninsured loss, and a release was taken after the judgment was paid. Thereafter, St. Clair pleaded the \$361 judgment as res judicata in the subrogation case, and obtained a summary judgment in the trial court. The appellate court reversed and remanded, holding that the resolution of Landsdowne-Moody's claim would not bar the insurer's subrogation claim, since St. Clair had notice of both claims at the time of the judgment and release of judgment in the Landsdowne-Moody case.<sup>147</sup>

*Rushing v. International Aviation Underwriters, Inc.* held that an insurer, subrogated to its insured's claim, was entitled to the benefits of its insured's contractual right to recover attorneys' fees.<sup>148</sup> Rushing leased an airplane from Hi-Performance and negligently damaged it during a landing. International Aviation paid Hi-Performance's loss, and asserted a subrogation claim against Rushing, both for the amount of the property damage to the aircraft and for attorneys' fees. The attorneys' fees claim was made under the terms of Hi-Performance's aircraft lease contract with Rushing. After trial to a jury, the district court awarded International Aviation judgment upon the verdict for the property damage, but denied recovery for the attorneys' fees found by the jury.<sup>149</sup>

Rushing appealed, arguing that International Aviation's claim was barred under a Texas tax statute<sup>150</sup> because Hi-Performance's corporate charter, though valid (1) at the time the aircraft was damaged, (2) at the time of payment by the insurer, and (3) at the time suit was filed, had subsequently been forfeited due to Hi-Performance's failure to pay its corporate franchise tax. International Aviation, by cross appeal, sought recovery of the attorneys' fees as found by the jury. The court held for International Aviation on both issues,<sup>151</sup> stating that while International Aviation stood in the shoes of its insured, vis-a-vis Rushing, its right to sue became irrevocably fixed at the time suit was filed and could not be af-

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147. *Id.* at 793.

148. 604 S.W.2d 239, 241 (Tex. Civ. App.—Dallas 1980, writ ref'd n.r.e.).

149. *Id.*

150. TEX. TAX—GEN. ANN. art. 12.14 (Vernon 1969) (repealed 1981) provided in part:

If the reports required by Articles 12.08, 12.09, and 12.19 be not filed in accordance with the provisions of this Chapter, or if the amount of such tax and penalties be not paid in full on or before September 15 of each year or, when an initial tax report or payment is required, on or before ninety (90) days after the time the initial report and payment is required, such corporation shall for such default forfeit its right to do business in this State; which forfeiture shall be consummated without judicial ascertainment by the Comptroller of Public Accounts. Any corporation whose right to do business shall be thus forfeited shall be denied the right to sue or defend in any court of this State, except in a suit to forfeit the charter or certificate of authority of such corporation.

151. 604 S.W.2d at 244-45.

fect by the subsequent forfeiture of the insured's corporate charter.<sup>152</sup> The court followed *Safway Rental & Sales Co. v. Albine Engine & Machine Works*,<sup>153</sup> decided under Oklahoma law, on the attorneys' fees issue, reasoning that because of the contract between the parties, the defendant would have been liable for attorneys' fees in the absence of insurance, and therefore it should not be relieved of such liability because the plaintiff carried insurance.<sup>154</sup> The *Rushing* court also observed that a contrary holding would only lead to an exaltation of form over substance, forcing insurers to require insureds to pay attorneys' fees initially in suits involving subrogation claims, thereby allowing the insurer to obtain clear subrogation rights with respect to attorneys' fees upon reimbursing the insured.<sup>155</sup> The trial court's judgment was modified to include attorneys' fees in favor of International Aviation, and otherwise affirmed.<sup>156</sup>

#### IV. HEALTH, LIFE, AND ACCIDENT INSURANCE

*Material Misrepresentation Defense.* *Lee v. National Life Assurance Co.*<sup>157</sup> illustrates that a suit on life insurance policy may not be barred even though the policy is issued in reliance upon false statements of fact knowingly made by the insured that are material to the risk. In *Lee* the Fifth Circuit reviewed a summary judgment in favor of the defendant life insurance company. To apply for life insurance, the decedent, Lee, had signed a two-page questionnaire application that was attached to and made a part of the policy when it was issued. Lee represented that he had no personal physician and that he had not suffered a heart attack, chest pain, or related symptoms within five years of the application date. In fact, as shown by the deposition testimony of Lee's doctors, he did have a personal physician and had suffered a heart attack within the five-year period. Additionally, he had continued to experience frequent chest pains and to receive treatment from his personal physician for his heart condition. Lee died of a heart attack within four months of the date the policy was issued.

The application for the policy had been completed almost entirely in the handwriting of a medical examiner, who had interviewed Lee and written the answers on the basis of Lee's statements and then presented it to him for his signature; a few answers however were in Lee's handwriting. The examiner's affidavit reflected that, although he had no specific recollection of his interview with Lee, the answers he wrote typically were not verbatim transcriptions of the applicant's words, that some interpretation of the applicant's statements was generally required, and that he tried to answer in favor of the applicant so that the insurance could be sold.

The district court granted summary judgment for the insurer, holding

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152. *Id.* at 241-42.

153. 343 F.2d 129 (10th Cir. 1965).

154. 604 S.W.2d at 244.

155. *Id.*

156. *Id.*

157. 632 F.2d 524 (5th Cir. 1980).

that all elements of the material misrepresentation defense were established as a matter of law.<sup>158</sup> On appeal, the beneficiary contended material fact issues remained. The Fifth Circuit restated that the elements of the misrepresentation defense under Texas law were:

- (1) that a representation was made; (2) that it was false; (3) that the misrepresentation was material to the risk; (4) that the insurer relied on the misrepresentation in issuing the insurance policy; and (5) that the misrepresentation was made willfully with the intent to deceive or to induce the insurance company to issue the policy.<sup>159</sup>

In reviewing *Lee*, the Fifth Circuit agreed that all elements were established as a matter of law, except the intent to deceive.<sup>160</sup> The court observed that under Texas law, when a signed application was attached to and made a part of the policy, the insured was conclusively presumed to have knowledge of and to have ratified any false statements contained in it,<sup>161</sup> and this conclusive presumption therefore established the elements of misrepresentation and falsity. Further, the court concluded that the misrepresentations were clearly material to the risk and were relied upon.<sup>162</sup> In reviewing the intent question, the court noted (1) that the medical examiner had stated that he had written the answers in the application on the basis of his interpretation of the applicant's statements, trying to answer in favor of the insured, and (2) that although the portion of the application completed by the medical examiner denied that Lee had a personal physician, in one of the answers written by Lee, Lee had given his doctor's name and address.<sup>163</sup> This evidence, the court held, created a fact issue on the intent in making the misrepresentations, and required reversal and remand for trial.<sup>164</sup>

*Inception/Termination of Coverage Period.* The survey period includes four cases dealing with inception and/or termination of coverage. In *United Travelers Insurance Co. v. Perkins*<sup>165</sup> the court was asked to determine the effective date of a life insurance policy. On May 13, 1978, Mrs. Perkins applied for membership in Lodge 10 of United Travelers Life Insurance Company, a fraternal benefit society organized into fourteen lodg-

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158. *Id.* at 527.

159. *Id.*

160. *Id.* at 525.

161. *Id.* at 527. For this rule the court properly relied upon *Odom v. Insurance Co.*, 455 S.W.2d 195, 199 (Tex. 1970).

162. 632 F.2d at 528-29.

163. *Id.* at 529. In its initial opinion the court interpreted *Washington v. Reliable Life Ins. Co.*, 581 S.W.2d 153 (Tex. 1979), as holding that the intent element could never be established as a matter of law without "either a warranty that the facts contained in the application are true or evidence of collusion between the applicant and the insurance agent." 632 F.2d at 528. On rehearing, on the basis of *Mayes v. Massachusetts Mut. Life Ins. Co.*, 608 S.W.2d 612 (Tex. 1980), the Fifth Circuit retracted this interpretation of Texas law, and recognized that even without a warranty or evidence of collusion, the insured's intent to deceive could be established as a matter of law. It reaffirmed its holding, however, that intent to deceive was not shown as a matter of law in the case before it.

164. 632 F.2d at 529.

165. 611 S.W.2d 152 (Tex. Civ. App.—Waco 1981, writ ref'd n.r.e.).



es. All applicants for membership in the society were required to apply for a policy of insurance with United Travelers, and Mrs. Perkins therefore applied for a life insurance policy in the amount of \$2,000 that named Mr. Perkins as beneficiary. A provision of the application stated that the insurance would not take effect until the policy was actually delivered to and accepted by the applicant during her life and good health. After completing the application, for which both Mr. and Mrs. Perkins furnished information, the Perkinses tendered, and the United Travelers' agent accepted, the first year's premium. The agent issued a "Temporary Premium Receipt," on United Travelers' form. United Travelers was required under state regulations, because of its limited reserves, to reinsure any policy in excess of \$1,000. The Perkinses, however, were not informed of this requirement or that the approval of the reinsurer was necessary before the policy would be issued. The application was approved by United Travelers in June and sent on to its reinsurer, Republic National Life Insurance Company of Dallas, for its approval. Republic, on August 25, approved the reinsurance and United Travelers received notification of the approval on August 28. On the same day, August 28, Mrs. Perkins died in an automobile accident. The policy was never issued, and a check refunding the premium was sent to Mr. Perkins in October.

Mr. Perkins's claim for insurance proceeds was denied, and he brought suit on several theories, including fraud, estoppel, and violations of the Deceptive Trade Practices Act and the Texas Insurance Code.<sup>166</sup> Trial was to the court, which rendered judgment for plaintiff for \$2,000, finding that defendant had falsely represented the coverage to be in effect on May 13, 1978, and that the elements of fraud and estoppel were proved.<sup>167</sup> No deceptive trade practices were found.<sup>168</sup>

The court of civil appeals reversed and rendered judgment for United Travelers, holding no evidence existed to support the trial court's finding that defendant represented the policy to be in effect on May 13, 1978.<sup>169</sup> The only evidence concerning the effective date was the provision in the application that the policy would not be effective unless delivered while the insured was alive and in good health. The court gave effect to this provision.<sup>170</sup> Relying on precedent,<sup>171</sup> the court held that in the face of such a stipulation, no delay in issuing the policy, whether reasonable or

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166. *Id.* at 154-55. Perkins claimed false, misleading, or deceptive acts or practices constituting a violation of TEX. INS. CODE ANN. art. 21.21, § 16 (Vernon 1981), which incorporates § 17.46 of the Deceptive Trade Practices Act. TEX. BUS. & COM. CODE ANN. §§ 17.46(b)(1)-(3), (5), (7), (12) (Vernon Supp. 1982) are the particular provisions under which Perkins sought recovery. In addition, he claimed that § 17.50 of the Deceptive Trade Practices Act was also applicable. TEX. BUS. & COM. CODE ANN. § 17.50(a)(3) (Vernon Supp. 1982).

167. 611 S.W.2d at 155.

168. *Id.* at 156-57.

169. *Id.* at 157-58.

170. The court stated that the Perkinses were charged with knowledge of the contents of the clause because they had had an opportunity to read it and no evidence was presented that Mrs. Perkin's signature was obtained by fraud. *Id.* at 157. Other cases have held an applicant to be charged with knowledge of application provisions under similar circum-

unreasonable, could operate as acceptance for formation of an insurance contract<sup>172</sup> and the defendant could not be estopped to deny the existence of a policy because no policy or contract was ever formed.<sup>173</sup>

In *Durham Life Insurance Co. v. Cole*<sup>174</sup> the court was again faced with a determination of the effective date of a life insurance policy. Cole's employer applied for a group policy on July 27, 1979, requesting an effective date of August 1, 1979. The application contained a provision that no insurance would become effective without the written approval of the insurer. The written approval was given August 30, 1979. Cole was killed in a motorcycle accident on August 17, 1979.

The understanding of the agent and the employer was that if all matters pertaining to the application for insurance were received by the 10th of August, the coverage would be effective from the preceding first of the month. The application, together with all paper work necessary for the insurance coverage including a check for the premium, was mailed to the agent's office on July 30, 1979. The check was deposited on August 7, 1979. On August 20, 1979, the agent contacted Durham's office to determine the effective date of the policy. An unidentified person in the office told the agent the effective date was August 1. The claim of Mrs. Cole, the beneficiary, was rejected, and she brought suit.

The trial court sitting without a jury found for the plaintiff and rendered judgment for the face amount of insurance plus a statutory penalty and attorney's fees.<sup>175</sup> The court of appeals reversed and rendered a take-nothing judgment, giving effect to the provision in the application stipulating that only one method of acceptance should be controlling, namely written approval of the insurer.<sup>176</sup> It was undisputed that the only written approval given by the insurer was dated three days after Cole's death; therefore the court found no insurance in effect on the date of his death. The court stated that as with any business contract, life insurance contracts do not become binding until a complete agreement exists between the parties evidenced by an offer and an acceptance.<sup>177</sup> Justice Dickinson dissented on the ground that the trial court's finding of offer and acceptance was supported by representations of the general agent, who had authority to bind the company, and the statement of the unidentified person at the agency that the coverage was in force as of August 1, 1979.<sup>178</sup>

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stances. See *Thigpen v. Locke*, 363 S.W.2d 247, 253 (1962); *Indemnity Ins. Co. v. W.L. Macatee & Sons*, 129 Tex. 166, 169, 101 S.W.2d 553, 556 (1937).

171. *Brownwood Benevolent Ass'n v. Maness*, 30 S.W.2d 1114 (Tex. Civ. App.—Eastland 1930, writ ref'd).

172. 611 S.W.2d at 156.

173. *Id.*

174. 608 S.W.2d 838 (Tex. Civ. App.—Eastland 1980, writ ref'd n.r.e.).

175. *Id.* at 839. Payment of attorney's fees is provided for by TEX. INS. CODE ANN. art. 3.62 (Vernon 1981).

176. 608 S.W.2d at 840.

177. *Id.* at 839.

178. *Id.* at 840.

In *Baker v. Penn Mutual Life Insurance Co.*<sup>179</sup> the court considered the effect of an offer of reinstatement on a policy that had lapsed, in reviewing a summary judgment for the defendant life insurance company. Baker bought a life insurance policy in 1976, but failed to pay the required annual premium in 1979. The policy's grace period expired and thereafter a notice of default and an offer of reinstatement, which by its terms would expire on April 6, 1979, was sent to and received by Baker. On March 30, 1979, after the end of the grace period and before any action was taken by Baker, he died in an accident. Penn denied coverage, and Baker's parents brought suit as the beneficiaries of the policy. The court of civil appeals affirmed summary judgment for the insurer.<sup>180</sup> The court pointed out that the original policy had expired and that the offer of reinstatement had not been accepted at the date of the insured's death.<sup>181</sup> After the date of death, theories of waiver and estoppel based on subsequent actions of the insurer could not retroactively create a life insurance contract.<sup>182</sup>

*Group Life & Health Insurance Co. v. Brown*<sup>183</sup> dealt with the issue of whether an insurer had a duty to convert a group life policy to an individual policy at the policyholder's request. Mrs. Tatom was a teacher covered by a group life and health policy that contained a conversion privilege entitling the insured to convert his coverage to individual policies when he was no longer a group member. The life insurance conversion privilege specified that the insured must make written application and pay the first premium payment within thirty-one days after termination of employment with the group. Mrs. Tatom retired at the age of sixty-five and requested that her life and health insurance be converted to individual policies, but failed to make any written application or pay any premium for the life coverage. Only the health insurance coverage was reissued as an individual policy. Upon Tatom's death, the executrix of her estate sued the insurer on theories of negligence and estoppel. The trial court rendered judgment for the estate upon a jury verdict.

The court of civil appeals reversed and rendered, determining that the insurer had no duty to issue a life insurance policy to Mrs. Tatom because she had not complied with the application and premium payment requirements in the group policy.<sup>184</sup> Without a duty running from the insurer to Mrs. Tatom, liability could not be predicated upon negligence.<sup>185</sup> The court held that there was no evidence to support findings on the elements of estoppel, including the elements of false representation by the insurer and of detrimental reliance by Mrs. Tatom.<sup>186</sup>

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179. 617 S.W.2d 814 (Tex. Civ. App.—Houston [14th Dist.] 1981, no writ).

180. *Id.* at 816.

181. *Id.* at 815-16.

182. *Id.* at 816.

183. 611 S.W.2d 476 (Tex. Civ. App.—Tyler 1980, no writ).

184. *Id.* at 480-81.

185. *Id.* at 480.

186. *Id.* The court restated the elements of estoppel:

In order to recover on the basis of equitable estoppel it must be shown:

(1) a false representation or concealment of material facts, (2) made with

*Beneficiary Designation Changes.* In *Prudential Insurance Co. of America v. Burke*<sup>187</sup> the contractual obligation of a life insurance company to change the beneficiary of a life insurance policy and the recoverability of attorney's fees in a suit on an insurance policy were decided. Burke filed suit to force Prudential to change the beneficiary of his life insurance policy from his former wife to his new wife and he also sought attorney's fees.<sup>188</sup> The policy had been purchased with community funds during the marriage to the first Mrs. Burke. Prudential argued that it could not make the requested change without the ex-wife's consent because she had a community property interest in the eventual proceeds of the policy, of which she could not be divested by the unilateral act or request of Mr. Burke. Trial upon stipulated facts resulted in judgment for the plaintiff, both declaring his right to a beneficiary change and awarding attorney's fees. The court of civil appeals affirmed the trial court's judgment.<sup>189</sup>

The appellate court stated that Prudential was correct in asserting that the former Mrs. Burke had a community property interest in the policy and its proceeds, when payable; even so, the company had no right to refuse to make the change, and no standing to assert the rights of the former Mrs. Burke. Noting that the change would only be effective as to Mr. Burke's one-half community property interest in the policy, and would not cut off the former Mrs. Burke's rights, the court held that Prudential was obligated to make the requested change of beneficiary.<sup>190</sup> In considering the award of attorney's fees, the appellate court initially reformed the trial court's judgment by deleting the award, holding that article 2226 of the Texas Revised Civil Statutes<sup>191</sup> clearly excluded from its scope policies issued by insurers subject to the Texas Insurance Code.<sup>192</sup> The court reversed this ruling on rehearing, and held that notwithstanding the language of the statute, which appears to exclude suits on insurance policies,<sup>193</sup> the purpose of the legislature was to exclude from the statute "only

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knowledge, actual or constructive of those facts, (3) to a party without knowledge, or the means of knowledge, of such facts, (4) with the intention that it should be acted on, and (5) reliance by the party to whom the representation was made, to that party's detriment.

*Id.*

187. 614 S.W.2d 847 (Tex. Civ. App.—Texarkana), *writ ref'd n.r.e. per curiam*, 621 S.W.2d 596 (Tex. 1981).

188. Burke sought attorney's fees under TEX. REV. CIV. STAT. ANN. art. 2226 (Vernon Supp. 1982), which provides for recovery of attorney's fees in "suits founded on oral or written contracts" when certain notice requirements are met.

189. 614 S.W.2d at 850.

190. *Id.* at 849.

191. TEX. REV. CIV. STAT. ANN. art. 2226 (Vernon Supp. 1982).

192. 614 S.W.2d at 850.

193. The statute on its face appears to exempt suits on insurance policies issued by insurers subject to regulation under the Texas Insurance Code. It reads:

The provisions hereof shall not apply to contracts of insurers issued by insurers subject to the provisions of the Unfair Claim Settlement Practices Act (Article 21.21—2, Insurance Code), nor shall it apply to contracts of any insurer subject to the provisions of Article 3.62, Insurance Code, or to Chapter 387, Acts of the 55th Legislature, Regular Session, 1957, as amended (Article 3.62—1, Vernon's Texas Insurance Code), or to Article 21.21, Insurance Code,

those claims against insurance companies where attorney's fees were already available by virtue of other specific statutes."<sup>194</sup> The court did not explain how it discovered this purpose and the holding is in clear conflict with an earlier case decided by the Houston court of civil appeals.<sup>195</sup> The supreme court, in a per curiam opinion, stated that the court of civil appeals had correctly decided the case, and refused Prudential's application for writ of error with the notation "no reversible error."<sup>196</sup> The lower court's holding, with respect to attorney's fees, was not disturbed nor directly commented upon in the opinion.

In *Anderson v. Anderson*<sup>197</sup> the insured's heirs brought suit against the insured's step-brother to set aside two change of beneficiary designations on life insurance policies executed by the insured prior to his death. Having discovered he had terminal cancer, the insured created a trust for the benefit of his two minor children to be funded from the proceeds of two life insurance policies and gave his step-brother a power of attorney. After a lengthy stay in the hospital, the insured moved to the home of his step-mother and step-brother. The insured subsequently executed two beneficiary designations that made all life insurance proceeds payable to the step-brother, and also executed a new will. The trust for the minor children was left unfunded because the new will provided that only proceeds from policies designating the estate as beneficiary were to be used to fund the trust. The jury found that the beneficiary changes had been prepared by the step-brother knowingly contrary to the insured's instructions and had been signed by the insured without awareness of the altered or incorrect designations. Judgment was rendered on the jury verdict for the heirs, setting aside the designations naming the step-brother as beneficiary. The court of civil appeals affirmed, holding that the circumstantial evidence presented adequately supported the jury's verdict.<sup>198</sup>

*Scope of Coverage and Exclusions from Coverage.* Several cases in the survey period dealt with the scope of coverage under a policy and various

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as amended, or to Chapter 9, Insurance Code, as amended, and each such article or chapter shall be and remain in full force and effect.

TEX. REV. CIV. STAT. ANN. art. 2226 (Vernon Supp. 1982).

194. 614 S.W.2d at 850.

195. In *Standard Fire Ins. Co. v. Fraiman*, 588 S.W.2d 681, 685 (Tex. Civ. App.—Houston [14th Dist.] 1979, no writ), the court held:

Article 2226, Tex. Rev. Civ. Stat. Ann. (Supp. 1978) states that its provisions are not applicable to insurance policies issued by insurance companies subject to the Unfair Claims Settlement Practices Act (Article 21.21—2 Insurance Code). Since this is a fire insurance company it falls within article 21.21—2, section 7, and thus is not within the provisions of article 2226.

The *Fraiman* holding was followed in *Reynolds v. Allstate Ins. Co.*, 629 F.2d 1111 (5th Cir. 1980), *rehearing granted in part and denied in part*, 633 F.2d 1208, 1209 (1981).

196. 621 S.W.2d 596, 597 (Tex. 1981). The court specifically reserved for future decision the question of "the extent of a spouse's community property interest in an unmaturing insurance policy, purchased with community property funds, but not mentioned in the property division of the divorce decree." *Id.*

197. 618 S.W.2d 927 (Tex. Civ. App.—Houston [1st Dist.] 1981, no writ).

198. *Id.* at 929, 931.

exclusions from coverage. In *Gulf Atlantic Life Insurance Co. v. Disbro*<sup>199</sup> Disbro and his wife filed a claim with Gulf Atlantic for medical expenses under a major medical expense policy. Gulf Atlantic denied coverage for a portion of the expenses on the basis of an exclusion for amounts covered "by or through the Federal government."<sup>200</sup> The expenses in question had been paid by Medicare. The case was tried upon an agreed statement of facts, and the trial court rendered judgment for plaintiff. On appeal the court of civil appeals reversed and rendered judgment for the insurer, enforcing the exclusion as written, and rejecting the insured's argument that the exclusion was ambiguous.<sup>201</sup>

*Huse v. Fidelity Interstate Life Insurance Co.*<sup>202</sup> was a suit on a life insurance policy in which the court gave effect to the policy's worker's compensation exclusion. The insured was killed in an automobile accident during the course and scope of his employment. The named beneficiary's claim was denied on the basis of a provision that excluded any accident or loss for which payment would be received under any workers' compensation law.<sup>203</sup> The beneficiary contended that since the worker's compensation benefits were paid to the decedent's minor daughter and not to her, the exclusion was inapplicable. The case was submitted pursuant to an agreed statement of facts in the trial court, where judgment was rendered for defendant. On appeal the court of civil appeals affirmed, stating that absent a statute prohibiting such an exclusion, the parties could freely contract to exclude coverage for losses also covered by worker's compensation.<sup>204</sup>

In *American National Insurance Co. v. Woodward*<sup>205</sup> the insured sued to recover benefits payable under a mortgage disability policy issued by American. Woodward had obtained a loan for the purchase of real estate and simultaneously purchased a group mortgage repayment disability policy. The policy excluded coverage for any disability caused by or resulting from "[a] pre-existing illness, disease or physical condition for which the debtor [insured] received medical diagnosis or treatment within the six months preceding the effective date of the debtor's [insured's] coverage."<sup>206</sup> Having become disabled as the result of an arthritic condition, Woodward made claim on the policy. Coverage was denied, and suit was defended on the basis of the preexisting disease exclusion. The trial court rendered judgment for Woodward upon a jury finding that Woodward's arthritis was not a condition for which she had received medical diagnosis or treatment within six months before the effective date of the coverage. On appeal, the court recognized that the insured had the burden of prov-

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199. 613 S.W.2d 511 (Tex. Civ. App.—Beaumont 1981, no writ).

200. *Id.* at 512.

201. *Id.* at 513.

202. 605 S.W.2d 351 (Tex. Civ. App.—Eastland 1980, no writ).

203. *Id.* at 352. The exclusion stated that "this policy does not cover any accident or loss, fatal or non-fatal, caused by or resulting from . . . injury for which compensation is payable under any Workmen's Compensation Law." *Id.* n.f.

204. *Id.* at 352-53.

205. 614 S.W.2d 201 (Tex. Civ. App.—El Paso 1981, writ ref'd n.r.e.).

206. *Id.* at 201-02.

ing the inapplicability of the pleaded exception. The court of civil appeals read the provision to exclude from coverage only illnesses for which the insured had received prior treatment and affirmed the trial court's holding, having found the evidence adequately supported the jury's verdict.<sup>207</sup>

In *Griffith v. Continental Casualty Co.*<sup>208</sup> the federal district court correctly placed on the plaintiff the burden of disproving the applicability of a pleaded exclusion in a group life policy. The insured, a pilot for Delta Airlines, took off in a private plane on October 28, 1975, for a destination in Florida and was never seen again. The insured's father, the beneficiary under the policy, had the insured declared legally dead,<sup>209</sup> and sought the proceeds of the policy. Continental denied coverage, contending that the death of the insured fell within the policy's exclusion for loss caused by "riding in any aircraft."<sup>210</sup> Suit was filed, and the case was submitted to the court on stipulated facts. The court held there was coverage unless the pleaded exclusion for loss from "riding in any aircraft" applied.<sup>211</sup> There was no evidence of cause of death; therefore the burden of proof was of determinative importance. Under Texas law, when an exclusion is pleaded and thereby put in issue, the insured has the burden of proving that it is not applicable.<sup>212</sup> Judgment was rendered for the insurer since the insured could not present any evidence on cause of death.<sup>213</sup>

In *Connecticut General Life Insurance Co. v. Shelton*<sup>214</sup> Mr. and Mrs. Shelton, insureds under a major medical and medical expense policy, brought suit against Connecticut General to recover the expenses from Mrs. Shelton's restorative surgery to reverse the effects of a prior tubal ligation performed while Mrs. Shelton was married to her first husband. She subsequently remarried and opted to reverse the procedure. The original operation was performed on a doctor's advice that she and her prior husband could not conceive a healthy child due to incompatible Rh factors in their blood. The Sheltons, however, had compatible Rh factors. The policy provided coverage for medical expenses "recommended by a physician as essential for the necessary care and treatment of an injury or sickness."<sup>215</sup> The case was submitted on an agreed statement of facts, and the trial court rendered judgment for plaintiffs. On appeal Connecticut General's sole point was that there was no evidence to show that the expenses were for necessary care or treatment of an injury or sickness. The court of

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207. *Id.* at 203.

208. 506 F. Supp. 1332 (N.D. Tex. 1981).

209. *Id.* at 1333.

210. The policy excluded loss caused by "riding in any aircraft, except to the extent permitted and specifically described in Part VIII 'Air Coverage.'" The air coverage section provided coverage only if an insured was "riding as a passenger in any aircraft properly licensed to carry passengers" or "operating or performing duties as a crew member of any aircraft owned, or operated by Delta [*sic*] . . . ." *Id.* at 1334.

211. *Id.*

212. *Id.* at 1335; see *Sherman v. Provident Am. Ins. Co.*, 421 S.W.2d 652 (Tex. 1967); *Hardware Dealers Mut. Ins. Co.*, 393 S.W.2d 309 (Tex. 1965).

213. 506 F. Supp. at 1337.

214. 611 S.W.2d 928 (Tex. Civ. App.—Fort Worth 1981, writ ref'd n.r.e.).

215. *Id.* at 930.

civil appeals sustained the point and reversed, reasoning that under general principles of law, insurance is intended only to protect against a risk or chance of loss and not a matter over which the insured has control or decision-making power.<sup>216</sup> The elective surgery of the insured was not a loss of a fortuitous character, such as the policy was intended to cover.<sup>217</sup>

In *Hopfer v. Commercial Insurance Co.*<sup>218</sup> the court dealt with a suicide exclusion. Mrs. Hopfer, widow of the insured, sued Commercial to recover the face value of the policy insuring the life of her husband, who had died as a result of a gunshot wound. The policy contained a suicide exclusion that the trial court, based on a jury's verdict, held to be a bar to recovery.<sup>219</sup> Mrs. Hopfer, on appeal, contended that the trial court erred in placing the burden of negating suicide upon her. The court of appeals affirmed, holding that the burden of proof was properly placed on the insured to negate the exclusion, and that the evidence was sufficient to support the jury's verdict.<sup>220</sup>

In *Connecticut General Life Insurance Co. v. Tommie*<sup>221</sup> the court held the evidence sufficient to support jury findings that the death of the insured was not the result of suicide and was accidental.<sup>222</sup> The evidence showed that the insured put a rope around his neck with the intent to tighten it to a degree necessary to reduce the amount of oxygen supplied to his brain and thereby to increase the intensity of orgasm during masturbation. Medical testimony indicated that the insured had transvestite tendencies and that his sexual practices were unusual, but that they were not such as would constitute a disease in either the medical or the ordinary sense of the word. Faced with adverse jury findings, Connecticut General argued on appeal that the evidence proved conclusively that the insured intentionally injured himself and that it was only the extent of the injury that was unintentional, but the court of civil appeals held the jury verdict was supported by the evidence.<sup>223</sup> The court approved the trial court's admitting into evidence opinion testimony from medical experts on the cause of death, even though such testimony was based in part on hearsay.<sup>224</sup> The court noted that the testimony was not based wholly on hearsay and that the hearsay came from sources ordinarily relied upon by the experts in their professional practices.<sup>225</sup>

In *Smith v. Tennessee Insurance Co.*<sup>226</sup> the court of civil appeals reversed a judgment for the defendant insurer based upon a verdict of suicide, because the trial court improperly admitted opinion testimony based wholly

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216. *Id.* at 932.

217. *Id.*

218. 606 S.W.2d 354 (Tex. Civ. App.—Eastland 1980, writ ref'd n.r.e.).

219. *Id.* at 355.

220. *Id.* at 357-58.

221. 619 S.W.2d 199 (Tex. Civ. App.—Texarkana 1981, writ ref'd n.r.e.).

222. *Id.* at 203.

223. *Id.*

224. *Id.* at 203-04.

225. *Id.* at 203.

226. 618 S.W.2d 829 (Tex. Civ. App.—Houston [1st Dist.] 1981, no writ).



on hearsay.<sup>227</sup> Testimony of the county medical examiner and a member of his staff indicated that the insured committed suicide. The doctors' opinions were based wholly on hearsay data, gathered by support staff, that was not introduced into evidence. The medical examiner had never personally examined the body. If the data on which the witness relied had been introduced into evidence through the investigators' testimony and used in formulating proper hypothetical questions, the opinion testimony would have been properly admissible.<sup>228</sup> The opinion testimony should have been excluded; therefore the case was remanded for a new trial.<sup>229</sup>

In *Pilot Life Insurance Co. v. Koch*<sup>230</sup> the court was asked to determine the meaning of the term "legally separated." The policy afforded life insurance coverage for employees and their eligible dependents. Eligible dependents were defined to include "your husband or wife, unless you were legally separated or divorced."<sup>231</sup> The evidence showed that Koch and his wife were living apart and that the wife had filed for divorce at the time of her death. During the pendency of the divorce, the court had granted interlocutory orders setting aside a residence to Mrs. Koch and dividing the household goods and furnishings. The jury found that Koch and his wife were legally separated at the time of her death.<sup>232</sup> The trial court entered judgment for Koch, notwithstanding the verdict, on the theory that under Texas law there was no status of legal separation for a husband and wife before the marriage was dissolved by a final decree of divorce.<sup>233</sup>

The court of civil appeals held that a status of legal separation was ambiguous as applied in Texas, since Texas law recognized no formal legal separation.<sup>234</sup> Under settled rules of interpretation, the court stated that ambiguous portions of insurance policies were to be interpreted and construed liberally in favor of the insured. The language of a policy was susceptible of more than one reasonable construction, and the court applied the construction that favored the insured and permitted recovery. Accordingly, the trial court's judgment for plaintiff was affirmed.<sup>235</sup>

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227. *Id.* at 832-33.

228. *Id.* at 832.

229. *Id.* at 834.

230. 617 S.W.2d 786 (Tex. Civ. App.—Eastland 1981, writ ref'd n.r.e.).

231. *Id.* at 787.

232. *Id.*

233. *Id.*

234. *Id.* at 788.

235. *Id.*