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INSURANCE LAW

by

Harvey L. Davis*

SOME of the trends indicated in last year's *Survey* were continued during the current year. Again, a majority of the insurance cases appealed during the year were decided favorably for insurers. Many turned on a technical construction and application of the language in insurance contracts. In addition, a number of decisions involved technical application of rule 94,¹ Texas Rules of Civil Procedure. Originally enacted as a reform to require insurers to plead specifically by way of exceptions only those defenses that are actually relied upon, rule 94 now appears to have been thoroughly emasculated by court decision.

I. HEALTH, LIFE, AND ACCIDENT

A. Procedural Decisions

Pleadings. The prostitution of rule 94's spirit of reform is quite evident in *Sherman v. Provident American Insurance Co.*² This case is the leading candidate for the worst insurance decision from a procedural standpoint in 1967.³ In this case the majority of the supreme court agreed that the thirty-four policy exclusions and limitations plead by the insurer were "obviously sham defenses" and that "to seek in this manner to frustrate the intended purpose of rule 94 violates both its spirit and its letter."⁴ But the majority held for the insurer because the insured had not made a procedurally proper complaint about the "sham defenses." A dissenting opinion by Justice Norvell, joined by Justice Smith, concluded that the results of the decision "can only be described as a procedural miscarriage."⁵ The dissenting opinion described the insurer's answer as "one which had for its objective the raising of fictitious issues contrary to the aims and purposes sought to be accomplished by Rule 94."⁶ On this basis the pleadings should have been treated as a nullity, whether or not the plaintiff excepted to them.

The majority, however, did make one point of law clear. It found a conflict between the holding of the court below and the holding in *Old Line Mutual Life Insurance Co. v. Tilger.*⁷ The supreme court held that the court below had correctly interpreted the Texas rule as placing the burden of proof on the plaintiff-insured to negate all exclusions and limitations in the policy which are pleaded as a defense by the insurer.

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¹ Tex. R. Civ. P. 94.

² 421 S.W.2d 652 (Tex. 1967).

³ The court of civil appeals decision in this case was rated as the worst insurance procedural decision in last year's *Survey*. Davis, *Insurance Law, Annual Survey of Texas Law*, 21 Sw. L.J. 88, 105 (1967).

⁴ 421 S.W.2d 652, 653 (Tex. 1967).

⁵ *Id.* at 656.

⁶ *Id.* at 655.

⁷ 264 S.W.2d 557 (Tex. Civ. App. 1953).

Similar prostitution of rule 94 was also evident in decisions of the courts of civil appeals. One court of civil appeals held a pleading (which insurer labeled a special denial) that the plaintiff's loss was a direct result of bodily injuries effected solely and independently of all other causes through external, violent and accidental means, cast the burden of proof upon the plaintiff to prove the loss of his leg was covered by the policy.⁸ The policy was a group accident policy. The court reasoned that the clause describing the general hazard insured against was not the loss of a foot, but the loss of a foot effected solely and independently of all other causes through external, violent and accidental means. This is the standard general hazard insuring clause found in almost all accident policies.

The court cited one of its 1957 opinions construing a narrowly written accident policy which insured against death only if injury should occur in specified circumstances and from specified causes.⁹ The court demonstrated its misapprehension of rule 94 by stating that, if the insurer had relied upon any of the policy's provisions listing the specific "limitations" of liability, the insurer would have to plead and prove such defense. This conclusion is contrary to the original concept of rule 94 which required the insurer to specifically allege that the loss was due to a risk or cause coming within a particular exception to the general liability, but continued the burden of proof on the insured.

A related case¹⁰ illustrates a method which allows the insurer to use an exclusion in a hospital and surgical insurance policy as a defense, while not pleading the exclusion by special denial. The exclusion in question provides that no indemnity was payable for loss resulting from skin grafts unless performed within 180 days of an accidental injury. The insurer was notified prior to the expiration of 180 days that a skin graft operation would be necessary, but the actual operation took place after the 180-day period. The plaintiff pleaded that the insurer was notified within 180 days after the injury that surgery would be required. The appellate court construed this pleading as plaintiff's attempt to bring himself within the terms of the policy. Apparently the insurer did not specifically plead the exclusion to cast the burden of proof on the plaintiff under rule 94. But the court permitted the insurer to achieve the same results. It held that the trial court should have permitted the insurer to file a trial amendment after the plaintiff had introduced the insurance policy for limited purposes. The defendant wanted the policy introduced for all purposes, including, of course, the 180-day exclusion provision.¹¹

Evidence: Rebutting the Presumption Against Suicide. In 1963, in

⁸ *Merriman v. Employers Nat'l Life Ins. Co.*, 416 S.W.2d 609 (Tex. Civ. App. 1967) *error ref. n.r.e.*

⁹ *Betha v. National Cas. Co.*, 307 S.W.2d 323 (Tex. Civ. App. 1967).

¹⁰ *American Bankers Ins. Co. v. Lovell*, 415 S.W.2d 705 (Tex. Civ. App. 1967).

¹¹ The court also upheld the insurer's contention that the trial court erred in rendering judgment for the insured in any amount because there was no admissible evidence of probative force to sustain a monetary judgment. The plaintiff failed to introduce evidence that the charges made by the doctor for the skin graft were reasonable.

Prudential Insurance Co. of America v. Krayner,¹² the supreme court changed the applicable rule concerning evidence necessary to establish suicide as a matter of law. The court in *Krayner* stated that, for a judgment n.o.v. to be warranted on the issue of suicide, the presumption against suicide must be *conclusively* rebutted by evidence upon which reasonable minds could not differ; there must be only one reasonable inference to be drawn from all the evidence. A recent court of civil appeals case¹³ considered facts similar to *Krayner*, where there was no direct evidence that the deceased did intend to commit suicide at the particular time and place in question. While there was no direct evidence that the deceased did accomplish a suicidal intent by shooting himself in the head, all the circumstantial evidence so indicated. In affirming the judgment n.o.v. for the insurer the court of civil appeals concluded that, under *Krayner*, the jury necessarily had to resort to pure fantasy and speculation to conclude that the deceased died as a result of a gunshot wound which was accidentally inflicted.

Venue. A court of civil appeals had held that the term "loss" as used in the Texas venue statute¹⁴ means that the event which gives rise to liability assumed under the policy has occurred.¹⁵ The insured's loss occurred when he incurred hospitalization expenses. Suit was by the hospital to whom the insured had assigned the insurance benefits. An attempt of the insurer to transfer the case from the county where the insured was hospitalized to the county of the insurer's home office failed. The insurer argued that the word "loss" in the statute was used in terms of indemnity; that is, insured's loss occurred only when the insured paid the hospitalization expenses and sought reimbursement from the insurer.¹⁶ Nevertheless, the court held that the suit was on the policy, not on the assignment, because the policy expressly provided that the insurer was liable to the insured for enumerated hospital expenses and that the benefits would be paid to the hospital if so authorized by the insured. The court properly treated the assignment as merely the insured's authorization to the insurer to pay the benefits to the hospital.¹⁷

Res Judicata: Separate and Distinct Actions on the Same Policy. Another hospitalization case¹⁸ involved the question of whether a judgment for insured in an action to recover hospital and surgical expenses incurred during the illness of the insured's wife was res judicata as to two subsequent suits, one to recover for hospital expenses resulting from the insured's broken collar bone. All of the suits were on the same policy. The

¹² 366 S.W.2d 779 (Tex. 1963).

¹³ *Rice v. Morris Plan Life Ins. Co.*, 407 S.W.2d 9 (Tex. Civ. App. 1966) *error ref. n.r.e.*

¹⁴ TEX. REV. CIV. STAT. ANN. art. 1995, § 28 (1964).

¹⁵ *American Sur. Life Ins. Co. v. Anderson Hosp. & Tumor Institute*, 408 S.W.2d 155 (Tex. Civ. App. 1966) *error dismissed*.

¹⁶ This theory applies under the "no action" clause in an automobile liability policy providing that no action should lie against an insurer unless as a condition precedent the amount of the insured's obligation to pay shall have been finally determined. Insurer's plea of privilege on this basis was upheld in *Pioneer Cas. Co. v. Miller*, 399 S.W.2d 389 (Tex. Civ. App. 1966).

¹⁷ A misconception of the nature of such assignments was noted in last year's *Survey*, Davis, *Insurance Law, Annual Survey of Texas Law*, 21 Sw. L.J. 88, 109-10 (1967).

¹⁸ *Reserve Life Ins. Co. v. Shelton*, 415 S.W.2d 281 (Tex. Civ. App. 1967) *error dismissed*.

court of civil appeals affirmed the trial court's judgment that these were three separate and distinct causes of action. The first action was not res judicata and the three suits did not split a single cause of action into separate suits, even though it might have been possible for the defendant to have consolidated the suits into one cause of action.

B. Substantive Decisions

Receipts for Premiums as Contracts of Insurance. In a case of first impression in Texas, the supreme court in *American-Amicable Life Insurance Co. v. Lawson*¹⁹ held that a binding receipt is "interim" insurance and that it is the only contract between the parties. A receipt, given for payment of the first premium, included the cost of a double indemnity provision to be included in the policy when issued. The application signed by the insured was for a \$25,000 policy with \$25,000 double indemnity benefits. The receipt provided that "the amount of the insurance becoming effective under the terms hereof shall in no event exceed \$25,000 less the amount of all other insurance in force with the company."²⁰ The insurer paid \$25,000 in life benefits but refused to pay the double indemnity liability on the ground that it was not included in the interim insurance contract set out in the receipt. The lower courts held that the provision in the receipt was ambiguous and construed it as a limitation only on the liability of the insurance company for the life benefits and not as a limitation on the double indemnity liability. The supreme court, reversing the lower courts, found no ambiguity in the receipt or in the application for insurance and held that the receipt did not incorporate the double indemnity provision into the interim insurance.

In a related case before a civil appeals court a binding receipt was held to be a valid contract of insurance where the insurer amended the application for insurance and the applicant assented to the amendment.²¹ The decision followed contract principles by treating the application for insurance as an offer by the applicant, the insurer's amendment of the application as a counter-offer, and the applicant's assent to the amendment as his acceptance of the counter-offer. Proof of the parties' agreement was aided by the fact that the insurer's agent delivered the policy pursuant to the amended application one hour after the applicant was injured. The case might be considered an extension of contract principles to the binding receipt problem following a recent court of civil appeals case,²² which held a binding receipt valid as of its date when the insurer approved the application in its home office, but attempted to revoke the approval when it learned that the applicant died of a heart attack before the policy was issued.

*Mutual Life Insurance Co. v. Anderson*²³ is a technical decision favorable

¹⁹ 419 S.W.2d 823 (Tex. 1967).

²⁰ *Id.* at 825.

²¹ *Stansberry v. Legal Sec. Life Ins. Co.*, 410 S.W.2d 663 (Tex. Civ. App. 1966) *error ref. n.r.e.*

²² *Great Southwest Life Ins. Co. v. Henson*, 401 S.W.2d 89 (Tex. Civ. App. 1966) *error ref. n.r.e.*

²³ 408 S.W.2d 335 (Tex. Civ. App. 1966) *error ref. n.r.e.*

to the insurer in construing a technically worded conditional receipt. Applicant's primary argument was that the insurer was estopped to deny coverage. The application for the insurance was made on January 24, 1964. A few days later applicant made the first premium payment and received a conditional receipt. The applicant thought he was covered when he signed the application and paid the first premium. There was testimony that the soliciting agent told the applicant on this date that he was covered. The applicant, in reliance upon the agent's representation, did not exercise a conversion privilege in a group hospitalization policy issued to his former employer which allowed him to convert his coverage thereunder to an individual policy without evidence of insurability. On February 18, 1964, the plaintiff was hospitalized for several days, was discharged and then was hospitalized again. He was finally discharged on March 13, 1964. On March 12, 1964, he applied to insurer's agent for proof-of-claim forms and was told his application of January 24 had been rejected. In reversing the trial court's judgment, the court of civil appeals held that the alleged representations made by the agent were contrary to the terms of the conditional receipt and were beyond the agent's authority.

The instant conditional receipt was a "satisfaction type" receipt. The insurer, after preliminary investigation, drew the policies and sent them to its Dallas agent. The policies were never delivered to the applicant, apparently because of a subsequent discovery of a poor medical history. Nevertheless, the plaintiff did not rely upon the conditional receipt and in fact by verified pleadings took the position that the conditional receipt formed no part of the contract; that he did not execute, accept, or agree to the conditional receipt; and that it was unilateral and without mutuality of consideration. The appellate court held that these admissions were conclusive against the plaintiff and that no judgment based on the receipt could be sustained. Additionally, the appellate court found that the application signed by the plaintiff contained this provision: "Except as otherwise provided in any conditional receipt issued, any policy issued shall take effect as of its Policy Date, provided its delivery and payment of the first premium are made while each person to be insured is living."²⁴ Since no delivery of the policies was made, no contract of insurance was created.

Delivery. The case that wins the 1967 award for the worst insurance decision of the year is *Scott v. Industrial Life Insurance Co.*²⁵ This case involved credit life insurance, a type of insurance rarely dealt with by the courts. One reason for this is that the loss ratio on such insurance is small; consequently, there are few claims and chances of such claims reaching court are small.

Lolithia Scott borrowed \$3,000 at the Bank of Dallas and her note was co-signed by her son, Jack. The bank required her to purchase credit life insurance as a lender is permitted to do under Texas law.²⁶ The bank held a

²⁴ *Id.* at 338.

²⁵ 411 S.W.2d 769 (Tex. Civ. App. 1967).

²⁶ TEX. INS. CODE ANN. art. 3.53 (1963).

group credit life policy issued by the defendant, Industrial Life Insurance Company, and put the insurance in force acting as agent for the insurer and received a commission for the insurance. While the premium for the policy was paid by withdrawing funds from Mrs. Scott's account, no copy of a policy or certificate of insurance was issued to her. This failure to deliver was in violation of the Insurance Code.²⁷ Mrs. Scott died while the insurance was presumably in force.

The insurer's first defense was based on a limitation or condition in the master group policy issued to the Bank of Dallas (but never seen by either Mrs. Scott or her son) that the insurance should not take effect on the life of any debtor who, on the date of the indebtedness, "is not alive and in sound health."²⁸ Mrs. Scott was not questioned about her health and did not apply in writing for the coverage.

During the trial the insurer was permitted to file a trial amendment alleging that Jack Scott, instead of his mother, was the insured. This defense was based on an additional condition in the master group policy that "In no case shall more than one person be insured on account of any one indebtedness. If there is more than one Debtor, . . . the person to be insured shall be the youngest of the Debtors."²⁹ The court of civil appeals held the condition valid, adding that there was no waiver or estoppel by the insurer and that, since co-signer Jack Scott was the younger debtor, he, rather than his mother, was the insured. The effect of the decision was to bind the Scotts to conditions of which they had no knowledge in a policy which they never received. The failure of the insurer and its agent, the bank, to deliver a certificate of insurance to Mrs. Scott or to Jack Scott was a violation of the Insurance Code. Section 6, article 3.53 provides:

. . . [G]roup Certificate of insurance shall be delivered to the insured debtor.

Each individual policy or group certificate . . . shall . . . set forth . . . the identity *by name or otherwise of the person, or persons, insured*, the full amount of premium or the total identifiable insurance charge, if any, to the debtor, separately for credit life insurance and credit accident and health insurance, *a description of the coverage*, including the amount and term thereof, *and any exceptions, limitations and restrictions*, and shall state that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness"³⁰

If the certificate of insurance had been delivered, there would be no question about who was the named insured. Also, the Scotts would have known about the conditions concerning the health of the insured. Had they known of these conditions and been dissatisfied with them, they could have purchased other insurance.

The Applicant: "Good Health;" "Sound Health." The supreme court in *Great American Reserve Insurance Co. v. Britton*³¹ construed a life insur-

²⁷ *Id.* §§ 6, 10 (Supp. 1967).

²⁸ 411 S.W.2d 769, 771 (Tex. Civ. App. 1967).

²⁹ *Id.*

³⁰ TEX. INS. CODE ANN. art. 3.53, § 6 (Supp. 1967) (emphasis added).

³¹ 406 S.W.2d 901 (Tex. 1966). For further discussion, see Teofan, *Commercial Transactions*, this *Survey*, at footnote 51.

ance policy providing that "the policy shall not take effect until it has been delivered to its owner during the lifetime and good health of the insured"³² The insured had "heart trouble" or "angina pectoris." The majority opinion stated the requirement that the insurer prove by preponderance of the evidence that the applicant was not in good health when the policy was delivered, declaring that such a finding is essential to the insurer's right to cancel the policy or to its defense against an action for the policy proceeds. The jury found that the applicant was in good health. The court stated that the true question on appeal was whether the evidence established conclusively, according to recognized legal standards, that the insured was not in good health. The majority examined medical testimony concerning the applicant's "heart trouble" and the *Webster's Third New International Dictionary* definition of "angina pectoris." Noting that the policy requirement of good health does not mean "perfect health," the court reasoned that the question becomes how "seriously" the "heart trouble" affected the health of the applicant generally and how "materially" it increased the risk of death. The majority concluded that "to hold the good health provision of the policy was breached as a matter of law we would have to take judicial notice that the nature of one or more of the ailments was such as to *seriously* affect the soundness of Britton's health or to *materially* increase Great American's risk. These are relative matters, and except in extreme cases should be left for jury determination from the evidence introduced on trial."³³

The court distinguished *Texas Prudential Insurance Co. v. Dillard*,³⁴ where the applicant had epilepsy in its most serious form when the policy was delivered. This epilepsy was the cause of death. On that proof the insurer established breach of the good health provision as a matter of law. In *Britton*, the court found that the evidence did not conclusively establish a *serious* infirmity when the policy was delivered nor was death from "angina pectoris" conclusively established.³⁵

A court of civil appeals relied upon the *Britton*³⁶ case to hold that a diabetic was in sound health.³⁷ The sound health provision in the body of the policy was as follows: "This policy shall take effect on the date of issue provided the assured is then alive and in sound health and free from accidental injury."³⁸ The insured suffered from diabetes when the policy was issued, but the diabetes was under control. The cause of death of the insured was a massive subdural hemorrhage caused by a fall from a scaffold.

The court found the evidence sufficient to sustain the trial court's finding that the insured was in good health at the time she took the policy and cited

³² *Id.* at 903.

³³ *Id.* at 905.

³⁴ 158 Tex. 15, 307 S.W.2d 242 (1957).

³⁵ Three dissenting judges urged that it is common knowledge that an angina pectoris patient who must take nitroglycerin tablets to dilate the blood vessels cannot be said to be in "good health." This minority opinion looked to the *Oxford Universal Dictionary* to support its view that angina pectoris is a dangerous and serious disease.

³⁶ 406 S.W.2d 901 (Tex. 1966).

³⁷ *Southern Life & Health Ins. Co. v. Grafton*, 414 S.W.2d 214 (Tex. Civ. App. 1967) *error ref. n.r.e.*

³⁸ *Id.* at 215.

Britton as authority. The insurer apparently advanced a theory of fraudulent misrepresentation predicated upon the fact that the application did not reveal that the applicant had diabetes. Rejection of this theory by the court appears sound under the misrepresentation statute which relieves insurers from liability where the insured has misrepresented material facts.³⁹ However, the policy did make sound health of the insured a condition precedent to the existence of the policy.⁴⁰ There is authority that the statute does not apply to such a provision. The appellate court in the instant case relied principally upon the supreme court's construction of the statute in *Lane v. Travelers Indemnity Co.*,⁴¹ an action on a fire policy, which held that the insurer must secure findings that any misrepresentations were material.

A court of civil appeals considered a hospitalization insurance policy limiting coverage to: "Any sickness which results in a surgical operation shall be covered only if the cause thereof originated after this policy had been in force for six months."⁴² In measuring the six-month period the question was whether the sickness originated when it first became manifest or when it had its medical origin. The insurer argued that the following jury instruction "re-wrote" the insurance contract: "[T]he cause of a sickness or disease originates where such sickness or disease first becomes manifest or active; and not necessarily at the earlier time when the medical cause of the disease may have begun or had its origin."⁴³ The court of appeals approved the instruction stating that the trial court "employed an explanatory technique of placing in juxtaposition an inclusive and exclusive statement; saying positively that a disease originates when it first becomes manifest etc., and highlighting such instructions by excluding the idea that a disease originates when its medical cause begins."⁴⁴ This case also held that an assignment of benefits to the hospital was not an assignment of the insurance contract. Therefore, the insured had an interest in the policy and was a proper party to bring suit. This sound reasoning may be contrasted to the erroneous conclusion reached in a recent case⁴⁵ noted in last year's *Survey*.⁴⁶

³⁹ TEX. INS. CODE ANN. art. 21.16 (1963).

⁴⁰ *Southern Sur. Co. v. Benton*, 280 S.W. 551 (Tex. Comm'n App. 1926).

⁴¹ 391 S.W.2d 399 (Tex. 1965). In *Lane* there was a property description in the fire policy that the insured property was to be occupied as a "dwelling, tenant." The property was not occupied by a tenant; it was occupied by its owners. The court of appeals held that the description was a contractual warranty and its falsity relieved the insurer of liability. The insurer took the position before the supreme court that the statement was a warranty, and that the truth of the matter warranted was a condition precedent to the validity of the contract and therefore the policy never became effective. Chief Justice Calvert stated that if the provisions of the policy were intended to relieve an insurer of liability because of mere misrepresentations, without proof and finding of materiality, it ran afoul of article 21.16. He also said that the statute is applicable whether the exonerating policy provision be that the contract "shall be void" or only that the insurer "shall not be liable." *Lane* is important for its discussion concerning the distinction between warranties and representations and that statements on a Texas standard fire insurance policy descriptive of the policy are representations and not warranties.

⁴² *East Tex. Life & Accident Ins. Co. v. Carver*, 407 S.W.2d 251 (Tex. Civ. App. 1966) *error dismissed*.

⁴³ *Id.* at 252.

⁴⁴ *Id.*

⁴⁵ *Dallas County Hosp. Dist. v. Pioneer Cas. Co.*, 402 S.W.2d 287 (Tex. Civ. App. 1966) *error ref. n.r.e.*

⁴⁶ *Davis, Insurance Law, Annual Survey of Texas Law*, 21 Sw. L.J. 88, 109 (1967).

Another court of civil appeals upheld a summary judgment for the insurer where the evidence was undisputed that the insured's "heart murmur" was either manifest before the policy's effective date or where there was a distinct symptom from which one learned in medicine could diagnose the sickness.⁴⁷

Contract Interpretation. In *Southern Life and Health Insurance Co. v. Simon*⁴⁸ a limited industrial accident policy which required that insured be "legally traveling" inside a steamship was held not to cover a longshoreman operating a motor-driven truck for the purpose of loading a moored steamship. The truck crashed through a hatch covering on the shelter deck of the ship and crushed the insured to death. In a case of first impression the supreme court reversed and rendered the judgments of the lower courts, finding no ambiguity in the language limiting coverage. Looking to the purpose of the policy, the supreme court found that the policy was intended to provide benefits for losses to travelers or pedestrians by accidental means. The longshoreman, engaged in moving from point to point inside the ship in the loading operation, was not "legally traveling" inside the ship under the reasonable intention of the policy. Coverage was also denied under a second condition which was limited to injuries received while driving or riding in a motor-driven truck on a public highway, since the accident occurred inside the steamship and not under the usual and normal transportation circumstances over a public highway.

In another case⁴⁹ where particular language in a contract was interpreted for the first time, a court of civil appeals held that an airplane pilot holding a student pilot certificate was not a "licensed or certified pilot" within the meaning of a life insurance policy provision. The insured was killed while traveling in an airplane piloted by the holder of a student pilot certificate. The certificate had printed thereon in large letters: "Passenger Carrying Prohibited." The court held that the term "duly licensed or certified pilot," as used in the policy's provision which limited liability to instances where the insured was a "passenger" on an aircraft operated by such a pilot, necessarily refers to a pilot who holds a license or certificate authorizing him to operate an aircraft carrying passengers. A person holding a student pilot certificate prohibiting him from carrying passengers is not such a pilot. This opinion has added significance in view of the supreme court's "error refused" approval.

Payment of Proceeds.

Possibility of Adverse Claim. The supreme court in *McFarland v. Franklin Life Insurance Co.*⁵⁰ considered the specific question of whether a beneficiary could recover a twelve per cent penalty and attorney's fees

⁴⁷ *Abel v. Occidental Life Ins. Co.*, 410 S.W.2d 451 (Tex. Civ. App. 1966) *error ref. n.r.e.*

⁴⁸ 416 S.W.2d 793 (Tex. 1967).

⁴⁹ *Mang v. Travelers Ins. Co.*, 412 S.W.2d 672 (Tex. Civ. App. 1967) *error ref.*

⁵⁰ 416 S.W.2d 378 (Tex. 1967). For further discussion, see McKnight, *Matrimonial Property*, this *Survey*, at footnote 31.

under article 3.62⁵¹ where the insurer refused to pay the policy proceeds to the designated beneficiary. The insurer pleaded that it anticipated a claim from the widow of the insured and demanded that the beneficiary secure a release from the widow. The court awarded the penalty and attorney's fees to the beneficiary, holding that the insurer did not have reasonable grounds for anticipating rival claims.

The insurer has a duty to investigate the validity of all rival claims to the proceeds. Investigation, which could have been made during the thirty-day period allowed by article 3.62, would have disclosed that the policy was taken out while the insured was unmarried and that all premiums were paid by the named beneficiary (the insured's mother) and her husband. The widow did not have a valid claim and there was nothing to warrant a belief that she did. The insurer was not justified in requiring the beneficiary to obtain a release from the widow and the insurer was under no duty to explain the failure to furnish a release. The court stated: "The mere possibility that facts giving rise to an adverse claim could exist does not constitute reasonable grounds for refusing to pay the designated beneficiary."⁵²

Anticipatory Breach. In *Continental American Life Insurance Co. v. McCain*⁵³ the insured recovered judgment for a principal sum of \$2,400, representing twenty-four monthly payments of \$100. Not all of the monthly installments had accrued when judgment was entered. The court of civil appeals upheld the judgment of the trial court on the ground that there had been an anticipatory breach of contract by the insurer.⁵⁴ The supreme court reversed, without granting writ of error,⁵⁵ and remanded the case to the trial court with directions to enter judgment for the insured as though no anticipatory breach had occurred. The court found the holding of the court of civil appeals in conflict with its decision in *Sanders v. Aetna Life Insurance Co.*⁵⁶ and distinguishable from its decision in *Universal Life & Accident Co. v. Sanders*.⁵⁷ The *Aetna* decision emphasizes that, to have an anticipatory breach of an insurance contract, the insurer must have taken the position that it was repudiating the policy rather than denying liability under provisions of the policy.⁵⁸

One case turned upon the distinction between a breach of the contract, which the insurer conceded, and a repudiation of the contract, which it denied.⁵⁹ The insurer claimed the insured, who ruptured a disc in his back by picking up a joint of tubing, did not suffer accidental injury because he intended to pick up the tubing. The court of civil appeals held this

⁵¹ TEX. INS. CODE ANN. art. 3.62 (1963).

⁵² 416 S.W.2d at 381.

⁵³ 416 S.W.2d 796 (Tex. 1967).

⁵⁴ *McCain v. Continental Am. Life Ins. Co.*, 412 S.W.2d 666, 672 (Tex. Civ. App. 1967).

⁵⁵ Under its authority, TEX. R. CIV. P. 483.

⁵⁶ 146 Tex. 169, 205 S.W.2d 43 (1947).

⁵⁷ 129 Tex. 344, 102 S.W.2d 405 (1937).

⁵⁸ The opinion did not mention the requirement of "just excuse" for the insurer to deny liability. Lack of a "just excuse" was the basis for holding an insurer liable for an anticipatory breach in *Continental Cas. Co. v. Vaughn*, 407 S.W.2d 818 (Tex. Civ. App. 1966) *error ref. n.r.e.* See the discussion of *Vaughn* in the text accompanying note 59 *infra*.

⁵⁹ *Continental Cas. Co. v. Vaughn*, 407 S.W.2d 818 (Tex. Civ. App. 1966) *error ref. n.r.e.*

contention was so utterly untenable and arbitrary that it was without "just excuse" as found by the jury. The principal authority relied upon was *Universal Life & Accident Insurance Co. v. Sanders*.⁶⁰ The court also upheld the award of attorney's fees based in part upon the amount granted to plaintiff for the anticipatory breach.⁶¹

Beneficiary: Putative Wife. The question of whether the designation by a husband of his putative wife as the beneficiary of a life insurance policy is a legal fraud on the legal wife was raised in one case.⁶² The insurers paid the proceeds of the policies into the court when suit was brought by the legal wife; the putative wife was impleaded. It was presumed that the policies were purchased with community funds, there being no showing otherwise. The court of appeals, citing *Brown v. Lee*,⁶³ stated that proceeds from a policy purchased with community funds are community in character; that where a named beneficiary other than the wife survives, a gift of the policy rights to such beneficiary is presumed to have been intended and completed by the death of the insured in the absence of a showing of fraud. The trial court's summary judgment for the putative wife was remanded for a determination of the fact issue as to whether the gift of the policy proceeds to the putative wife was fraudulent to the legal wife.

II. FIRE AND CASUALTY

Fire Policy Endorsement. A court of civil appeals⁶⁴ considered a "General Change Endorsement" adding the name of Hensley, the purchaser, as a named insured at the time of the execution of a contract of sale of the insured dwelling. The seller's policy provided coverage of \$24,000 on the dwelling and \$5,000 on household goods while in the main dwelling, the seller's furniture having been removed. The insurer took the position that the only property sold under contract was the dwelling; therefore, the purchaser's household goods were not included in the general change endorsement.

The court of civil appeals held that the endorsement made the purchaser a "named insured." The policy covered the main dwelling while occupied by the owner and covered household goods of a named insured while lo-

⁶⁰ 129 Tex. 344, 102 S.W.2d 405 (1937).

⁶¹ Another point of interest in the opinion was the introduction into evidence of the stipulation of the life expectancy of the plaintiff. This was justified on the basis that it merely informed the jury of the usual life expectancy of persons of the plaintiff's age and was some evidence which the jury might consider although the jury was not bound to measure the plaintiff's life span by the mortality tables.

The trial court's order discounting the award of the jury at the rate of six per cent per annum for 20.8 years, the life expectancy of the plaintiff, was reversed. The amount of reduction which should be made is solely within the province of the jury. The court reasoned that the suit for anticipatory breach of an insurance policy is not a suit upon a contract but is a suit for damages for the breach. In a suit for damages the instruction in a damage issue "if paid now in cash" directs the attention of the jury to the element of present value and the extent to which a jury actually discounts the "damages" is peculiarly within the province of the jury. *Texas Consol. Transp. Co. v. Eubanks*, 340 S.W.2d 830 (Tex. Civ. App. 1960) *error ref. n.r.e.*; *Texas & N.O.R.R. v. Flowers*, 336 S.W.2d 907 (Tex. Civ. App. 1960).

⁶² *Alexander v. Alexander*, 410 S.W.2d 275 (Tex. Civ. App. 1966). For further discussion, see McKnight, *Matrimonial Property*, this *Survey*, at footnote 59.

⁶³ 371 S.W.2d 694 (Tex. 1963).

⁶⁴ *Millers Mut. Fire Ins. Co. v. Hensley*, 414 S.W.2d 488 (Tex. Civ. App. 1967).

cated in the main dwelling. The endorsement did not exclude coverage of household goods of either party so it was susceptible to a construction allowing recovery.⁶⁵

Breach of Endorsement as a Defense. An interesting and educational opinion was written by a court of civil appeals⁶⁶ summarizing the history and application of the "anti-technical" statute⁶⁷ which was enacted to prevent fire insurance companies from avoiding liability for loss and damage to personal property under technical and immaterial provisions of the fire policy.

The fire policy, insuring a cotton-picking machine against various risks including loss by fire, bore a stamped endorsement providing that the "cotton pickers insured under this policy are limited to custom farming within a radius of 50 miles from the principal place of garagement." The cotton-picking machine was damaged by fire while 150 miles from its principal place of garagement. The insurer denied liability urging that, since the insured's admitted breach of endorsement could not have contributed in any way to the loss, the breach did not come within the terms of article 6.14. That article has been interpreted in *McPherson v. Camden Fire Insurance Co.*⁶⁸ to apply only in instances where the breach might have contributed to the loss; it has no application to a clause which is material to the insurer's risk, the violation of which could not, from the very nature of the provision, contribute to the loss. In the latter situation the policy provision could be urged as a defense by the insurer irrespective of article 6.14.

The insured's position was that this was the type of provision the breach of which might have contributed to bring about the loss, but which, as a matter of fact, did not. The court of civil appeals opinion gives numerous examples of provisions coming within or outside the anti-technical statute applied to the endorsement in question and affirmed the judgment for insured since the breach did not contribute to the loss.

The insured also urged that the provision was a limitation of coverage. The court rejected this argument; in order to be a limitation, the language used must be positive and unequivocal not as a condition for insuring the property but as to the insurance coverage afforded.⁶⁹

Breach of Promissory Warranty by Insured. In a case of first impression in Texas a court of civil appeals construed the provisions of a "Jewelers' Block Policy" and decided that a breach of promissory warranty by the insured was a valid defense to the insurer against a claim of loss of jewelry through burglary.⁷⁰ When applying for the insurance the insured signed a

⁶⁵ Trahan v. Southland Life Ins. Co., 155 Tex. 548, 289 S.W.2d 753 (1956); Providence Washington Ins. Co. v. Proffitt, 150 Tex. 207, 239 S.W.2d 379 (1951)

⁶⁶ Texas Farm Bureau Mut. Ins. Co. v. Carnes, 416 S.W.2d 863 (Tex. Civ. App. 1967) *error ref. n.r.e.*

⁶⁷ TEX. INS. CODE ANN. art. 6.14 (1951).

⁶⁸ 222 S.W. 211 (Tex. Comm'n App. 1920).

⁶⁹ Fireman's Ins. Co. v. Alonzo, 112 Tex. 283, 246 S.W. 84 (Tex. Comm'n App. 1923).

⁷⁰ Great Am. Ins. Co. v. Lang, 416 S.W.2d 541 (Tex. Civ. App. 1967) *error ref. n.r.e.*

proposal that the proportion by value of property on his premises that would be kept in a locked safe would be sixty-five per cent; the proportion outside of the safe would be thirty-five per cent. Burglars broke into the premises and stole jewelry and other property outside of the safe. In rendering judgment for the insurer, the court of civil appeals held that the jury's finding that the insured had locked in his safe sixty-five per cent by value of all property insured under the policy to be contrary to the weight of evidence.

The warranty involved was a "promissory warranty" because it required the insured to do something after the date of the policy.⁷¹ The insured urged the application of article 21.16.⁷² This statute provides that answers made as part of an application for insurance if untrue or false are not defenses to the contract unless it be shown on trial that the matter misrepresented was material to the risk or actually contributed to the loss. The court held the statute inapplicable because it does not apply to promissory warranties.⁷³ The court further concluded that the breach of the promissory warranty was in fact material to the risk and contributed to the loss. It was material to the risk because without the warranty the insurance company would not have issued the policy at the premium charged. It contributed to the loss because the only property stolen was the property outside of the safe. The court concluded that the facts on this not being in dispute, the promissory warranty was material to the risk as a matter of law.

Non-Waiver Agreement as a Defense. In an interesting opinion the supreme court, by divided vote in *Massachusetts Bonding & Insurance Co. v. Orkin Exterminating Co.*,⁷⁴ held that a "non-waiver agreement" prevents waiver of rights of the insured accruing under the policy before the time the non-waiver agreement is made and that if the insurer had waived a policy defense prior to the non-waiver agreement such agreement does not affect the waiver.

The insured had been previously held liable to Gulf Coast Rice Mills for damage caused by application of a chemical called lindane, a pesticide used by the insured in the rice mills facilities.⁷⁵ Orkin, the insured, paid the judgment and demanded reimbursement from the insurer. The insurer defended upon the ground that Orkin's activity with respect to the chemical was not an accident within the meaning of the policy and that, even if it had been an accident, the insurer had an absolute policy defense because insured had not given notice of the accident "as soon as practical" as required by the policy. The incident occurred in August 1955. Notice was not given until May 24, 1956.

The court disposed of the defense of "no accident" by holding that the

⁷¹ Home Ins. Co. v. Henderson, 263 S.W. 650 (Tex. Civ. App. 1924).

⁷² TEX. INS. CODE ANN. art. 21.16 (1951).

⁷³ Home Ins. Co. v. Henderson, 263 S.W. 650 (Tex. Civ. App. 1924).

⁷⁴ 416 S.W.2d 396 (Tex. 1967).

⁷⁵ Orkin Exterminating Co. v. Gulf Coast Rice Mills, 362 S.W.2d 159 (Tex. Civ. App. 1962) error ref. n.r.e., cert. denied, 375 U.S. 57 (1963).

insurer was bound by the findings and the final judgment in the *Gulf Coast Rice Mills* litigation. That case had held that the application of lindane by Orkin in August 1955 had been negligence. The supreme court construed the term "accident" as used in the policy to include negligent acts of the insured causing damage which is undesigned and unexpected. The court reversed the court of civil appeals' judgment for the insured and remanded the case to the trial court to determine the fact question as to whether the insurer had waived its defense of notice.

The inquiry with regard to the issue of waiver is whether the conduct of the insurer shows "an intentional relinquishment of a known right or intentional conduct inconsistent with claiming it."⁷⁶ The fact question was raised because the insurer assumed the complete investigation and adjustment of the Rice Mills claim for thirteen months after the insured had given notice of the accident. At no time between receipt of notice of the accident and execution of the non-waiver agreement had the insurer indicated in any way that it denied coverage under the policy. The insurer did more than merely obtain facts concerning the accident. There were conferences with the attorney for Gulf Coast Rice Mills and conferences with Orkin, the insured. All these acts were taken after the insurer was aware that it had an absolute defense to liability on the policy.

High Water Exclusion as a Defense. An insured with extended coverage on his property for loss caused by windstorm, hurricane and hail argued that the destruction of his pier at lake Texoma by a windstorm and waves caused by the high wind did not come within the policy exclusion that the insurer shall not be liable for loss "caused by . . . tidal wave, high water, or overflow, whether driven by wind or not; . . ."⁷⁷ The jury found that a windstorm was the proximate cause of the damage, but the trial court entered judgment n.o.v. for the insurer. The insured argued on appeal that the damage was done by waves created by high wind and that such waves do not constitute "high water" within the exclusion. The evidence was that the level of the lake was not appreciably higher when the storm struck, and at the time the storm struck the lake was below flood level. The court of civil appeals, relying upon the supreme court decisions in *Hardware Dealers' Mutual Insurance Co. v. Berglund*⁷⁸ and *Coyle v. Palatine Insurance Co.*,⁷⁹ affirmed the trial court's judgment for the insurer.

In answer to the argument that there is a distinction between "high water" and "wind-driven water," the court of civil appeals said that *Berglund* and *Coyle* made no such distinction. This answer is not particularly persuasive because the distinction was not urged in either of those cases. *Berglund* involved hurricane Carla which created high water. The precise decision in *Coyle* was based on stipulation of facts by the parties. The parties agreed that "the combined action of wind and water" caused

⁷⁶ 416 S.W.2d at 401.

⁷⁷ *Wheelock v. American Fire & Cas. Co.*, 414 S.W.2d 61 (Tex. Civ. App. 1967) *error ref.*

n.r.e.

⁷⁸ 393 S.W.2d 309 (1965).

⁷⁹ 222 S.W. 973 (Tex. Comm'n App. 1920).

the damage and that "it is impossible to determine to what extent each was an element or factor" in causing it. In *Coyle* Chief Justice Phillips said, "The effect of this is clearly to exclude the loss in controversy from the indemnity provided by the policy. That indemnity was only against direct loss or damage by the wind."⁸⁰

Coverage of Liability to Third Party. The insured took out a comprehensive liability insurance policy which provided coverage for certain liability injury and property damages.⁸¹ The insured's business was described as "oil producing and oil well drilling." The insured entered into an oil and gas lease with owners of real estate, the lease containing a provision that the insured should be liable for any damage to growing crops caused by the oil well drilling operations. The property owners were successful in a suit against the insured for damages to the land caused by a blowout of the oil and gas well drilled by insured. The opinion in the landowner's suit stated that the "suit was based on breach of contract and not one of negligence."⁸²

A specific exclusion in the policy provided: "(e) under the liability coverage, to liability assumed by the insured under any contract or agreement except liability of another assumed under a written contract relating to the premises." The court of civil appeals held the loss fell within this exclusion since the final judgment in the landowners's suit was conclusive as to the nature of that action. The insured argued that the insurer should be liable under the doctrines of waiver or of estoppel. This argument was rejected under the rule that waiver and estoppel cannot create a new and different contract with respect to risks covered by the policy.⁸³

Coverage: Title Insurance. In a case of first impression a court of civil appeals upheld the insured's claim of damage for the reduced market value of real estate purchased by the insured due to the existence of an unknown easement and waterline underneath the property.⁸⁴ The title insurance policy contained a description of the property which did not mention the easement nor indicate the existence of the waterline, but the description did refer to the map and plat of the property on record in the office of the county clerk with the statement, "to which reference is here made for all pertinent purposes." The recorded map and plat showed the waterline easement. The insurer contended that the reference in the policy to the map and plat "for all pertinent purposes" constituted an exception and exclusion to the insured risk. The court upheld the trial court's judgment that the description of the land in the title policy was for the purpose of identifying the land covered by the policy and not for the purpose of limiting the insurance protection purchased.

The court stated that the nature and the purpose of the insurance con-

⁸⁰ *Id.* at 975.

⁸¹ *Employers Cas. Co. v. West*, 410 S.W.2d 291 (Tex. Civ. App. 1966) *error ref. n.r.e.*

⁸² *West v. Carpenter*, 366 S.W.2d 826 (Tex. Civ. App. 1963) *error ref. n.r.e.*

⁸³ *Washington Nat'l Ins. Co. v. Craddock*, 130 Tex. 251, 109 S.W.2d 165 (1937).

⁸⁴ *San Jacinto Title Guar. Co. v. Lemmon*, 417 S.W.2d 429 (Tex. Civ. App. 1967) *error ref. n.r.e.*

tract was to insure and guarantee a good title and to relieve the insured from the necessity and responsibility of checking and examining public records to determine the condition of the title to the land. Such purpose would not be carried out if the interpretation of the policy urged by the insurer were adopted. The court adopted the view of the Supreme Court of Texas that "an insurance policy must be strictly construed against the company writing it, and particularly of provisions which tend to defeat coverage."⁸⁵

Burden of Proof. A first impression case construed the meaning of "control" in a fire insurance policy.⁸⁶ Insured's house was vacant at the time a water pipe froze and burst. Insured had moved out of state but had left his brother-in-law in charge of the house. The brother-in-law listed the house with a real estate agent, giving him a key, and also hired several workmen, giving them access to the house. Prior to the accident the brother-in-law had turned off the water and had opened several valves in the water system to drain the remaining water. Insured asserted that, prior to the date of the accident, some unknown person had reactivated the water system.

The insurance policy in question was issued by a Lloyd's-type insurance company and apparently was not a Texas Standard Homeowner's Policy. Listed under a section called "Other Provisions," the policy contained a provision reading: "Control of Property: This insurance shall not be prejudiced by any act or neglect of any person (other than the named insured) when such act or neglect is not within the control of the named insured."⁸⁷ The "control" clause apparently was not an exclusion or exception to liability in the policy but the court of civil appeals in reversing and remanding the case gave it that effect by placing the burden of proof on the insured to prove that the asserted unknown person who had turned the water back on was not under his control. The Texas Rules of Civil Procedure place the burden of proof upon the insured where the insurer specially pleads exceptions or exclusions to general liability.⁸⁸

Instead of being an exclusion or exception the "control" clause appears to have been written for the benefit of insured. It states that the insured is not responsible for the acts or neglect of others not under his control. This appears to be another case misapplying rule 94. The result of this case appears contrary to a recent case construing the Texas Standard Homeowner's Policy which provides for loss by freezing but with an exclusion of loss caused by freezing while the building is unoccupied unless the insured exercised "due diligence."⁸⁹ In that case the court's strict construction of the policy required due diligence only by the insured, not of the insured's employee.

⁸⁵ National Sec. Life & Cas. Co. v. Davis, 152 Tex. 316, 257 S.W.2d 943 (1953).

⁸⁶ Fort Worth Lloyd's Ins. Co. v. Willham, 406 S.W.2d 76 (Tex. Civ. App. 1966) *error ref.*

n.r.e.

⁸⁷ *Id.* at 78.

⁸⁸ TEX. R. CIV. P. 94.

⁸⁹ International Ins. Co. v. Reid, 400 S.W.2d 939 (Tex. Civ. App. 1966) *error ref. n.r.e.*

III. AUTOMOBILE AND LIABILITY INSURANCE

Legal Responsibility for Use of Automobile. In a case of first impression in Texas, a court of civil appeals rejected the contention of an automobile repairer that it was an insured under a provision in its customer's liability policy which covered the auto owner and "Any other person or organization legally responsible for the use of . . . an owned automobile."⁹⁰ The auto owner had taken the car to Montgomery Ward for brake repair. Not having time to fix the brakes that day, the service manager assured her that the automobile could be safely driven until repairs could be made the following day. While returning for service the next day, the owner had a rear-end collision due to failure of her brakes. When the third party sued the owner and Montgomery Ward, the insurer refused to defend Montgomery Ward. The instant action was then instituted by Montgomery Ward seeking a declaratory judgment that it was an assured within the above-quoted clause. The court held that Montgomery Ward was not legally responsible for the use of the vehicle by the insured and was not covered by the policy. Any responsibility for Montgomery Ward's own negligence does not make Montgomery Ward "legally responsible for the use of the vehicle" within the meaning of the policy.

Uninsured Motorist. In a venue case⁹¹ an insured was unable to make out a prima facie case that an alleged third party tortfeasor was an "uninsured motorist" in order to maintain his cause of action in the county where the accident occurred. The third party, Cofer, was killed in the accident along with the insured's wife and thirteen-year-old daughter. The court of civil appeals, in a lengthy detailed examination of the facts, reversed the trial court, holding that the evidence was insufficient to establish a prima facie case that the alleged tortfeasor was an uninsured motorist. The court said that, under the terms of the uninsured motorist endorsement, the insured was required to prove by a preponderance of the admissible testimony that the deceased, Cofer, was an uninsured motorist and that this was a condition precedent to a cause of action under the terms of the endorsement. Testimony that plaintiff had received negative replies upon writing to several insurance companies to determine if Cofer had been insured by them was held insufficient to satisfy the condition precedent. The case illustrates the difficulty one may have finding whether there is insurance coverage when the automobile owner is killed in the accident.

Ownership of Automobile by Minor. A named insured was held to be the owner of an automobile for automobile liability purposes when the insured held the certificate of title since, at the time of the accident, the person for whom the automobile was purchased and who was paying for the automobile was a minor and could not compel transfer and assignment of legal title.⁹² One of the cases relied upon by the court was a supreme

⁹⁰ *Montgomery Ward & Co. v. Allstate Ins. Co.*, 417 S.W.2d 764 (Tex. Civ. App. 1967) error ref.

⁹¹ *Pan Am. Fire & Cas. Co. v. Lloyd*, 411 S.W.2d 557 (Tex. Civ. App. 1967).

⁹² *Cimmaron Ins. Co. v. Price*, 409 S.W.2d 601 (Tex. Civ. App. 1966) error ref. n.r.e.

court decision holding that a person having the legal right to have the title certificate to an automobile transferred to him was the "sole" owner of the car under an insurance policy calling for such ownership.⁸³ The court applied the converse of the rule established in the supreme court case in reaching its decision.

Extent of Permission for Use of Automobile. A court of civil appeals held that permission by the named insured to another to use the insured automobile gave rise to an implied permission for a third person to use the insured automobile.⁸⁴ The existence of such implied permission entitles the third person to protection under the "omnibus clause." Whether such implied permission exists is usually a factual determination.

The named insured gave permission to a Catholic priest to use the insured automobile for an out-of-town trip in connection with the priest's duties as youth director. Nothing was said about who was to drive the car. On previous similar occasions the priest had directed various youths under his direction to drive the car. The accident occurred while a youth was driving the car carrying out the instructions of the priest and executing the purpose for which the car had been borrowed from the named insured. The youth driving the car had a valid driver's license. His father's insurance covered him as excess insurance if the insurance on the borrowed automobile was primary insurance.

The court, relying upon an earlier Texas case⁸⁵ and an annotation of cases from other jurisdictions,⁸⁶ held the evidence justified a finding that the priest had the implied consent of the named insured to permit another to drive the car on this occasion.

Extension of Liability Coverage to Devisee of Insured Owner. In a case of first impression a court of civil appeals held there was automobile insurance coverage of a devisee of an automobile.⁸⁷ The devisee had "proper temporary custody" of the automobile within the meaning of the decedent's automobile policy. The policy provided that if the insured should die the policy would cover any person having proper temporary custody of the automobile until the appointment and qualification of the legal representative.

The insured automobile owner died leaving a will naming his aunt as devisee of the automobile. The named executor turned the automobile over

⁸³ Pioneer Mut. Compensation Co. v. Diaz, 178 S.W.2d 121 (Tex. Civ. App. 1943), *aff'd*, 142 Tex. 184, 177 S.W.2d 202 (1944). Important facts to sustain the holding that the insured was the owner of the automobile were that the insured alone was obligated for the payment of the encumbrance against the automobile held by a bank and that the person who was paying for the car, the insured's minor brother-in-law, could use the car only by the permission of the insured and could not acquire ownership of the automobile until he reimbursed the insured for the purchase price of the automobile.

⁸⁴ Phoenix Ins. Co. v. Allstate Ins. Co., 412 S.W.2d 331 (Tex. Civ. App. 1967).

⁸⁵ United Serv. Auto. Ass'n v. Zeller, 135 S.W.2d 161 (Tex. Civ. App. 1939) *error dismissed*.

⁸⁶ Omnibus Clause of Automobile Liability Policy as Covering Accidents Caused by Third Person Who is Using Car with Consent of Permittee of Named Insured, 4 A.L.R.3d 10 (1965).

⁸⁷ Atlantic Ins. Co. v. Fulfs, 417 S.W.2d 302 (Tex. Civ. App. 1967) *error ref. n.r.e.*

to the aunt before the will was probated and before the executor qualified. Prior to probate the automobile was demolished and the aunt injured.

The insurer denied any liability for collision damage and medical payments contending that the executor had not given the aunt "temporary custody" but had turned the automobile over to her to keep permanently because it was willed to her and would not be needed for payment of debts. The court affirmed the trial court's judgment holding the aunt had "proper temporary custody" within the meaning of the Texas Family Automobile Policy. Under the Probate Code the named executor not only has the right to possession of the decedent's property but also the duty to acquire such possession pending probate of the will. The aunt's possession was temporary because it was subject to the executor's right to possession.

Accidental Death Benefits—Failure To Purchase Disability Coverage. An example of strict construction in favor of the insurer rather than a liberal construction in favor of the insured is found in the opinion of a court of civil appeals in a case of first impression construing what is apparently an unusual endorsement to an automobile policy.⁸⁸ The insured sought recovery of \$10,000 for the accidental death of his wife claiming coverage under an endorsement in a family automobile policy which provided for death indemnity benefits "provided the death shall occur (1) within ninety days after the date of the accident or (2) within fifty-two weeks after the date of the accident and during a period of continuous total disability of the insured for which weekly indemnity is payable under the Total Disability Coverage."⁸⁹ The insured had not purchased coverage for total disability and paid no additional premium therefor. The accident occurred August 22, 1964, and rendered the insured's wife totally disabled. She died as a result of the accident on January 4, 1965. The appellate court held that the quoted clause was not ambiguous and that it meant that, since there was no total disability coverage, there could be no weekly indemnity payable. The clause did not specifically require such payment.

It is submitted that the clause is ambiguous. A reasonable interpretation of the clause is that the death benefit would be paid if death occurred within fifty-two weeks after the date of accident and during a period of continuous total disability of the insured under the circumstances for which weekly indemnity would be payable if there was total disability coverage. It would have been easy for the insurance company, when it sold this accidental death coverage, to have written this clause to provide that it applied only if there was also total disability coverage for an additional premium.

Oral Notice of Accident to Agent Does Not Discharge Policy Requirement of Written Notice. A horrible example of the harsh operation of the law requiring strict compliance with the policy requirements of notice is seen in a case where there was timely oral notice on two occasions to the agent

⁸⁸ Willeford v. Home Indem. Co., 411 S.W.2d 640 (Tex. Civ. App. 1967).

⁸⁹ *Id.* at 641.

who sold the insurance policy.¹⁰⁰ No written notice was filed until more than four months after the accident when the insured brought the matter to her attorney. A severe consequence to the insured of the now established rule that the notice requirement in an automobile policy is a condition precedent to liability is that a failure to comply strictly with the policy requirements invalidates the claim for indemnity regardless of whether there is prejudice to the insurer because of the delay.¹⁰¹ In the instant case, two days after the accident the insured went to the office of the insurer's agent who sold her the policy to report the accident to him. The agent told her he was engaged in a trial of a law suit and did not have time to talk to her. The agent apparently did not even have time to give the insured forms on which to report the accident. Eight days after the accident, insured called the agent long distance from California, reported the accident and claim to him in full, requested him to advise her of any additional information needed in order for him to fully handle the claim, and received the reply that the agent had all the information he needed and nothing further would be required of her. The court held, "[N]evertheless the policy provided for written notice and no notice was given for more than four months after the accident, and we hold that as a matter of law, because of her failure to perform conditions precedent, or show a valid excuse for not doing so, appellee was not entitled to recover."¹⁰²

It is submitted that this is an unduly strict and unjust application of the law on notice. The facts show a valid excuse for the insured not filing a written notice sooner than she did. She was first told by the insurer's agent who was also an attorney that he was too busy in the trial of a law suit to talk to her. She was not told by the agent to file a written notice. When she went to the expense and trouble of calling the agent long distance from California she was told that he had all the information he needed and nothing further would be required of her. These facts are sufficient to show both waiver and estoppel. An agent with authority to issue and collect premiums for a policy certainly should have the authority to waive strict compliance with the notice provision.

Seller's Insurer Not Liable When Equitable Title Has Passed. A court of civil appeals held that the purchaser's insurer could not recover from the seller's insurer on the theory that the purchaser did not have valid title to the insured truck because of the failure of seller and purchaser to comply with the Certificate of Title Act.¹⁰³ The theory of the purchaser's insurer was that the seller's insurer should be liable because the purchaser was using the truck with permission of the seller and not as owner. The facts showed that the parties intended that the sale of the truck take place on December 28, 1961. The accident occurred on December 30, 1961, while the purcha-

¹⁰⁰ Aetna Ins. Co. v. Durbin, 417 S.W.2d 485 (Tex. Civ. App. 1967).

¹⁰¹ Klein v. Century Lloyds, 154 Tex. 160, 275 S.W.2d 95 (1955); New Amsterdam Cas. Co. v. Hamblen, 144 Tex. 306, 190 S.W.2d 56 (1945); White v. Transit Cas. Co., 402 S.W.2d 212 (Tex. Civ. App. 1966) error ref. n.r.e.

¹⁰² 417 S.W.2d at 487.

¹⁰³ Viator v. American Gen. Ins. Co., 411 S.W.2d 762 (Tex. Civ. App. 1967) error ref. n.r.e.

ser was driving the truck. The decision is sound since the legislative intent of the Certificate of Title Act is to prevent or lessen theft and traffic in stolen motor vehicles; not to prevent sales and transfers of interest in motor vehicles.¹⁰⁴

Burden on Insurer To Prove Insured Truck Was Used on "Regular or Frequent Trips" Beyond a 150-Mile Radius. The meaning of "regular or frequent trips in an automobile policy wherein the insured warranted that no regular or frequent trips of his trucks would be made to any location beyond a 150-mile radius was considered by a court of civil appeals.¹⁰⁵ The insured truck had been used during the nine-month period for his farming operations within the 150-mile limit except for eight trips beyond the 150-mile limit.

The court held that the burden was upon the insurer to prove that the truck was used on "regular" and "frequent" trips beyond the 150-mile limit. Eight trips in the nine-month period was not sufficient as a matter of law to defeat the insured's right to recovery.

The opinion improperly placed the burden of proof on the insurer if the court is correct in calling the 150-mile limit an "exclusionary" provision.¹⁰⁶ However, the provision itself is in terms of a promissory warranty by the insured and the burden is on the insured to prove such a breach of warranty.¹⁰⁷

Seven of the trips were made by a lessee while the truck was under lease. The court said the insurer would not be liable for loss during these trips because of a provision of the policy that "This policy does not apply: . . . if the automobile is or at any time becomes subject to any bailment lease, conditional sale, purchase agreement, mortgage or other encumbrance not specifically declared and described in this policy."¹⁰⁸ This interpretation is doubtful as the quoted provision applies to title encumbrances and not to lease of the automobile for use.

Insurer as Beneficial Owner of Insured's Claim Against Third Party. Defendant hit insured's car while it was parked, damaging it to the extent of \$333.10. He paid the insured \$100, the amount of the deductible on insured's policy. The insurer paid insured the balance. The tortfeasor was then sued by the insurer in the name of the insured. The insured testified that she did not make any claim for damages against the defendant and did not want a judgment against the defendant. The court of civil appeals rendered judgment for the insurer on the theory that the insurer was the beneficial owner of the cause of action, could sue in the name of the insured and the fact the insured had no claim against the defendant was immaterial.¹⁰⁹ One wonders about the principle that only real parties in interest may participate as parties in a suit.

¹⁰⁴ Motor Inv. Co. v. Knox City, 141 Tex. 530, 532, 174 S.W.2d 482, 483 (1943).

¹⁰⁵ Emmco Ins. Co. v. Waters, 413 S.W.2d 484 (Tex. Civ. App. 1967) *error ref. n.r.e.*

¹⁰⁶ TEX. R. CIV. P. 94.

¹⁰⁷ Springfield Fire & Marine Ins. Co. v. Whisenant, 245 S.W. 963 (Tex. Civ. App. 1922) *error ref. n.r.e.*

¹⁰⁸ 413 S.W.2d at 486.

¹⁰⁹ Jaskolski v. Jahn, 410 S.W.2d 858 (Tex. Civ. App. 1966).