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INSURANCE LAW

by

Harvey L. Davis*

THE TREND indicated in the last two *Surveys* continued during the current year. Many of the insurance cases which were decided favorably for insurers turned upon technical construction and application of insurance contract language. A number of the cases dealt with "good faith" clauses in applications for life or health and accident insurance; a number dealt with conditional receipts or temporary insurance; and a number dealt with incontestable clauses. The technical application of rule 94 of the Texas Rules of Civil Procedure¹ was continued except for one opinion which emphasized that rule 94 was not intended to change the rules regarding burden of proof.

I. HEALTH, LIFE AND ACCIDENT INSURANCE

A. Procedural Decisions

Pleadings. The general status of rule 94, requiring an insurer to plead specifically any exception in the policy relied upon as a defense, was eroded somewhat by one court of civil appeals.² The court held that the insured had the burden of proving that the specific loss sustained was covered by the policy even though the insurer filed only a general denial and did not plead any policy limitations or exceptions in defense. Another court of civil appeals held that where the defense by the insurer went to a promissory warranty which affected the validity of the policy, such as the issue of "good health," the burden of proof was still upon the insurer under rule 94.³

Evidence. The "entire" contract statute of the Insurance Code⁴ generally has been interpreted to mean that unless an application for an insurance policy is attached to the policy as required by the statute, the application does not become a part of the contract and is inadmissible in evidence.⁵ However, a court of civil appeals held that it was not fundamental error to admit in evidence an application, not attached to the insurance policy at the time of its issuance or at the time of the trial, where such application was admitted as evidence of fraudulent representations concerning

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¹ TEX. R. CIV. P. 94.

² Reserve Life Ins. Co. v. Crager, 421 S.W.2d 697 (Tex. Civ. App. 1967). The court relied upon its own opinion in Merryman v. Employers Nat'l Life Ins. Co., 416 S.W.2d 609 (Tex. Civ. App. 1967), *error ref. n.r.e.*, which was commented upon in the last *Survey* as having demonstrated a misapprehension of rule 94. Davis, *Insurance Law, Annual Survey of Texas Law*, 22 Sw. L.J. 30, 31 (1968).

³ Life & Cas. Ins. Co. v. Rivera, 420 S.W.2d 788 (Tex. Civ. App. 1967).

⁴ TEX. INS. CODE ANN. art. 21.24 (1963).

⁵ Harris v. Allstate Ins. Co., 249 S.W.2d 669 (Tex. Civ. App. 1952), *error ref.*; National Life & Accident Ins. Co. v. Love, 282 S.W. 829 (Tex. Civ. App. 1926), *error dismissed*.

the sound health of the insured.⁶ The court relied upon *First Texas Prudential Insurance Co. v. Pedigo*,⁷ which held that false representations in an application upon which the insurer relied in entering the contract were collateral in nature and thus could serve as a basis of defense even though the application was not a part of the policy.

Special Issues. It is settled law in Texas that the insured's possession of sound health on the date the life insurance policy is issued may be made a condition precedent to the operative effect of the policy.⁸ In a recent court of civil appeals decision,⁹ suit was brought upon a life insurance policy issued on the life of a six-week-old baby. The policy contained a sound health clause providing that the policy "shall take effect on the date of issue, provided the insured is then alive and in sound health, but not otherwise."¹⁰ The trial court refused to submit to the jury numerous requested issues and instructions, but instead submitted only the ultimate issue of whether the baby was in unsound health on the date the policy was issued. The court of civil appeals agreed that there was sufficient evidence to support the jury's finding that the baby was not in unsound health at that time, even though a possible heart murmur had been detected by the baby's doctor.

Incontestable Clauses. In a case of first impression, a court of civil appeals held that a suit filed by an insurer on the last day of a two-year incontestable period was a timely "contest" within the meaning of the incontestable clause, even though citation was not served until after the two-year period.¹¹ The court examined two supreme court opinions¹² dealing with the application of incontestable clauses and the incontestable statute,¹³ but concluded that those cases did not provide an answer to the current problem. Instead, the court decided that the case should be governed by the doctrine established by the supreme court in statute of limitations cases:¹⁴ "The purpose of the limitation contained in the policy under consideration as required by the Insurance Code is properly implemented by a decision that an appropriate suit be filed within the contestable period and the citation be issued and served with reasonable promptness thereafter."¹⁵

⁶ *Cox v. Nat'l Life & Accident Ins. Co.*, 420 S.W.2d 213 (Tex. Civ. App. 1967), *error ref. n.r.e.*

⁷ 50 S.W.2d 1091 (Tex. Comm'n App. 1932), *holding approved*.

⁸ *Lincoln Income Life Ins. Co. v. Mayberry*, 162 Tex. 492, 347 S.W.2d 598 (1961); *Texas Prudential Ins. Co. v. Dillard*, 158 Tex. 15, 307 S.W.2d 242 (1957).

⁹ *National Life & Accident Ins. Co. v. Salas*, 426 S.W.2d 327 (Tex. Civ. App. 1968), *error ref. n.r.e.*

¹⁰ *Id.* at 328.

¹¹ *Fields v. Universal Life & Accident Ins. Co.*, 424 S.W.2d 704 (Tex. Civ. App. 1968), *error dismissed*.

¹² *Patton v. American Home Mut. Life Ins. Co.*, 143 Tex. 373, 185 S.W.2d 420 (1945); *Trevino v. American Nat'l Ins. Co.*, 140 Tex. 500, 168 S.W.2d 656 (1943).

¹³ TEX. INS. CODE ANN. art. 3.44 (1963), *as amended*, (Supp. 1968).

¹⁴ *Owen v. City of Eastland*, 124 Tex. 419, 78 S.W.2d 178 (1935); *Windom v. Howard*, 86 Tex. 560, 26 S.W. 483 (1894); *Ricker v. Shoemaker*, 81 Tex. 22, 16 S.W. 645 (1891).

¹⁵ *Fields v. Universal Life & Accident Ins. Co.*, 424 S.W.2d 704, 708 (Tex. Civ. App. 1968), *error dismissed*.

Another case¹⁶ dealt with a 1963 amendment to the Insurance Code and its effect upon incontestable clauses in policies issued prior to amendment. This amendment provides that a policy shall become incontestable "after it has been in force *during the lifetime of the insured* for two (2) years from its date."¹⁷ The policy involved contained, in accordance with the Insurance Code prior to 1963,¹⁸ a provision that it would be incontestable after two full years from the date of issuance. The insured died within the two-year contestable period, but the insurer did not contest the policy until more than two years after the date of issuance. The insurer argued that the insured was not in sound health at the time the policy was issued and that the incontestable clause did not apply because the policy had not been in force for two years during the lifetime of the insured. The court held that the amendment did not apply to policies issued prior to its effective date; thus, the policy had become incontestable since the insurer sought to contest it only after the expiration of two years from the date of issuance.

A third civil appeals case held that the two-year incontestability statute did not apply to a group policy or certificate issued to a named insured for more than two years where the policy and the certificate never became effective.¹⁹ The group policy was written in accordance with the provisions of a special statute authorizing group life insurance covering purchases of land under the Veteran's Land Program.²⁰ The proceeds of the policy on the death of the insured would cancel any indebtedness remaining as a result of the purchase. The statute provided that the master contract could contain a provision that coverage would terminate when the purchaser of the land reached age sixty-five. The master policy and the certificate issued to the named insured contained such a provision. In addition, the master policy contained a provision that if a premium was paid on a person over sixty-five years of age, the insurance company would have no liability in regard to such person. The court distinguished between contesting the validity of an insurance contract, to which the two-year incontestability statute would apply, and contesting the coverage, meaning, or application of an insurance contract.²¹ The insurer was not contesting the validity of the master policy, but was merely insisting upon the observance of the policy terms and upon compliance with the statute under which the master policy was issued;²² thus the statute did not apply.

B. Substantive Decisions

Receipt for Premium and Temporary Coverage as a Contract of Insurance. Three cases held that no contract of insurance was created where a prem-

¹⁶ Lee v. Universal Life Ins. Co., 420 S.W.2d 222 (Tex. Civ. App. 1967), *error ref. n.r.e.*

¹⁷ TEX. INS. CODE ANN. art. 3.44 (1963), *as amended*, (Supp. 1968) (emphasis added).

¹⁸ *Id.* art. 3.44 (1963).

¹⁹ Great Am. Reserve Ins. Co. v. Fry, 418 S.W.2d 716 (Tex. Civ. App. 1967), *error ref. n.r.e.*

²⁰ TEX. REV. CIV. STAT. ANN. art. 5421m (1962).

²¹ The court cited a number of cases on this point, including the latest, Mainer v. American Hosp. & Life Ins. Co., 371 S.W.2d 717 (Tex. Civ. App. 1963), *error ref. n.r.e.* The leading case is McCann v. Nat'l Life & Accident Ins. Co., 226 S.W.2d 177 (Tex. Civ. App. 1949), *error ref.*

²² See Mainer v. American Hosp. & Life Ins. Co., 371 S.W.2d 717, 719 (Tex. Civ. App. 1963), *error ref. n.r.e.*

ium had been accepted, receipt issued therefor, and temporary coverage provided. One case was decided on the theory that waiver or estoppel cannot create insurance coverage in a group policy where no coverage ever existed for the plaintiff-employee.²³ The employee's claim of waiver or estoppel was based on payment of the premiums, submission of proof of loss at the request of the insurer, delivery of the insurance certificate and identification card to the employee, and partial payment of the proceeds due under the policy.

The group policy would not become effective in regard to any employee who was not actually at work on the date his insurance contract was to become effective until such employee actually returned to work. In this case, the plaintiff was not at work on the date the coverage would have become effective, and he never returned to work. The court held that there was no insurance coverage, relying on *Washington National Insurance Co. v. Craddock*²⁴ in which the supreme court held that contractual insurance liability cannot be created by waiver.

In another case the beneficiaries of a deceased insured were denied recovery under the terms of the conditional receipt which had been issued by the insurer to the insured upon payment of the first month's premium.²⁵ At the time the insured made application for insurance, he furnished information to the soliciting agent that he had been treated for an ulcer in 1963 and that in 1965 an ulcer had affected him adversely in insurance matters. The conditional receipt provided: "The insurance for which application is made shall be effective (1) on the date of this receipt or (2) on the date of completion of all medical examinations required by Company rules and practices, whichever date is later, if on such effective date all persons to be insured are in good health and acceptable for insurance under the established rules and practices of the Company for the plan amount, and premium applied for."²⁶ Shortly after paying the first premium, the applicant died from causes unrelated to any condition of health stated in his application for insurance.

Under the rules and practices of the insurance company, an applicant for insurance who had suffered from or been treated for an ulcer within the past five or ten years was required to undergo a medical examination regardless of the amount of insurance sought. The court held that there was no liability under the receipt because a medical examination was prerequisite to insurance coverage and the applicant had not undergone such an examination.

In the third case²⁷ an applicant for disability insurance was assured by the soliciting agent that his coverage would become effective immediately upon his signing an application, paying an amount in excess of the monthly premium, and receiving a receipt therefor. Both the receipt and the application were dated December 1, 1965. Shortly thereafter, applicant was

²³ *Boyd v. Travelers Ins. Co.*, 421 S.W.2d 929 (Tex. Civ. App. 1967), *error ref. n.r.e.*

²⁴ 130 Tex. 251, 109 S.W.2d 165 (1937).

²⁵ *Bobbitt v. American Nat'l Ins. Co.*, 419 S.W.2d 919 (Tex. Civ. App. 1967).

²⁶ *Id.* at 920.

²⁷ *Marshall v. Bankers Life & Cas. Co.*, 425 S.W.2d 45 (Tex. Civ. App. 1968).

accidentally injured, and sometime later he received a policy which showed an issue date of December 14, 1965, which was subsequent to his injury. The application, the receipt, and the policy provided that no coverage would become effective until the date the policy was issued and that the agent had no power to make an oral contract for the company. The court found that these instruments conclusively negated the existence of a valid, temporary insurance policy.

Contract Interpretation.

Conflicting Provisions, Yet Harmonious. The award for the worst insurance decision of the year goes to a court of civil appeals which found that certain provisions in a life insurance policy were inconsistent and in conflict with each other, yet by the use of misapplied rules of construction "harmonized" the conflicting provisions.²⁸ The court then concluded that the policy was unambiguous and upheld the conflicting provision which was most advantageous to the insurer. A detailed presentation of this case is necessary to explain the results.

The parents of Randy Davis purchased an insurance policy on Randy's life when he was five years old. Under the conflicting provisions of the policy,²⁹ the insurer agreed to pay:

A. The Initial Face Amount if the death of the Insured occurs prior to the anniversary of this policy nearest the 21st birthday of the Insured.

B. The Ultimate Face Amount if the death of the Insured occurs on or after the anniversary of this policy nearest the 21st birthday of the Insured.

In conflict, the following phrases appeared on the same page in a box outlined in black: "Face Amount to Age 21 (Initial Face Amount) \$3000; Face Amount Thereafter (Ultimate Face Amount) \$9000." At the bottom of the same page appeared the following phrase: "Juvenile Endowment at Age 60 with Increased Death Benefit at Age 21 with Return Premiums."

Randy became twenty-one years of age on October 11, 1966. He died on February 3, 1967. Consequently, Randy's mother, the named beneficiary, relying upon the policy provisions calling for payment of "Face Amount To Age 21 . . . \$3000. Face Amount Thereafter . . . \$9000." and the words "Juvenile Endowment at Age 60 with Increased Death Benefits at Age 21, with Return Premiums" contended that the insurer was obligated to pay \$9,000. However, the court rejected this contention.

The anniversary date of the policy was April 10. April 10, 1967, was three days nearer Randy's twenty-first birthday than April 10, 1966. Finding no vagueness in the provisions of A and B, as set out above, the court ruled that under those provisions, only the initial face amount (\$3,000) was due. At the same time, the court admitted: "*It is true provisions A and B are inconsistent with, and in conflict with both the provisions in the box, (and the provisions following), when considered alone.*"³⁰ However, the court reasoned that the general rules of construction of in-

²⁸ Davis v. Texas Life Ins. Co., 426 S.W.2d 260 (Tex. Civ. App. 1968), error ref. n.r.e.

²⁹ *Id.* at 261 (emphasis added).

³⁰ *Id.* at 262.

insurance policies were the same as those that govern other contracts. Thus, the court concluded that when a contract contains both general and specific provisions relating to the same thing, the specific provisions prevail over the general if the general provisions follow the specific provisions.³¹

No reason was given for the conclusion that the language in the box and that following was a generalization of the language used in *A* and *B*. Even if this conclusion is correct, the mere process of classifying provisions as "general" and "specific" does not make otherwise conflicting provisions harmonious. The theory applied in the instant case permits the insurer to make promises in the "general provisions" and take them away in the "special provisions." The court should have applied the following rule of construction: when a conflict exists between various provisions of an insurance policy, the provision more favorable to the insured will control.³² As stated by one Texas court: "[T]here is an apparent conflict between the two provisions, which renders the bond or contract ambiguous and uncertain, and calls, therefore, for the application of the rule that where two interpretations equally fair may be given, that which gives the greater indemnity will prevail."³³

Hudman Extended. A court of civil appeals applied the rule laid down by the supreme court in *Mutual Benefit Health & Accident Ass'n v. Hudman*³⁴ and held that, as a matter of law, a disability caused to the insured by a fall was not covered by the accident policy where there was medical testimony that the insured had a pre-existing disease that was a concurring cause of the disability.³⁵ The insured failed to prove that the accidental injury was the sole proximate cause of the loss; therefore, he failed to meet the burden imposed by *Hudman*. Thus the *Hudman* rule now applies in disability as well as in death cases.

Exclusion Riders. In an opinion reflecting inconsistency on its face, a court of civil appeals affirmed a summary judgment for an insurer even though the insurer failed to prove conclusively that it had complied with the terms of its own exclusion riders, which compliance was necessary to make the riders valid exclusions in the policies.³⁶ When the insured applied for two policies of insurance, one covering hospital and medical expenses and the other providing for disability payments, he disclosed previous trouble with his left knee and pain in his lower back. The insurer claimed that it had issued policies with "valid exception riders" reading: "If the

³¹ The authority cited by the court to support this rule of construction was 17 AM. JUR. 2D *Contracts* § 270 (1964); however, in the same paragraph from which a statement of the general rule was drawn, the general rule is qualified with the words "although this is not universally or necessarily so." The court said: "Applying the foregoing rules of construction, we think the language in the box (and the following), a generalization of the specific language used in *A* and *B*; and that a reasonable construction with all provisions harmonized renders the policy unambiguous." *Davis v. Texas Life Ins. Co.*, 426 S.W.2d 260, 262 (Tex. Civ. App. 1968), *error ref. n.r.e.*

³² *Missouri State Life Ins. Co. v. Hearne*, 226 S.W. 789 (Tex. Civ. App. 1920), *error dismissed*; *Indiana & Ohio Live Stock Ins. Co. v. Keiningham*, 161 S.W. 384 (Tex. Civ. App. 1913), *error ref.*

³³ *Ferris v. Southern Underwriters*, 109 S.W.2d 223, 226 (Tex. Civ. App. 1937), *error ref.*

³⁴ 398 S.W.2d 110 (Tex. 1965), *discussed in Davis, Insurance Law, Annual Survey of Texas Law*, 21 Sw. L.J. 88 (1967).

³⁵ *Great Am. Health & Life Ins. Co. v. Lothringer*, 422 S.W.2d 543 (Tex. Civ. App. 1967), *error ref. n.r.e.*

³⁶ *Reeves v. New York Life Ins. Co.*, 421 S.W.2d 686 (Tex. Civ. App. 1967), *error dismissed*.

written acceptance of the insured is indicated hereon, it is hereby agreed that, in addition to other exceptions set forth in this policy, this policy shall not cover any loss resulting from any injury to the left knee or to the lumbosacral or sacroiliac regions of the back.³⁷

In the summary judgment action, the insurer failed to introduce into evidence the original riders, but instead introduced copies which bore only the typewritten name of the insured. The insured argued that no written acceptance was shown or that at least a genuine issue of material fact concerning such acceptance existed. In addition, he argued that the exclusions were either waived by the insurer or that the insurer was estopped from relying upon them because the insurer had paid a surgeon's bill for removal of a disc from the insured's back, and because the insurance agent had made certain statements when soliciting the insurance. The court of civil appeals affirmed summary judgment for the insurer on the basis of testimony in the insured's deposition indicating that he knew he had to agree to the terms of the riders before the policies would be delivered to him. Furthermore, the court said that the exclusion riders were plain and unambiguous and that any statements made by the soliciting agent could not alter them.

This decision seems questionable because the same "plain and unambiguous" provisions of the riders also required them to be accepted in writing by the insured. The court reiterated the well-known principle that a contract cannot be created by estoppel, but the insured was not trying to create a contract by estoppel. He merely sued on the contract in an attempt to estop the insurer from relying upon the exclusion in the riders. Thus the insured took the position that the riders were not part of the contracts. Although not stated by the court, the theory apparently underlying its decision was that the riders were created and made valid as part of the contract through a type of estoppel on the part of the insured. The court reasoned that the insured knew that the riders must be attached to the policy and that he must agree to the terms thereof before the policies were delivered to him, therefore, once the policies were delivered to him, he was estopped to deny that the riders had been created.

Continuous Illness Converted into a "Different" Sickness Under Terms of Hospital Policy. An example of how a court's construction of an insurance provision may change the nature of a sickness is illustrated by an opinion in which the court construed a family hospital policy.³⁸ The policy provided that "[i]f, following a period for which expense is payable under this policy by reason of any one period of sickness, no expense covered by this policy is incurred as a result of such sickness for a period of six consecutive months, but thereafter expenses are incurred from the same cause, such expense so incurred shall be deemed to be the result of a different sickness and compensable as a new period of sickness, subject to a new Deductible Amount."³⁹ The insured had been confined to a hospital on

³⁷ *Id.* at 687.

³⁸ *Washer v. Continental Cas. Co.*, 418 S.W.2d 900 (Tex. Civ. App. 1967), *error ref. n.r.e.*

³⁹ *Id.* at 902-03.

May 10, 1965 and the expenses for such confinement came within the terms of the policy and were paid by the insurer. The insured was again confined to the hospital on July 8, 1966, for a recurrence of the same illness. Between the first and second hospital confinements, the insurer cancelled the policy. In affirming summary judgment for the insurer, the court found the above provision to be clear and valid. The second hospital confinement admitted by both parties to be for a recurring illness was, under the terms of the policy, for a "different" sickness occurring after the policy had been cancelled.

The Insurance Code contains a provision, specifically referring to hospitalization insurance, which states in part: "Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation."⁴⁰ The court agreed that the settled law in Texas is that cancellation of the type of policy involved must be without prejudice to any claim originating prior to the effective date of cancellation.⁴¹ Although the policy provision has the effect of changing the settled law and the Insurance Code effect, the court upheld it, stating: "We are bound to give clear and valid provisions of the contract effect."⁴²

Payment of Proceeds.

Assignee Rights Superior to Subsequently Named Beneficiary. In *McAllen State Bank v. Texas Bank & Trust Co.*⁴³ the Texas Supreme Court adopted the position that an assignment or pledge of a life insurance policy as security created in the assignee or pledgee rights in the proceeds of the policy that were superior to a subsequently named beneficiary even though the insured reserved the right to change beneficiaries. The court found that the first bank was entitled to the proceeds as pledgee of the policy in question, although the insured retained possession of the policy and subsequently changed the beneficiary of the policy to a different bank as trustee. The court's ruling was based upon the theory that an assignee or pledgee of a policy for security obtains a lien on the proceeds and, therefore, has a vested interest while the named beneficiary has only an expectancy in the proceeds. The court approved the policy reasons stated in *Davis v. Modern Industrial Bank*⁴⁴ that a vested right in the assignee or pledgee makes the insurance policy a more valuable property for purposes of borrowing in time of financial need.

Wife's Powers as Community Manager To Change Beneficiary Named by Husband in Policy on His Life. In a case of first impression, a court of civil appeals held that the wife of an incompetent insured, where the wife was the manager of the community, had the right to change the beneficiary under a policy purchased with community funds on the life of her

⁴⁰ TEX. INS. CODE ANN. art. 3.70-3(8) (1963).

⁴¹ *Washer v. Continental Cas. Co.*, 418 S.W.2d 900, 903 (Tex. Civ. App. 1967), *error ref. n.r.e.*; see *American Bankers Ins. Co. v. McDonald*, 369 S.W.2d 688 (Tex. Civ. App. 1963), *error dismissed*; *Drinkard v. Group Hosp. Serv., Inc.*, 366 S.W.2d 637 (Tex. Civ. App. 1963), *error ref. n.r.e.*; *American Benefit Ass'n v. Russell*, 278 S.W.2d 316 (Tex. Civ. App. 1954), *error dismissed*.

⁴² *Washer v. Continental Cas. Co.*, 418 S.W.2d 900, 903 (Tex. Civ. App. 1967), *error ref. n.r.e.*

⁴³ 433 S.W.2d 167 (Tex. 1968).

⁴⁴ 279 N.Y. 405, 18 N.E.2d 639 (1939).

husband.⁴⁵ The insured husband had been unconscious for several years and probably would remain incompetent for the remainder of his life. Thus, the probate court had entered an order giving the wife full authority to manage, control, and dispose of the community estate, including the part which the incompetent husband would legally have power to manage in the absence of his incompetency.

The wife sought to change the beneficiary from the estate of the husband to herself, and should she not survive the husband, then to her estate. The children of the husband by a prior marriage opposed the application for the change of beneficiary, and the insurance company brought a declaratory judgment action for a determination of whether the wife had the power to change the beneficiary. Citing *Brown v. Lee*,⁴⁶ which held that the right to receive insurance proceeds payable at a future but uncertain date is property and, when purchased with community funds, is community property, the court in the instant case held that the ownership of the unmaturing policy was a portion of the community estate of the wife and the incompetent husband. The court then concluded that neither the insurance company nor the beneficiaries presently named in the policy had any vested interest in the policy or present legal standing to question the validity of the wife's action. The court left unanswered the question concerning the ownership of the policy proceeds which would arise should the incompetent husband predecease the wife. Such question, the court reasoned, was not properly the subject for a declaratory judgment.

II. FIRE AND CASUALTY INSURANCE

Proving the Loss. In *Jacaman v. Fidelity & Guaranty Insurance Underwriters, Inc.*⁴⁷ a divided Texas Supreme Court upheld an instructed verdict for the insurer on the theory that the loss sustained on insured property was a matter of speculation. Suit was brought on two fire insurance policies covering the "contents," including the stock of merchandise, of a specifically described building. All of this merchandise was moved from the building to a new location and commingled with other merchandise. The insurer's local agent orally agreed that the policies would cover the merchandise moved to the new location. Shortly thereafter, merchandise at the second location was destroyed by fire.

The insured asserted that the acts of the insurer's agent in assuring him that coverage was not impaired and in taking no action to cancel the policies or to return the unearned premiums constituted a waiver of the insured's breach of the policies. The majority agreed that the cases cited by the insured supported this proposition.⁴⁸ However, the court held that the

⁴⁵ *Salvato v. Volunteer State Life Ins. Co.*, 424 S.W.2d 1 (Tex. Civ. App. 1968).

⁴⁶ 371 S.W.2d 694 (Tex. 1963).

⁴⁷ 422 S.W.2d 154 (Tex. 1967).

⁴⁸ The insured cited the following cases: *Girard Fire & Marine Ins. Co. v. Mallard*, 13 S.W.2d 895 (Tex. Civ. App. 1929), *error dismissed*; *United States Fid. & Guar. Co. v. Taylor*, 11 S.W.2d 340 (Tex. Civ. App. 1928), *error ref.*; *Camden Fire Ins. Ass'n v. Bond*, 202 S.W. 220 (Tex. Civ. App. 1918).

legal effect of such action was to provide insurance only upon the property described in the policies (*i.e.*, the contents of merchandise at the original location); there was nothing in the record to indicate that the insurer had agreed to extend the coverage under these policies to *all* merchandise at the second location. The court reasoned that even though the insured had established the total loss of commingled merchandise caused by the fire at the second location, he had failed to prove the proportion of the destroyed merchandise which had been moved from the original location to the second location. Thus the insured had failed to prove the loss covered by the policies.

The dissenters, however, argued that the legal effect of the agent's agreement to provide coverage upon the stock of merchandise at the new location was tantamount to a written endorsement to the policies, giving the insurer's consent to a change of location. Therefore, the policies provided coverage on a changing stock of merchandise at the new location just as those policies had provided coverage on a changing stock of merchandise at the original location. Thus, since the value of the merchandise destroyed was in excess of all insurance coverage, the insurer should be liable for the full amount of the policies. Since all of the justices agreed that there was coverage at the new location and since the insured suffered a loss in excess of the total policy limits, the dissenting opinion appears to be the better view.

Making the Contract. In an unusual case, a court of civil appeals upheld an oral contract of fire insurance on an airplane even though subsequent to this agreement the insurer had issued a written policy of insurance which did not conform to the oral agreement.⁴⁹ The oral agreement provided "trip insurance" coverage on the airplane while it was being flown from Guatemala to Texas, a trip which required several days because the airplane was not equipped to fly at night. The airplane was destroyed by fire on the third day of the trip. After the insurer learned of the loss, it issued a written policy containing a provision that insurance coverage was for only one specific day which was two days before the trip began. The court upheld a jury finding that the policy was willfully and fraudulently written so as not to conform to the oral agreement. Thus the insurer was liable for actual and exemplary damages for the wrongful acts of its agents.

Contract Interpretation.

Policy Provision Requiring Suit To Be Filed Within Two Years and One Day After Claim Arose Held To Be a Forfeiture Provision Subject to Waiver or Estoppel. One insured recovered for sonic boom damage to his home even though he did not file suit until about three months after the time limit set in the policy for bringing such action.⁵⁰ The jury found that the insured's claim was not finally and conclusively denied by the

⁴⁹ *Export Ins. Co. v. Herrera*, 426 S.W.2d 895 (Tex. Civ. App. 1968), *error ref. n.r.e.*

⁵⁰ *Trinity Universal Ins. Co. v. Howeth*, 419 S.W.2d 704 (Tex. Civ. App. 1967).

insurer on the date claimed by the insurer but, instead, the insurer's agents, by their actions, had led the insured to believe, even up to the time of suit, that his claim was still being considered and was in the process of adjustment. The trial court held that the insurer was estopped to rely upon the limitation provision in the policy. The court of appeals affirmed on the theory that the limitation provision was a forfeiture clause which should be strictly construed and subject to waiver or estoppel upon slight evidence.⁵¹

Damage to Brick Flooring by Muriatic Acid Is Corrosion Not Contamination. Webster's Dictionary performed an important role in the supreme court's consideration of the difference between "corrosion" and "contamination."⁵² The insured sued the insurer on a Builders Risk Insurance Policy, which covered all risks of physical loss to the particular building described in the policy. Under the exclusions were these words: "[T]his policy does not insure against . . . loss by contamination, including such loss by radioactive or fissionable materials."⁵³ The jury found that the building was damaged as a result of the application of muriatic acid to the brick flooring, and the trial court rendered judgment for the insured. The court of civil appeals reversed, holding that the evidence established as a matter of law that the loss was due to contamination and came within the exclusion.⁵⁴

However, the supreme court held that the damage sustained was due to corrosion of the metal parts and thus fell within the policy coverage. The court consulted Webster's *Third New International Dictionary* for the definitions of "corrode" and "contaminate" and concluded that corrosion and contamination are not synonymous terms. The connotation of contamination is a mixing of substances like dirt and water which results in an impure mixture. Corrosion, on the other hand, denotes disintegration, oxidation, decay of metal, and the like. The court also held that the insured was not required to sue on the original policy where the insurer had delivered to the insured only a copy of a memorandum of insurance. In this regard, the court cited *Standard National Insurance Co. v. Bayless*⁵⁵ with approval: "[A]ppellees being the insured therein had a property right in said policies, and having instituted suit upon them, the very nature of the suit puts the opposite party who holds the instruments upon notice to produce them."

Homeowner's "All Risks of Physical Loss" Policy Does Not Cover Loss to Bricks Caused by Inherent Vice and Extreme Temperatures. In another civil appeals decision summary judgment for the insured was reversed because the loss came within the exclusionary provisions of the homeowner's

⁵¹ The court relied upon several old Texas cases to support its theory. *Burlington Ins. Co. v. Tobey*, 30 S.W. 1111 (Tex. Civ. App. 1895); *Gulf, C. & S.F. Ry. v. Trawick*, 80 Tex. 270, 15 S.W. 568 (1891); *St. Paul Fire & Marine Ins. Co. v. McGregor*, 63 Tex. 399 (1885).

⁵² *McConnell Constr. Co. v. Insurance Co. of St. Louis*, 428 S.W.2d 659 (Tex. 1968).

⁵³ *Id.*

⁵⁴ *Insurance Co. of St. Louis v. McConnell Constr. Co.*, 419 S.W.2d 867 (Tex. Civ. App. 1967), *rev'd*, 428 S.W.2d 659 (Tex. 1968).

⁵⁵ 338 S.W.2d 313 (Tex. Civ. App. 1960), *error ref. n.r.e.*

"all risk of physical loss" policy.⁵⁶ The walls of the home were made of porous brick which would absorb water, and upon freezing, the water caused the bricks to crack and fall away. The policy specifically excluded loss caused by "inherent vice" and "extreme temperatures." The court relied upon *Employers Casualty Co. v. Holm*⁵⁷ for the definition of "inherent vice": "The term 'inherent vice' as a cause of loss not covered by the policy, does not relate to an extraneous cause but to a loss entirely from internal decomposition or some quality which brings about its own injury or destruction. The vice must be inherent in the property."⁵⁸ The court held that the damage was caused by "inherent vice" as well as "extreme temperatures" within the meaning of the exclusionary clause of the policy.

While the bricks were defective in that they were porous and absorbed water more freely than other bricks, expert opinion indicated that the loss was caused by rainwater entering the brick, causing the damage upon freezing. This does not appear to come within the definition of "a loss entirely from internal decomposition or some quality that brings about its own injury or destruction." The bricks would not have cracked solely because of their porous condition; it was necessary that the water enter them and freeze. Thus it seems to this writer that the loss did not come within the "inherent vice" exclusionary provision of the policy.

Failure of Insured To Notify Insurer of Illness of Race Horse Precluded Recovery. The importance of knowing the reporting requirements of the insurance policy is illustrated by a court of civil appeals decision in which the insured owners of a race horse failed to recover the value of a horse which died from an illness that occurred while the policy was in force.⁵⁹ The court based its decision upon a provision of the policy requiring the insured to notify the insurer immediately when an animal became ill. Failure to give such notice released the insurer from all liability. The policy also contained a thirty-day extension clause providing that the insurance would be extended to cover the death of an animal occurring within thirty days after the expiration date as a result of an illness manifesting itself during the period of insurance, provided that the insurer had been notified in writing prior to the expiration date.

The horse had been ill for twenty-three days before it died and had been treated by veterinarians several times during this period. The policy expiration date was October 31, 1962. The horse died on November 4, 1962, and the insurer was notified the following day. The insurer had not been notified of the illness prior to the notification of death. The court held that the insurance policy had expired and that the thirty-day extension clause had never become operative because the insured had failed to give the notice necessary to activate the extension.

⁵⁶ *State Farm Fire & Cas. Co. v. Volding*, 426 S.W.2d 907 (Tex. Civ. App. 1968), *error ref. n.r.e.*

⁵⁷ 393 S.W.2d 363 (Tex. Civ. App. 1965).

⁵⁸ 426 S.W.2d at 908.

⁵⁹ *Underwriters at Lloyd's, London v. Harkins*, 427 S.W.2d 659 (Tex. Civ. App. 1968), *error ref. n.r.e.*

III. AUTOMOBILE AND LIABILITY INSURANCE

Insurer's Duty To Defend. The Supreme Court of Texas has held that where the insurer's refusal to defend its insured is based upon the belief that the claim of the third party against the insured is groundless, false, or fraudulent, the insurer's duty to defend is to be determined by looking only to the policy provisions and to the petition of the third-party claimant.⁶⁰ However, one court of civil appeals drew a distinction between this situation and that in which the insurer's refusal to defend is based upon the belief that the claim against the insured is not covered by the insurance contract. This court held that in the latter situation, the insurer's duty to defend its insured is to be determined by looking to known or ascertainable facts, including in this case a stipulation between the insurer and the insured and an affidavit attached to the insurer's motion for summary judgment.⁶¹

Payment of Premiums. The insured purchased a policy of automobile insurance and mailed to the insurance agent a check in payment of the monthly premium. Even though the check was payable to the agent and bore a notation that it was for payment on insurance, the agent held the check and did not apply it to the premium because the agent wanted the insured to come to his office to discuss some insurance matters. The insurer cancelled the policy on December 26, 1966, for the insured's failure to pay the premium. Three days later the insured was killed and his automobile demolished. The widow sued to recover the value of the insured's automobile, and the trial court rendered judgment against her. However, the court of civil appeals rejected the insurer's contention that the check was not a premium payment since there was no express agreement not to accept checks in payment of premiums, and held that premiums could be paid by check where the policy or contract of insurance did not provide otherwise.⁶²

Insured Represented by Experienced Insurance Agent Is Bound by Negligence of That Agent. One insured sued the insurer for reformation of his automobile liability policy because it did not include coverage for medical payments even though in the written application the insured had requested such coverage.⁶³ The insurer issued a policy containing no medical payment provision and did not charge a premium for that type of coverage. This entire transaction had been handled by an experienced insurance agent employed by the insured to handle insurance matters for him. The court held that where the insured is at all times represented by an experienced insurance agent, the insured is bound by his agent's negligence

⁶⁰ Heyden Newport Chem. Corp. v. Southern Gen. Ins. Co., 387 S.W.2d 22 (Tex. 1965).

⁶¹ Cook v. Ohio Cas. Ins. Co., 418 S.W.2d 712 (Tex. Civ. App. 1967).

⁶² Bishop v. Commonwealth County Mut. Ins. Co., 425 S.W.2d 57 (Tex. Civ. App. 1968), error ref. n.r.e.

⁶³ Dugan v. General Accident, Fire & Life Assur. Corp., 421 S.W.2d 717 (Tex. Civ. App. 1967), error ref. n.r.e.

in failing to ascertain that the policy contained no medical payment provision as requested by the insured.

Contract Interpretation.

Insured Bank Fails To Recover Attorneys' Fees Spent in Defending Suit Believed To Be Within the Provisions of Bankers Blanket Bond. Recently, the Supreme Court of Texas⁶⁴ indicated that where the provision for reimbursement of court costs and attorneys' fees is listed in an indemnity bond under the caption, "[t]he losses covered by this bond are as follows," such court costs and attorneys' fees are classified by the bond itself as "losses." Therefore, the insured need not suffer an actual loss under another loss provision of the bond before being entitled to reimbursement for court costs and attorneys' fees incurred and paid in defending against a third party's claim which appears to be covered by the indemnity provisions of the bond. However, other language in the bond specifically limited the indemnitor's liability for court costs and attorneys' fees to situations in which such were incurred in suits or legal proceedings in which liability or alleged liability of the insured, if established, would constitute a valid and collectible loss under other loss provisions of the bond. Thus the court denied the bank recovery because the petition of the third party claimant against the insured bank did not allege liability of the bank which if established would have caused it a loss subject to indemnification under the bond.⁶⁵

Fraud Exclusion Held Not Applicable Where Policy Also Covers Separate Liability for Breach of Contract. In an action by insurance agents against their insurer, a court of civil appeals dealt with the construction of an insurance policy covering the agents' liability to their principals arising from the agents' "negligence, errors, or omissions."⁶⁶ In a former case, the insurance agents had been held liable to one principal on two distinct grounds—breach of contract and fraud.⁶⁷ The "negligence, errors, or omissions" insurance policy contained an exclusionary clause stating that the policy did not apply to any dishonest, fraudulent, or criminal acts of the insurance agents. The court reasoned that since the agents had been held liable to one principal on the two distinct and separate grounds of breach of contract and fraud, each ground constituted an independent cause of the entire loss to the principal. Therefore, the clause excluding coverage for the agents' fraud was not applicable, and the agents' liability for breach of contract was within the policy coverage.⁶⁸

⁶⁴ National Surety Corp. v. First Nat'l Bank, 431 S.W.2d 353 (Tex. 1968).

⁶⁵ This decision extends to Bankers Blanket Bonds the Texas rule with respect to general liability policies that if a third party's pleadings allege facts which bring the loss within the provisions of the policy then regardless of the truth or falsity of the pleadings, the insurer owes a duty to defend or is liable for the fees incurred by the insured in providing his own defense. See Heyden Newport Chem. Corp. v. Southern Gen. Ins. Co., 387 S.W.2d 22 (Tex. 1965); Maryland Cas. Co. v. Moritz, 138 S.W.2d 1095 (Tex. Civ. App. 1940), *error ref.*

⁶⁶ Cagle v. Commercial Standard Ins. Co., 427 S.W.2d 939 (Tex. Civ. App. 1968).

⁶⁷ National Auto. & Cas. Ins. Co. v. Allco Ins. Agency, 403 S.W.2d 174 (Tex. Civ. App. 1966).

⁶⁸ As authority for its position, the court quoted from the following annotation: 63 A.L.R.2d 1122, 1123 (1959). No Texas cases were cited.

Medical Payment Coverage Extends to Passenger Struck by an Automobile. The impact of our affluent society as seen by multiple automobile ownership continues to raise problems under the "expenses for medical services" provisions of insurance policies.⁶⁹ A court of civil appeals held that a family automobile liability policy on three different automobiles, providing for medical payments coverage on one automobile but not on the other two, covered medical expenses for the insured's daughter who was killed while riding as a passenger in one of the automobiles for which no medical payment coverage was written.⁷⁰ The court's theory was that the policy coverage for medical payments extended expressly to relatives who sustained bodily injury "through being struck by an automobile." In addition, the court found no exclusions or limitations to this express coverage.

Automobile Parked on Shoulder of Street by Driver Is Not Being "Operated" Within the Meaning of the Policy Exclusion. Another case involved the construction of an exclusionary clause in an automobile policy providing that coverage "shall not apply with respect to any claim arising from accidents which occur while any automobile is being operated by Alfred Calvin Rogers."⁷¹ At the time of the accident the insured automobile had been parked on the shoulder of a street for at least three minutes before it was struck in the rear by another automobile. Rogers had been driving the car immediately before parking it, and he was still in the driver's seat when the automobile was struck. The court, applying the general rules that policies will be strictly construed against the insurer and liberally construed in favor of the insured, held that the parked automobile was not being "operated" by Rogers at the time it was struck. A 1924 civil appeals decision⁷² holding that a truck temporarily stopped on the highway was being "operated" within the meaning of a statute requiring automobiles to carry lights when in operation during certain times of the day was distinguished by the court on the basis that insurance policy construction was not involved and that the question of whether the truck was being "operated" at the time of the collision was immaterial since the basic issue in that case was whether the failure to have lights was an act of negligence resulting in injury to the plaintiffs.

⁶⁹ See Davis, *Insurance Law, Annual Survey of Texas Law*, 21 Sw. L.J. 88, 107 (1967).

⁷⁰ Cockrum v. Travelers Indem. Co., 420 S.W.2d 230 (Tex. Civ. App. 1967).

⁷¹ Commercial Ins. Co. v. Rogers, 418 S.W.2d 584, 585 (Tex. Civ. App. 1967), *error dismissed*.

⁷² Horton v. Benson, 266 S.W. 213 (Tex. Civ. App. 1924), *aff'd*, 277 S.W. 1050 (Tex. Comm'n App. 1925).