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## Insurance

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of abandoning the business or waiving his right of appeal. Perhaps subsequent cases in this field will develop a workable rule which will allow a proper settlement of the rights of the parties without forcing upon one of the parties a choice between unfair financial hardship and waiver of his right to appeal.

*A. E. Collier.*

## INSURANCE

### INSURANCE COMPANY AS A NECESSARY PARTY

*Arkansas.* In *McGeorge Contracting Co. v. Mizell*<sup>1</sup> plaintiff sued to recover \$5,000 for personal injuries and \$1,000 for damages to his automobile. The jury found the defendant negligent and the plaintiff free of contributory negligence and awarded the plaintiff a judgment for \$2,000. Plaintiff carried collision insurance with the State Farm Mutual Automobile Insurance Company (with a \$25.00 deductible clause). Plaintiff's employer was subject to the Arkansas Workmen's Compensation Act, and the Maryland Casualty Company was its insurer. The State Farm Company paid the plaintiff \$764.50 for damages to his automobile, and the Compensation Commission awarded him \$27.00 and his medical and hospital bills in the amount of \$164.00, which sums were paid by the Maryland Casualty Company. On appeal defendant alleged as error the action of the trial court in overruling his motion to require that the two insurance companies be made party plaintiffs. Neither insurance company had sought to be made a party plaintiff. The question in the case was whether the two insurance companies were necessary and indispensable parties to the suit.

The supreme court answered in the negative and affirmed the trial court's judgment. The court stated the rule followed by the weight of authority to be that where an insurance company has only partially reimbursed an insured for his loss, the insured is

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<sup>1</sup> \_\_\_\_\_ Ark. \_\_\_\_\_, 226 S. W. 2d 566 (1950).

the real party in interest and can maintain the action. An insurance company would be a proper party plaintiff, should it wish to intervene, but it would not be a necessary or indispensable party.

The holding is in conformity with *Arkansas Statutes 1947 Annotated*, Section 27-801, providing that every action must be prosecuted in the name of the real party in interest, and Section 27-806, providing that all persons may join in one action as plaintiffs if they assert any right to relief jointly, severally, or in the alternative in respect of, or arising out of the same transaction, occurrence, or series of transactions or occurrences and if any question of law or fact common to all of them will arise in the action. The theory is that the insured bears the relation of a trustee to the insurer and that the wrongdoer should not have the cause of action against him split so that he is compelled to defend two actions for the same wrong.<sup>2</sup>

The insurer, while not a necessary party, may be a proper party. In the case of *Home Insurance Company v. Lack*<sup>3</sup> the insurance company had paid part of the loss to the insured, and in a suit against the tortfeasor, the insurance company was held to be a proper party plaintiff.

#### SUBSTITUTED SERVICE ON FOREIGN NON-CONSENTING CORPORATION

*Arkansas.* In *American Farmers Ins. Co. of Phoenix, Arizona v. Thomason*<sup>4</sup> defendant insurance company was an Arizona corporation. The policy of insurance had been entered into in California in 1944 while the insured, a resident of Arkansas, was temporarily employed in California. The injury for which suit was brought and which was covered by the policy occurred in California. There was no evidence that defendant was doing business in Arkansas at the time the policy was executed and delivered in California. At the time of the suit, in 1949, defendant had been doing business in Arkansas without authorization. By *Arkansas Statutes 1947 Annotated*, Section 66-244, a foreign corporation

<sup>2</sup> 29 AM. JUR., *Insurance*, § 1358, p. 1016.

<sup>3</sup> 196 Ark. 888, 120 S. W. 2d 355 (1938).

<sup>4</sup> ..... Ark. ...., 234 S. W. 2d 37 (1950).

doing unauthorized business in the state, and issuing or delivering a policy of insurance to a citizen or resident, appoints the Insurance Commissioner as its service agent in any action arising out of the contract of insurance. Substituted service was had on defendant, and a plea to the jurisdiction was filed. The trial court gave plaintiff a judgment, and the defendant appealed. The question raised was whether the substituted service was authorized by the statute.

In reversing, the supreme court said the statute provided for substituted service only in suits on a policy or contract issued to a citizen or resident of Arkansas by an insurance company which is doing business in Arkansas without authorization. In this suit, not only was plaintiff's policy not issued in Arkansas, but there was no evidence that defendant was doing any business in Arkansas when the policy was issued. Seemingly substituted service under the statute can be made only when the policy is issued in Arkansas by a company which is doing unauthorized business in Arkansas at the time. The court reasoned that the Due Process Clause of the Federal Constitution would be violated if substituted service were allowed in this case. In *Old Wayne Mutual Life Ass'n of Indianapolis, Indiana v. McDonough*<sup>5</sup> a statute similar to the Arkansas statute was complied with, but substituted service was held not to give the court jurisdiction because the cause of action did not arise out of a business carried on, or other acts done, in the state where suit was brought.

The policy behind substituted service statutes is to avoid the inconvenience which would result if one having a claim against a corporation were required to sue at its domicil in order to obtain a personal judgment.<sup>6</sup> In this case the insurance company was "doing business" in the state at the time of suit, and in interpreting the statute as requiring also that the company be doing business in the state at the time when the policy was issued the court was unduly technical.

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<sup>5</sup> 204 U. S. 8 (1907).

<sup>6</sup> STUMBERG, CONFLICT OF LAWS (2d ed. 1951) 84.

## WAIVER OF BREACHED POLICY PROVISIONS

*Arkansas.* In *Service Fire Insurance Company v. Payne*<sup>7</sup> plaintiff purchased a White Truck from Schmieding Brothers. A part of the purchase price was financed by Universal C.I.T. Credit Corporation (hereinafter referred to as C.I.T.) through its Fort Smith office. Harvey Mixon was the manager of the office. C.I.T. required that the truck be insured by the Service Fire Insurance Company. C.I.T. furnished the application form for the financing and insurance, and Harvey Mixon and Schmieding Brothers prepared it. Plaintiff (Payne) had nothing to do with procuring the insurance on the truck, and he paid all premiums through C.I.T. and Schmieding Brothers. Shortly after the policy was issued, Payne, after discussing the matter with the manager of Schmieding Brothers and Harvey Mixon, sold a half interest in the truck to Shastid. Subsequently, Payne made a conditional sale of his remaining interest to Shastid. Payne, with H. C. Schmieding as co-maker, had also borrowed money from a bank and given a mortgage on the truck as security.

The insurance policy made Payne and C.I.T. the insured, as their interests might appear. The policy contained two provisions: one stating that the policy was inapplicable during any bailment, lease, conditional sale, mortgage, or any other encumbrance; and the other stating that notice to any agent, or knowledge possessed by any agent, or by any other person, should not effect a waiver, or estop the company from asserting any right under the terms of the policy; nor should the terms of the policy be waived or changed except by endorsement issued to form a part of the policy.

The question in the case was whether the two provisions in the policy would prevent the insured owner, Payne, from recovering for destruction of the truck. The trial court held that the insured, Payne, was not precluded from recovery, and the supreme court affirmed, stating that the evidence was sufficient to support a finding that the insurance company waived the provisions of the policy. The insurance company and C.I.T. were so closely connected and

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<sup>7</sup> .....Ark....., 236 S. W. 2d 1020 (1951).

related to the entire transaction as to be parties to it from the beginning. The court said, "A fair inference, we think, would have warranted a finding by the jury that appellant, insurance company, had knowledge of the conditional sale of the truck, as well as the mortgage to the bank, through the knowledge thereof of C.I.T. and H. C. Schmieding."<sup>8</sup> The court attached significance to the fact that the insurance company paid C.I.T. for its unpaid interest in the truck (\$1400 balance due from Payne) but refused to pay Payne \$2850.

The importance of the case rests in the treatment by the court of C.I.T. and Schmieding as agents of the defendant insurance company for the purpose of imputing knowledge of the breaches of the policy provisions to the insurance company. The only facts which could be said to support the existence of the agency relation were the joint execution of the application for the insurance by C.I.T. and Schmieding, and the acquiescence on the part of the insurance company in allowing C.I.T. to collect the insurance premiums from Payne. The court deemed them sufficient and seemingly treated the agency relation as existing as a matter of law.

The insurance company treated C.I.T.'s rights under the insurance contract as independent and not derivative of Payne's rights, but the court was unable to detect any reason why the insurance company should treat the policy as valid in so far as C.I.T. was concerned and void as to Payne.

#### PROOF OF LOSS AS CONDITION PRECEDENT

*Louisiana.* In *Robbert v. Equitable Life Assur. Soc. of United States*<sup>9</sup> Robbert sued to recover total and permanent disability benefits alleged to be due under a policy. The policy provided:

##### "Total and Permanent Disability

"(I) Disability Benefits before age 60 shall be effective upon receipt of due proof, before default in the payment of premium, that the Insured became totally and permanently disabled by bodily injury or disease after this policy became effective and before its anniversary

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<sup>8</sup> 236 S. W. 2d at 1022.

<sup>9</sup> 217 La. 325, 46 So. 2d 286 (1950).

upon which the Insured's age at nearest birthday is 60 years, in which event the Society will grant the following benefits:—

“(a) Waive Payment of All Premiums payable upon this policy *falling due after the receipt of such proof and during the continuance of such total and permanent Disability*; and

“(b) Pay to the Insured a Monthly Disability-Annuity as stated on the face hereof; *the first payment to be payable upon receipt of due proof of such Disability* and subsequent payments monthly thereafter during the continuance of such total and permanent Disability.” (Italics supplied by the court.)

On January 7, 1939, while the policy was in effect and all premiums paid, the plaintiff became ill and was totally disabled until August 31, 1939. During this period all premiums falling due were paid by the plaintiff. On July 9, 1940, he was informed of the disability provisions in the policy and presented his claim to the company. Defendant company denied liability, and plaintiff sued. Plaintiff made no showing that the disability rendered him incapable of presenting his claim or furnishing proof in support thereof during the eight-month disability period.

The question in the case was whether the insurance company was liable for waiver of premiums falling due during the disability period prior to receipt of proof of the disability, or for disability payments accruing before receipt of such proof. The district court rendered a judgment dismissing plaintiff's action. The supreme court affirmed, stating that the obligation of the company to waive premiums and to make disability payments was on a condition precedent that proof of permanent disability be submitted. The court thought that the provisions of the policy were free from ambiguity.

Justice Hamiter concurred with the majority that the waiver of premiums was conditioned on the receipt of proof of disability, but he dissented as to the disability annuity provision. He stated that the disability annuity provision was susceptible of the construction that the company was liable for disability benefits from the inception of the disability, the obligation to pay arising only after receipt of due proof:

"It stipulates that the company will 'Pay to the Insured a Monthly Disability-Annuity as stated on the face hereof; the first payment to be payable upon receipt of due proof of such Disability and subsequent payments monthly thereafter during the continuance of such total and permanent disability.'

"... [P]receding the semi-colon is a complete sentence expressing unqualifiedly an obligation to pay a monthly disability-annuity. Standing alone this could only mean payment for the entire disability. Then follows a recitation of the method by which the annuity is to be paid, it being that the first payment (not necessarily the first monthly payment) is payable upon receipt of due proof. This first payment, especially since the word 'monthly' is not used in connection with it, may well be interpreted as covering all of the disability theretofore experienced, that is from its inception to the date of such first payment."<sup>10</sup>

Justice Hamiter relied also on the general rule that ambiguous terms should be given a construction most favorable to the insured.

On rehearing the supreme court adopted Justice Hamiter's opinion, annulled the previous affirmance of the district court's decision, and set aside the judgment below.

Appleman states the majority rule to be that where the contract limits recovery of benefits to the time after proof of loss is received, or to a certain length of time after proof of loss is made, the insured may not recover any benefits prior to the time proof of loss is received by the insurer, regardless of the date of inception of the disability.<sup>11</sup> Louisiana has followed this general rule, as is evidenced by the case of *Jones v. Metropolitan Life Ins. Co.*<sup>12</sup> The *Jones* case held, under a provision of a group policy that after receipt of proof of disability insurer would make regular monthly payments, that the insured was not entitled to a lump payment for the time between the date of the accident and the date proof was made, but was entitled only to monthly payments after proof was made. It is to be noted that this decision was by a court of appeals. Apparently the supreme court in the reported case has overruled this decision and has joined those jurisdictions which oppose the general rule. These jurisdictions state that the

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<sup>10</sup> 46 So. 2d at 293.

<sup>11</sup> 1 APPLEMAN, INSURANCE LAW AND PRACTICE (1941) § 615.

<sup>12</sup> 157 So. 147 (La. App. 1934).



time stipulated in a disability contract refers to the time of payment and not to the disabilities covered, so that while the insured may receive no money until the date stipulated, after proof of loss is received, the amount is calculated upon the entire period of disability.<sup>13</sup>

INJURED PARTY NOT BARRED FOR LACK OF NOTICE  
TO INSURANCE COMPANY

*Louisiana.* In *West v. Monroe Bakery Inc.*<sup>14</sup> plaintiff sued Monroe Bakery Inc. and General Casualty Company of America, Monroe's insurer, for the death of his minor daughter, who was killed as a result of negligent operation of a bakery truck. The district court rendered judgment *in solido* against Monroe Bakery and the General Casualty Company. Defendant Casualty Company appealed. The court of appeals reversed, entering judgment in favor of the General Casualty Company on the ground that the insurance policy covering the bakery truck required that the assured give notice to the insurer, as soon as practicable, of any accident rendering the assured liable. The assured had failed to give such notice. By Act 55 of 1930<sup>15</sup> a direct right of action *in solido* against the assured and insurer is given to third persons injured by the negligent operation of automobiles.

The question before the supreme court was whether the insurer could escape liability to the third party because of the failure of its insured to give notice as soon as practicable after the accident had occurred. The supreme court answered in the negative, reversed the decision of the court of appeals and reinstated the judgment of the district court. The statute expressed a public policy that a liability insurance policy was not issued as much for the protection of the insured as for the protection of the public. The statute conferred a right on third persons, and the right would be of little value if its existence depended on the action of another, *i.e.*, notice by the assured to the insurer.

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<sup>13</sup> 1 APPLEMAN, INSURANCE LAW AND PRACTICE (1941) § 615.

<sup>14</sup> 217 L.A. 189, 46 So. 2d 122 (1950).

<sup>15</sup> LA. GEN. STAT. (Dart, 1939) § 4248.

Three justices dissented on the ground that the majority failed to consider a clause in Act 55 of 1930 reading as follows: "It being the intent of this act that any action brought hereunder *shall be subject to all of the lawful conditions of the policy contract and the defenses which could be urged by the insurer to a direct action brought by the insured*; provided the term and conditions of such policy contract are not in violation of the laws of this State."<sup>16</sup> They reasoned that notice was a lawful condition, breach of which would be a valid defense to an action by the assured and would therefore be a defense as against the third party.

Before this case was decided, two of the courts of appeals in Louisiana were in conflict as to the right of an insurer to defeat an action by an injured party under Act 55 of 1930 by setting up that the assured had failed to give the required notice. In *Howard v. Rowan*<sup>17</sup> the court stated that compliance with a policy term requiring immediate notice of accidents and claims is a condition precedent to insurer's liability. In *Edwards v. Fidelity and Casualty Co. of N. Y.*<sup>18</sup> the rule was stated to be that a compliance with a policy requirement of immediate notice of accidents and claims is not a condition precedent to the insurer's liability.

The principal case resolves the conflict in accordance with the views expressed in *Edwards v. Fidelity and Casualty Co. of N. Y.* This view is said to be against the great weight of authority.<sup>19</sup> However, the decision follows the trend indicated by the Financial Responsibility Law enacted in many states and by compulsory insurance laws such as that enacted in Massachusetts.<sup>20</sup>

#### "PERMISSION" UNDER AN "OMNIBUS CLAUSE"

*Louisiana.* In *Dominguez v. American Casualty Co.*<sup>21</sup> plaintiff sued Thomas and his insurer for damages resulting from an automobile accident caused by the negligence of Thomas' employee, Williams. Williams was employed as a truck driver; his duties

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<sup>16</sup> 46 So. 2d at 131. Italics added by the court.

<sup>17</sup> 154 So. 382 (La. App. 1934).

<sup>18</sup> 11 La. App. 176, 123 So. 162 (1929).

<sup>19</sup> See Comment, 10 Tulane L. Rev. 69 (1936).

<sup>20</sup> MASS. GEN. LAWS (Ter. Ed. 1932) c. 175, § 113A.

<sup>21</sup> 217 La. 487, 46 So. 2d 744 (1950).

were to drive employees to Thomas' mill in the morning, deliver loads of wood during the day, and take the employees back into town in the evening; after which he drove the truck to his home and parked it until the following morning. Thomas had specifically instructed Williams not to use the truck for his own personal use. On the night of the accident Williams had taken the truck to assist a fellow employee in pulling his car out of a ditch. En route the accident occurred, between 10:30 p. m. and 11:00 p. m.

The insurance policy, in the "Omnibus Clause," defined the insured as the named insured and any person using the automobile, provided the actual use of the automobile was with the permission of the named insured.

Plaintiff recovered judgment in the trial court, but the court of appeals reversed and dismissed the suit on the ground that, assuming the employee was negligent, the negligence was not chargeable to the employer and his insurer. The question on appeal was whether the conclusion that Williams was operating the truck without permission of the insured within the contemplation of the policy was correct.

The supreme court held that Williams was operating the car with the permission of Thomas, and reversed and remanded. The court stated that Louisiana was one of the jurisdictions holding that initial permission by the employer is all that is required to constitute "permission" to an employee under an "Omnibus Clause." The court gave weight to the fact that the employee had complete dominion and control of the vehicle day and night, and to say he lost the initial permission merely because he parked the truck for a short time would be a highly technical distinction.

There was a dissent on the ground that an extension of the "initial permission" rule to the facts in this case was going too far. It was argued that the initial permission ended when Williams parked the car after work and that when he took it to help the fellow employee some six or seven hours later, said use was expressly forbidden by the employer and was outside the employer's contemplation.

The result would seem to place Louisiana among those jurisdic-

tions which have adopted the "Hell or High Water Rule": "... if the vehicle was originally entrusted by the named insured . . . to the person operating it at the time of the accident, then, despite hell or high water, such operation is considered to be within the scope of the permission granted, regardless of how grossly the terms of the original bailment may have been violated."<sup>22</sup> Certainly it can be said that the initial permission granted (to take the employees to the mill, deliver loads of wood during the day, and take the employees back into town in the evening) did not extend beyond a reasonable time necessary to drive the employees back into town in the evening. To approve the majority opinion is to say that six or seven hours was a reasonable time to return the employees to town. The dissent would seem to be on sounder ground; when Williams parked the truck in the evening, the initial permission ended.

#### OBTAINING PROPERTY UNDER FALSE PRETENSES—COVERAGE OF THEFT POLICY (BROAD FORM)

*Oklahoma.* In *Thompson v. Conn. Fire Ins. Co.*<sup>23</sup> recovery was sought under an insurance policy by the terms of which defendant company agreed to pay the cash value of insured's automobile in the event of its loss by theft (broad form). Plaintiff Thompson alleged that one Markley had agreed to give him \$750 for his automobile and gave him a check for that amount. In pursuance of the agreement Thompson assigned his title to the automobile to Markley and gave his possession. The following day Thompson learned he had taken a "hot check." Defendant insurance company demurred to the complaint, and the question was whether Markley's acts constituted larceny under Oklahoma law. The pertinent statute says: "Larceny is the taking of personal property accomplished by fraud or stealth, and with intent to deprive another thereof."<sup>24</sup> The trial court held that the acts did not amount to larceny and dismissed the action.

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<sup>22</sup> 7 APPLEMAN, INSURANCE LAW AND PRACTICE (1941) § 4366.

<sup>23</sup> Okla., 223 P. 2d 757 (1950).

<sup>24</sup> 21 OKLA. STAT. ANN. (Perm. Ed.) § 1701.

The supreme court affirmed the action of the trial court and stated: “. . . [W]here the owner of an automobile enters into a contract of sale of the automobile, assigns his certificate of title to the vendee, and in pursuance of his contract of sale transfers possession and title to the vendee who pays therefor with a worthless or forged check, and in connection therewith makes false statements as to the genuineness of said check, and other false statements, the offense is obtaining property under false pretenses and does not constitute theft within the terms of an insurance policy which insures the owner against loss by ‘theft (broad form).’ ”<sup>25</sup>

Whether the facts in any given case amount to theft or obtaining property under false pretenses depends on the statutes in each state. The distinction between the two offenses lies in what the owner intended to pass. If in parting with possession the owner also intended to part with title, the offense is obtaining property by false pretenses. If the owner did not intend to part with title, the offense is theft or larceny.<sup>26</sup>

#### “PREMISES OPERATIONS” INCLUDE INCIDENTAL OPERATIONS ELSEWHERE

*Texas.* In *Lloyds Casualty Insurer v. McCrary*<sup>27</sup> Lloyds issued to Grimes, doing business as Crockett Butane Service, a “Manufacturer’s and Contractor’s Policy” of liability insurance. During the policy period Grimes and his son installed a butane gas system in a house belonging to McCrary. The installation was not completed in that the pressure gauge, valves and fittings on the storage tanks were defective. Grimes knew of these defects and intended to complete the installation at a later date by repairing or exchanging the defective apparatus. Before the defect was corrected, a leak in the gas system caused a fire destroying McCrary’s house and his tenant’s household goods. McCrary recovered a judgment against Grimes, and the execution issued was returned

<sup>25</sup> 223 P. 2d at 761.

<sup>26</sup> 32 AM. JUR., *Larceny*, § 7, p. 89.

<sup>27</sup> \_\_\_\_\_ Tex., 229 S. W. 2d 605 (1950).

*nulla bona*; whereupon McCrary sued to recover the amount of the judgment from Grimes' insurer.

Under the insuring agreement the insurance company agreed to pay all property damage for which the insured became liable under the law, if the damage was caused by accident and arose out of the hazards enumerated. The "Premises Operations" hazard was defined as "the ownership, maintenance or use of the premises, and all operations during the policy period which are necessary or incidental thereto."

The trial court held that plaintiff failed to state a cause of action, and plaintiff appealed. The court of civil appeals certified to the supreme court the question whether the clause "Premises Operations" covered damages occurring on premises other than those of the insured.

The supreme court reversed the judgment of the trial court and held that the clause did cover operations on premises other than those of the insured and that a cause of action was stated. The holding was based on the inclusion in the hazard clause of the phrase, "and all operations during the policy which are necessary or incidental thereto." The phrase covered all operations, whether on the premises or elsewhere, if they were incidental or necessary in relation to the declared use of the premises. The business of the insured was "Butane Gas Operation," and it was reasonable to conclude that a necessary or incidental use of the premises for the declared purpose would include installation of butane systems on premises elsewhere. The court adopted the much quoted rule: "... ambiguous terms of an insurance policy should be construed in favor of the insured where they are reasonably susceptible of such a construction."<sup>28</sup>

This holding is in accord with the general rule that in the absence of restrictions, a policy indemnifying against liabilities resulting from the performance of certain designated work or operations covers liabilities resulting from the performance of ordinary operations incidental to the designated work.<sup>29</sup>

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<sup>28</sup> 229 S. W. 2d at 609.

<sup>29</sup> 45 C. J. S., *Insurance*, § 828, p. 882.

## RATE-UP OF PREMIUM AS COUNTER OFFER

*Texas.* In *Republic National Life Insurance Co. v. Hall*<sup>30</sup> plaintiff made an application for a twenty year pay life policy through a Mr. Coder, the local soliciting agent of defendant insurance company. The insured was 36 years old, and because he was "overweight," Mr. Coder informed him that his premium rate would be slightly higher than normal. Mr. Coder testified that Hall said he still wanted the insurance.

The application contained a blank space for the amount of the premium which was not filled in. It also contained another blank space entitled, "Home Office Corrections or Additions." The last line of the executed application read, "I have paid the Agent taking this application cash \$..... being the Mo. S. S. premium hereon."

At the time of making the application Hall signed and delivered to defendant's agent a "Salary Deduction Order" to cover future premiums. A medical report, the application, and the "Salary Deduction Order" were forwarded to the home office. Defendant company then issued a policy of insurance in accord with the application, registered the policy with the State Department of Insurance and then mailed the policy to the agent. Defendant company had rated up Hall's age from 36 to 44 so that his premium was about \$140 per year more than normal. The rated up premium was written in the blank space entitled "Home Office Corrections or Additions."

Hall, before he received the policy from the agent, was killed in an airplane crash. The question in the case was whether a contract of insurance existed between Hall and defendant at the time of his death. In the trial court the jury found that Hall and the insurance company had intended the policy to become effective when mailed by the defendant to its agent shortly before Hall's death, and a judgment for recovery on the policy was entered. The court of civil appeals affirmed the judgment.

The supreme court reversed stating that, as in the case of all contracts, the offer and acceptance in insurance negotiations must

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<sup>30</sup> .....Tex....., 232 S. W. 2d 697 (1950).

be such as to evidence a complete agreement and that an essential element to be agreed upon in a life insurance contract is the amount of the premium. Since the insurance company rated up the policy, there was no meeting of the minds, or agreement, on the new rate until Hall accepted the policy. When the insurance company sent the policy to its agent, a counter offer was made which had to be accepted before the insurance contract came into existence. The court said that there was insufficient evidence to support the jury verdict that a contract existed after the insurance company mailed the policy to its agent and before the insured's death.

There was a dissent in the case based on the theory that there was sufficient evidence to make it a fact question for the jury as to whether the contract was made. It was not fatal, as a matter of law, to the making of a contract that a blank amount was to be filled in where one party entrusted it to another in the narrow range here involved (the rate-up of a healthy 36-year-old man because he was overweight).

A strict application of the general rule stated by Appleman to the effect that "he [the insured] is not bound to take a life policy raising the premium above that proposed in the application" supports the majority opinion.<sup>31</sup> However, this rule is subject to the qualification that the insured would be bound to take a life policy raising the premium, if the rated up premium was "proposed in the application."

It would seem that there was sufficient evidence to justify a finding that Hall, in his application, proposed a premium which included a reasonable rate-up for his being overweight, the rate-up to be determined by known standards and policies of defendant insurance company. Such an understanding would satisfy the requirement that the terms of an offer be definite.<sup>32</sup> The theory of the dissent appears to have considerable merit.

*Morton J. Hanlon.*

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<sup>31</sup> 12 APPLEMAN, INSURANCE LAW AND PRACTICE (1941) § 7151.

<sup>32</sup> 1 RESTATEMENT, CONTRACTS (1932) § 32.