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Insurance Law

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MAJORITY of the insurance cases during the year were decided favorably for insurers. A number of such cases turned on technical construction and application of the insurer’s language in insurance contracts; some, on technical application of procedural rules. Whether this is a current trend or is a chronic tendency cannot be stated without further survey and research. The Texas Supreme Court wrote nine insurance law opinions. Three were in the life, health and accident insurance area; three were in the fire insurance area; and three involved automobile insurance policies.

I. LIFE, HEALTH AND ACCIDENT INSURANCE

Supreme Court Rules Plaintiff Has Burden To Prove Accidental Injury Was Sole Proximate Cause of Loss. Probably the most significant insurance opinion of the supreme court was Mutual Benefit Health & Acc. Ass’n v. Hudman. The opinion construed an accident policy which limited coverage to death from accidental injury “independently of other causes.” The evidence was that the death of the insured was from the effects of two causes, one accidental and one a pre-existing disease. The supreme court found that two causes proximately concurred to produce death; thus there was no coverage because the policy limited its coverage to one cause, an accidental bodily injury. The limiting clause placed the burden upon the plaintiff to prove that accidental injury was the sole proximate cause of the loss.

The concept had been used by courts of civil appeals that a pre-existing condition making the insured more susceptible to injury or constituting a remote cause of his loss does not prevent recovery when the accident was the proximate cause of the loss. The supreme court disapproved the language in those cases inconsistent with its Hudman opinion. But the court made it clear that the rule in Hudman does not apply to policies which do not have a limiting clause such as “independently of other causes.” On the

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1 398 S.W.2d 110 (Tex. 1965).

other hand, the opinion specifically mentions requirements in some policies that injury result from "external, violent and accidental means."

_Hudman_ was followed by a court of civil appeals in a case involving limiting language almost identical to that found in _Hudman_. However, on motion for rehearing the court held that the plaintiff was entitled to benefits payable in a "dividend certificate," issued by the insurer in addition to the insurance policy, and not containing limiting language such as was found in the accident policy. The court held that in the absence of an express limiting clause such as "solely" or "independently of other causes," the plaintiff was not under the _Hudman_ burden to prove that accidental injury was the sole proximate cause of loss.  

Another civil appeals case found a plaintiff unable to sustain the burden of proof placed upon him by _Hudman_ that the loss resulted from bodily injuries caused by accident, "directly and independently of all other causes." The warden of the Darrington Prison Farm, insured by a state employees’ group life insurance policy which provided double indemnity if the insured's death resulted solely from accidental bodily injury, was seen riding on a horse assisting in the efforts to recapture escaped prisoners. He was later found lying on the ground where he had fallen from his horse, unconscious, gasping for breath; soon thereafter he died.  

Reversing a judgment for the plaintiff and noting the warden’s past history of heart trouble, the court of civil appeals concluded that the record was equally consistent with a conclusion that he had suffered a heart attack and later fell from his horse.  

In a suit for accidental death benefits due under a group insurance policy with policy provisions somewhat similar to those in _Hudman_, a civil appeals court used a test stated in _Hudman_ in upholding a finding that pre-existing disease was not a contributing cause of the insured’s death. The insured, severely injured in an automobile accident, developed a mental depression of great intensity about two weeks after the accident. As a result of the depression, the doctors prescribed certain drugs to which the insured had an idiosyncracy, hyposensitivity or allergy, causing a toxicity of his liver which resulted in death less than two months after the initial accident. An autopsy showed the insured's liver to be damaged from a disease described as "early portal cirrhosis."

The court’s affirming a judgment for the injured party leads to the rule that an idiosyncracy consisting of a hypersusceptibility to a harmless drug

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3 The certificate did not in terms exclude coverage if a disease was a contributing or concurring cause. The evidence showed that although the insured did suffer from a pre-existing disease the accidental injury that the insured received was the primary and proximate cause of the bodily injury.
is not a “bodily infirmity” within the terms of a policy exclusion. The findings that mental depression resulted from the automobile collision and resultant injury and therefore was within the policy coverage led to the court's conclusion that the collision was the sole cause of death.

In another civil appeals case an insurer tried to bring the case within the rule of Hudman where the policy called for payment of three times the policy's face amount if death resulted directly and "independently of all other causes from bodily injuries affected solely through external, violent and accidental means." The insured died in a hospital after suffering injuries in an automobile accident but there was evidence that he drank from a bottle containing liquid which smelled like cyanide. Refuting a theory of death by internal poisoning, two doctors testified that they could not state the death was from cyanide, and the attending physician stated that the insured died from a blunt blow on the head received in the accident. The court stated: "A distinction may be made in the instant case and the Hudman case because in the Hudman case the evidence showed that pre-existing serious heart disease and overexertion concurred to cause the fibrillation of the insured's heart and in turn his death." The court concluded the accidental injuries caused the death of the insured within the pre-existing frailty or enfeeblement of the human body and that death was not contributed to by any other cause. The contrast of this case to Hudman may best be seen in a concurring opinion stating that the possible weakened condition of the insured due to the ingestion of cyanide was factually only a "pre-existing condition or disorder," not one of the causes of death, and a mere condition existing at the time of death. In this perspective, the jury would determine whether a weakened condition due to the possible ingestion of cyanide "materially contributed" to death.

Institution Not a "Hospital" Unless All Its Facilities for Care and Treatment Are Self-Contained. The supreme court in Guardian Life Ins. Co. of America v. Scott, construing the terms of a major medical expense policy, found that a Victoria, Texas, institution was not a "hospital" within the policy definition. The institution was staffed by medical doctors, had access to all of the facilities set out in the definition of a hospital, and was a member of two hospital associations. The case turned on a strict definition of "hospital" in the policy and a strict interpretation of that definition by the court. The policy stated: "Hospital means a legally constituted and operated institution which has organized facilities for the care and treatment of sick and injured people on an in-patient basis, including facilities for diagnosis and major surgery, 24-hour nursing service, and medical

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8 Id. at 104.
9 405 S.W.2d 84 (Tex. 1966).
supervision." The institution had access to these facilities located in one or more hospitals in Victoria. But the court dismissed these associated facilities, stating that: "A policy which provides coverage only if it 'has' stated facilities does not mean that there is coverage if it 'has access' to such facilities in another institution at a different place." This strict interpretation deprived the insured of all medical expense benefits even though all the required facilities for care and treatment were available. It seems that the purpose of the definition of hospital was met. The insured should not be denied coverage on such technicality.  

Supreme Court Retains Rule That Insurer Has Burden To Prove Misrepresentations Are Material to Risk. In Manhattan Life Ins. Co. v. Harrrider the supreme court in a per curiam opinion agreed with the holding of a court of civil appeals and reaffirmed the established rule that the burden of proof is upon the life insurer to prove that alleged misrepresentations by the insured were material to the risk.

Erroneous Dicta That Beneficiary Need Not Have Insurable Interest. The opinion that qualifies for stating the most erroneous dicta of the year in the life insurance category is Henry v. Lincoln Income Life Ins. Co., where it was said: "Neither was the defense of no insurable interest available to defendant. The contract with plaintiff made no provision requiring insurable interest. It is not against public policy for a person with no insurable interest to be named beneficiary." This is dicta. The beneficiary did have an insurable interest because the beneficiary was the creditor of the insured. This is erroneous dicta because article 3.49-1 of the Insurance Code, did not abolish the requirement that the beneficiary have an insurable interest in the life of the insured. Instead that statute confers the necessary insurable interest upon any person designated by an insured as beneficiary or assignee. This quotation misstates the Texas policy on the requirement of insurable interest in life insurance. It also misstates the legal effect of article 3.49-1. An insurable interest in the life of the insured is necessary in Texas, but the effect of article 3.49-1 is that when a person is properly designated in writing by the insured as a beneficiary or as an owner of the policy, such person does have an insurable interest.

Binding Receipt Held Binding Where Insurer Approved Application.

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10 A Florida case holding the Victoria institution to be a "hospital" within the meaning of the term "hospital" as defined in the Florida insurance policy was distinguished on the basis that the Florida policy defined the term hospital differently and less strictly than did the policy before the court. Travelers Ins. Co. v. Esposito, 171 So. 2d 177 (Fla. Civ. App. 1965).
11 402 S.W.2d 511 (Tex. 1966).
15 Swift, Insurable Interest Changes, 16 Texas B.J. 583 (1933).
The only case to pass on the effect of a “binding receipt” issued by a life insurer at the time of application for life insurance was considered by a court of civil appeals. In that case the applicant died of a heart attack before a policy had been issued, but his application at the time of death was being processed in the home office of the insurance company. In Henson the applicant’s application was approved by the chief underwriter on September 12, 1961, and given a policy number and effective date of September 28, 1961. These notations had a line drawn through them. The chief underwriter testified that at one time he had approved the application but later changed his mind and cancelled it. The jury found in answer to special issue number 1 that the proper official of the insurance company had approved the application; but found in answers to numbers 2, 3 and 4 that prior to the applicant’s death in the opinion of the proper official of the insurance company, the applicant was not insurable, that this was a good-faith opinion, and that a reasonably prudent officer of the insurance company would not have found that the applicant was insurable.

The court upheld the trial court’s entry of judgment for the beneficiary of the applicant, holding that regardless of the subsequent jury finding, the fact remained that the application was approved. In terms of contract principles, the case stands for the proposition that the insurance application had been accepted by the approval, thus creating a binding contract. This result is consistent with the Texas rule concerning binding receipts, that the insurer has the right to accept or reject the application and that a contract of insurance does not come into existence until acceptance.

Beneficiary Paying Premiums Acquires Vested Interest in Life Insurance Policy.—A court of civil appeals held that where a person designated as beneficiary in a life insurance policy pays the premiums pursuant to an agreement that he shall remain the beneficiary or receive the proceeds of the policy, such person acquires a vested interest in the policy even though the policy gives the insured the right to change the beneficiary. An agreement between two brothers was that one would take out a life insurance policy on his life and make the other the beneficiary if the other would pay all of the premiums on the policy.

The policy had the usual provision authorizing the insured to change the beneficiary of the policy by written request. The insured executed a change of beneficiary in favor of his minor daughter and died less than a month later, at which time the company issued a duplicate policy showing the daughter as beneficiary. The court reversed a summary judgment in favor

16 Great Southwest Life Ins. Co. v. Henson, 401 S.W.2d 89 (Tex. Civ. App. 1966) error ref. n.r.e. The binding receipt was worded substantially like the binding receipt in the latest Texas Supreme Court case passing on the legal effect on such “binding receipts.” United Founders Life Ins. Co. v. Carey, 363 S.W.2d 236 (Tex. 1962).

of the daughter, stating that a fact issue was raised by the surviving brother's affidavit.\textsuperscript{18}

\textit{The Case of the Incidental Hernia.} In a civil appeals case\textsuperscript{9} the insured asked indemnity under a hospital and disability policy which waived any claim for indemnity if “any loss or disability . . . shall be caused by or contributed to by hernia, either directly or indirectly. . . .” The insured, had three operations, one for hernia, one for hemorrhoids, and one for a nodule in the right epididymis. He entered hospital originally to have the hemorrhoids removed, and would not have entered the hospital if his sole complaint had been the hernia.

The court held that the evidence was legally and factually sufficient to support the jury’s findings that the insured had loss of time and total disability due to sickness within the meaning of the policy. The question was not whether he had a hernia or an operation on the hernia, rather the court defined the issue as whether the insured would have suffered the loss of time and disability on account of the covered sickness regardless of the hernia and its treatment. If the hernia did, in fact, cause the insured’s loss and disability, then to the extent that it so contributed, he was not entitled to recover. The court held that the hemorrhoids and nodule condition were sufficient to cause the loss of time and disability without reference to the hernia.\textsuperscript{10}

The insurer argued that the words “either directly or indirectly” were part of the contract between the parties and should have been included in a special issue. The court rejected this argument, stating that the hernia either directly caused or contributed to Bruce’s loss or disability or it did not: Thus; the words “directly or indirectly” were non-essential to a correct submission of the issue when the issue used the words “caused or contributed.” The court is to be commended for refusing to go along with double-wording the special issue.

\textit{A Mixup in Signals Between Policy and Certificate Drafters.} Maternity benefits were conferred via certificate in a case before a court of civil appeals.\textsuperscript{11} The insurance company issued a group plan hospitalization policy. The terms of the master policy excluded maternity benefits for dependents

\textsuperscript{18} There was a dissent on the basis that Ramon did not agree to make Aureilo his irrecoverable beneficiary. The dissent also said there was no contract based upon a consideration between the two brothers; that there was no consideration passing from Aureilo to Ramon because Ramon got nothing out of the transaction. Aureilo paid Ramon nothing to take out the policy of insurance and Ramon would get nothing while living and nothing at his death. The argument of no consideration passing to Ramon overlooks the part of the agreement that the reason for taking out the policy was that Ramon was living with Aureilo and that Aureilo might have to take care of him in case anything happened to him.

\textsuperscript{10} American Cas. & Life Co. v. Butler, 215 S.W.2d 392 (Tex. Civ. App. 1948) \textit{error ref. n.r.e.}

of employees, but a certificate issued to the insured included such benefits. The court affirmed a judgment for the plaintiff in the trial court, holding that provisions of the policy inconsistent with the certificate were required to yield to the certificate by the very language of the contract. For future cases the master policy drafters and the certificate drafters should get together.

High School Cheerleader Not Covered by Student Accident Policy While Returning Home From His Duties at Basketball Game. High School cheerleaders, baton twirlers and other students engaged in building the images of their respective schools will need to remain in close proximity to their teachers to meet the requirement of direct supervision of the details of their duties for alma mater if they expect to recover under student accident policies of the type considered in a civil appeals case. A student was insured while traveling home from a basketball game in his own automobile. He had been directed by school authorities to be present at the game to participate in his activity as a cheerleader and was told that school transportation would not be furnished. The policy provided coverage while traveling under the "supervision" of a proper school authority to and from a school-sponsored activity. The trial court's judgment for the student was reversed. In rendering judgment for the insurance company, the court held that the student accident policy did not cover him because at the time of the accident he was not under the "supervision" of a proper school authority.

Instead of looking to insurance cases construing the word "supervision," the court quoted from a case which considered a contract requiring "direct supervision." The court could have extracted a definition of "supervise" from the same case which would not require detailed direction but only power to oversee and power of direction. Such a definition would provide coverage for the student because the school authorities did have power to see that his participation as a cheerleader was done under the circumstances where the authorities directed him to furnish his own transportation.

-- Busse quoted that case as follows:

A common meaning of 'supervise' is 'to superintend,' which was defined by the Supreme Court of Texas in Burrell Eng. & Constr. Co. v. Grisier, 111 Tex. 477, 240 S.W. 899, as meaning: 'To have charge and direction of; to direct the course and oversee the details; to regulate with authority; to manage; to have or exercise the charge and oversight of; to oversee with the power of direction; to take care of with authority; to oversee; to overlook.'

Actually, the 1922 supreme court case quoted above defined the word "superintendent." It was concerned with whether the superintendent in charge of an entire construction work received notice of a defective condition of an elevator engine which defect caused injury to the plaintiff employee. The point of that case was that notice to the superintendent was in effect notice to the engineering company who employed the superintendent. Neither of these cases had relevancy to the problem in Busse.
The court cited a Florida case as supporting authority for its position. But a later Florida case held that the word "supervision" was ambiguous and therefore should be construed most liberally in favor of the insured and most strictly against the insurer.

The court commented several times that the student could have taken a twenty-four hour protection policy at an annual premium of nine dollars rather than the small restricted three dollars per annum policy which he did take. Perhaps the moral of this case is that students who have their own automobiles should purchase the more expensive policy.

The court also interpreted another policy provision of coverage, "while travelling in or struck by a public conveyance or a vehicle of any kind directly between home and school," as meaning travel directly between home and the school in which the insured is enrolled as a student. Unfortunately for the student the accident did not occur after a home game. At the time of his injury, he was traveling home from a cross-town rival school.

**Insured, as Condition Precedent to Recovery, Has Burden To Prove Personal Care and Regular Attendance of Physician.** A civil appeals case involved a suit on an accident policy which provided monthly benefits of $100 for loss of time from injury which shall "independently of all other causes totally and continuously disable and prevent the insured from performing each and every duty pertaining to any occupation, and shall require the personal care and regular attendance of a legally qualified physician or surgeon." The court reversed and remanded the trial court's judgment for the insured.

Since this decision was prior to Hudman, the insured did not have the burden to prove that the accident was the sole proximate cause of her disability. But the court held that the provision "shall require the personal care and regular attendance" of a physician or surgeon is a condition prece-

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25 Continental Cas. Co. v. Borthwick, 177 So. 2d 687 (Fla. Dist. Ct. App. 1965). Borthwick, with facts similar with Busse, held that there was coverage of a student who was injured while driving her father's car to a private swimming pool at which the student, as a member of the school swimming team, was to participate in a swimming meet. With respect to the Charles case Borthwick stated:

We do not consider that the Third District Court of Appeals' holding in the Charles case, supra, is controlling or even pertinent to the problems confronting us in the case at bar. In the first place, the language in the critical provision of the policy before us is much broader in scope ("provided such group is at the time under supervision of proper authority of the school"), while the provision in the Charles case restricts the word 'supervision' to operation of the 'vehicle selected' by the duly delegated school authorities. The second and probably more decisive distinction is that in the appellate court's statement of the facts in its opinion in the Charles case, there is no mention of anything that would indicate that Charles was riding in a group at the time of his accident, and riding in a group was essential to his recovery under the policy—and this was no doubt the basis for the trial and appellate court's holding in the Charles case.

dent to recovery on which the insured had the burden of proof." Although the insured had not recovered and had been seen, treated, or attended by a physician near the end of the fifteen-month period for which judgment was rendered, the court found that the evidence did not show when "personal care and regular attendance" ceased but that it was clear it did not continue for the fifteen-month period. The decision appears to be based on automatic application of the concept that such provisions should be treated as conditions precedent to recovery or as exclusionary clauses rather than treating them as only evidentiary in nature.

Notice of Claim Filed 134 Days After Hospital Confinement Held Valid. More than 130 days confinement in a hospital before filing notice of a claim for hospital expenses was the problem in another civil appeals case. That case held that the insured, covered by a hospital and surgical expense insurance contract, had filed notice of claim as soon as it was reasonably possible after commencement of the loss on which the claim was based. Considering all the facts and circumstances such as the age, physical condition and physical suffering of the insured during her lengthy confinement in the hospital it could not be said that there was no evidence showing or tending to show that she did not file notice of claim as soon thereafter as was reasonably possible within the meaning of the policy requirements of notice of claim and article 3.70-3(a) (5) of the Insurance Code.

On motion for rehearing, the insurer pointed out that the claim had been assigned to the hospital and the attending doctor shortly after the insured entered the hospital. Since the claim was their property and their responsibility, the condition of the insured throughout the 134 days was of no importance. The basis for overruling this contention is not clear in the opinion, but it apparently was dismissed because the record did not clearly show the date Mrs. Rutledge's claim was assigned to the hospital. The insurer's argument on this point appears sound. If the claim was assigned to the hospital and the doctor, then it normally would be the duty of these assignees to give notice of the claim. In such a case the physical condition of the insured would be irrelevant.

II. Fire Insurance

Personal Nature of Fire Insurance Contracts Prevents Waiver of Change of Ownership Clause. The supreme court in Maryland Cas. Co. v. Palestine

57 The authority cited for this proposition was United Am. Ins. Co. v. Selby, 161 Tex. 162, 338 S.W.2d 160, 164, 84 A.L.R.2d 367 (1960), where it is indicated that Selby changed the Texas law from a liberal construction to a strict construction of such provisions against the insured.


59 The opinion states that the assignment of benefits to the hospital and the doctor bears the date "12/13/64." There apparently was a mistake in the date of the year because Mrs. Rutledge entered the hospital in December 1963, and was released in April 1964.
Fashions, Inc., reversing both lower courts, held that a local agent for fire insurers did not waive a change in ownership clause in fire insurance policies. The agent was told by Hickman, the insured seller, that the insured property had been sold; Hickman asked the agent to prepare endorsements, but he did not know the names of the new owners. The agent told Hickman that the endorsement on the policy in favor of the new owners could not be issued without their names. The agent was not told to cancel the policies; he did not cancel them; nor did he return any premiums prior to a fire which occurred fourteen days later. The names of the new owners had not been furnished to the agent prior to the fire.

The opinion of the supreme court emphasized the concept of the personal nature of a fire insurance contract in that the contractual agreement between insurer and insured is not an insurance of property without regard to the ownership but rather is an agreement of indemnity against loss by the insured by reason of his ownership of the property. The court viewed the policies as personal contracts solely between Hickman, the insured, and the insurers. Since the evidence showed no endorsement on the policy in favor of anyone other than Hickman, the lower courts were in error in awarding policy proceeds to the new owners; these parties were "complete strangers to the contract and not in a legal position to recover an interest in the policy proceeds." This case can be rationalized on the basis that a fire insurance policy is personal to the extent that the insurer does not waive change of ownership provisions of a fire policy where the identity of the new owner is not known and that an insurer is entitled to know the new owners in order to decide whether to continue the risk. Had the court chosen to apply the concept that money proceeds of a fire insurance policy stand in place of a destroyed building it could have led for the new owners even though they were "strangers to the contract."

Insured Must Specifically Request Insurance Agency To Provide Additional Coverage for Known New Location. In McCall v. Marshall, the supreme court held that an insurance agency which had handled the insurance needs of an automobile dealer for approximately seven years did not have a duty to provide additional insurance coverage for the dealer at a new branch location where a fire destroyed seven of the dealer's automobiles. The agency was told of the new location but was not specifically requested by the dealer to include the new location in the insurance policy as an "additional named location." These facts were not believed sufficiently analogous to cases where duties were found for an insurance agency to

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30 402 S.W.2d 883 (Tex. 1966).
31 See Honea v. Lee, 312 S.W.2d 717, 718 (Tex. 1962) expressly approving the court of civil appeals' holding on this point in 349 S.W.2d 110 (1961).
32 398 S.W.2d 106 (Tex. 1965).
provide additional coverage when specifically requested to renew a policy\textsuperscript{33} or to notify the insured that his policy has lapsed or to place insurance with a solvent insurer when the present insured becomes insolvent.\textsuperscript{34} Without quoting any authority or giving any reason, the court concluded, "An insured's expectation of the agent to either renew his policy or at least inform him of the impending lapse is different from an expectation for extended coverage." The insurance agency voluntarily insured the automobiles at their salvage value after the fire, but this fact did not persuade the court to hold that the agency was under a legal duty to insure the new location without being requested to do so.

Continued After-Effects of Hurricane Carla. The supreme court again viewed some of the havoc and destruction caused by Hurricane Carla on the Texas Gulf Coast in 1961 in \textit{United States Fid. & Guar. Co. v. Morgan}.\textsuperscript{35} Morgan's insurance policy provided that the coverage was subject to the following exclusion:

\begin{quote}
Company shall not be liable \ldots for loss caused by \ldots tidal wave, high water, or overflow, whether driven by wind or not, unless the wind or hail shall first make an opening in the walls or roof of the described building and then shall be liable only for the loss to the interior of the building, or the insured property therein, caused immediately by the rain entering the building through such openings.
\end{quote}

The lower courts entered judgment for Morgan in the amounts of $3,000 to a cottage and $2,250 to a warehouse and $1,000 to the contents of the warehouse. The insurer argued there was "no evidence" to support the judgment because some damage was caused by the excluded perils (high water and wave action) and because the insured did not sustain his burden of proof that the damage was caused solely by the insured perils. The opinion reflects the presence of evidence necessary to prove that damage to the cottage and warehouse was caused solely by the wind's tearing off the roofs of the buildings and toppling the buildings. This proof brought these two losses within the coverage terms of the policy, and the court affirmed the judgment awarding damages for the cottage and warehouse.

The proof with respect to the contents of the warehouse presented an insurmountable burden for Morgan. Although heavy rain fell on the contents after the roof of the warehouse was blown off by the wind, the contents were completely inundated by the rising water. Some items were missing after the water subsided and others were damaged by rust corrosion. It could not be proved whether the missing items were blown away by the wind or washed away by the rising water, nor was there evidence.

\textsuperscript{33} Burroughs v. Bunch, 210 S.W.2d 211 (Tex. Civ. App. 1948) error ref.
\textsuperscript{34} Diamond v. Duncan, 107 Tex. 216, 172 S.W. 1100 (1915).
\textsuperscript{35} 399 S.W.2d 537 (Tex. 1966).
that the rust corrosion and other damage to machinery, tools and electric appliances were caused by falling rain rather than by rising water or by a combination of the two. The court held that there was no evidence of probative value in the record supporting the jury's findings that damages to the contents of the warehouse were caused solely by rain entering through the open top of the warehouse or by the wind.

One court of civil appeals affirmed a judgment for an insured, finding that loss was caused by the lusty winds of Hurricane Carla and not by excluded perils of tidal wave, high water or overflow. The lengthy opinion is of value in illustrating the type of evidence introduced by the insured in sustaining his contentions to win the battle of special issues. The court of civil appeals successfully waded through the myriad points raised through numerous special issues in a sufficiently clear opinion to obtain "error refused n.r.e." from the supreme court.

No Coverage on Property Lost From Overturned Fishing Boat on Windy Lake. Analogous to the Hurricane Carla cases was another civil appeals case. The policy holder sued on a fire insurance policy for the loss of personal property. Her husband went fishing on Lake Tawakoni and was later found drowned. His boat was capsized, and the insured's personal property disappeared. No eye witness was available. The insurer defended on the policy provision specifically excluding loss caused by or resulting from flood, surface water, waves, tidal water or tidal waves, overflow of streams or other bodies of water. The jury found that loss of the personal property was caused solely by wind, not surface water, waves or spray, whether driven by wind or not. The court found no evidence to support the jury's answers to the special issues. The burden of proof was upon the policy holder not only to prove that the loss came within the insurance contract but that such loss was not excluded therefrom. A Hurricane Carla case decided by the Texas Supreme Court was cited for this proposition. After summarizing the evidence, the court believed that the inference that the boat capsized due to the wind and rough water was just as reasonable and probable as an inference that the boat capsized solely due to the action of the wind.

The First of Two Fire Policies on the Same Property Held Valid; The Second Policy Held Unenforceable. Two fire insurance policies on the same property can often spell trouble, often creating a moral hazard for the insurer. A court of civil appeals wrestled with this problem and found a

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34 For other Hurricane Carla cases see: Hardware Dealers' Mut. Ins. Co. v. Berglund, 393 S.W.2d 309 (Tex. 1961); Paulson v. Fire Ins. Exch., 393 S.W.2d 316 (Tex. 1961).
38 Republic Nat'l Life Ins. Co. v. Bullard, 399 S.W.2d 376 (Tex. Civ. App. 1966) error ref. n.r.e., was cited to support the court's position.
solution. It reaffirmed the rule laid down by the supreme court in *American Ins. Co. v. Kelley* that where a fire insurance policy is in effect on property, a subsequent fire insurance policy on the same property is unenforceable when the second insurer is not advised of the existence of the first policy. The second policy is unenforceable from its inception because of breach of the co-insurance clause which provides that no other fire insurance is permitted unless the total amount of insurance on each item is inserted in the blanks. The insured did not know that the first policy was valid; thus this moral hazard arising from double insurance did not exist.

The first insurance policy issued by National, which was held liable for the entire loss, was valid. National sued Canadian, the second insurer, for a proportionate share of the loss and sought to distinguish *Kelley* because of an apportionment of insurance clause in the "Physical Loss Form" endorsement. Such a clause was not involved in *Kelley*. Nevertheless, the clause was held inapplicable because it was intended to extend coverage to physical loss in addition to that caused by fire. The cause of the loss was fire, and this fire loss was covered by the basic conditions of the policy including the co-insurance clause. The supreme court's decision in *Kelley* was based on its interpretation of the co-insurance clause.

**Authority To Obtain Insurance for Another Does Not Imply Authority To Cancel the Insurance.** A suit brought by Austin, the contractor for construction of a building on Western's premises, on a fire insurance policy taken out by Western for both Western and Austin was decided by a civil appeals court. Western cancelled the policy without notice to Austin. Thereafter, a fire occurred damaging and destroying some of Austin's building equipment that was kept in the building. Much of the opinion deals with theories of agency and joint adventure, but the essential insurance law decision was that authority to procure insurance for another does not imply authority to cancel the insurance; therefore, Western did not have authority to cancel the insurance in which Austin was a named insured. The jury's findings that Western was not an agent for or joint adventurer with Austin was upheld; consequently Western's action in cancelling the policy did not bind Austin.

**No Right of Subrogation Where Lease Contained Mutual Waiver of**

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42 *160 Tex. 71, 328 S.W.2d 370 (1959).*
44 The fire occurred in Kansas but Texas law was applied, *Tex. Ins. Code Ann.* art. 6.14 (1963) provides that no breach or violation of any provision of any fire insurance policy shall constitute a defense to a suit for loss thereon unless such breach or violation contributed to bring about the destruction of the property. The court held alleged violation of an occupancy clause by Western was not a defense because it did not contribute to the fire in the building or the destruction of Austin's personal property under the rule of article 6.14.
Claims to the Extent Insurance Proceeds Cover Loss. In a case of first impression in Texas it was ruled because of a lease provision that an insurer had no rights of subrogation against a lessor. The lease provided that the lessee waived any claim it might have against the lessor for loss or damages to the premises caused by the lessor to the extent that the lessee was fully compensated by actual receipt of proceeds from insurance policies covering such loss or damage. The lease gave a reciprocal waiver by lessor. The insurer paid the lessee for a loss and then sued the lessor, claiming the rights of the lessee under subrogation. Summary judgment for the lessor was affirmed. The theory of decision was that the insurer's right of subrogation was derived from the rights of the insured against the defendant and is limited to those rights. There can be no subrogation where the insured has no cause of action against the defendant.

Insured Not Responsible for Failure of His Employer To Exercise Due Diligence To Prevent Freeze Damage. A Texas homeowner's policy covered loss by freeze but contained an exclusion of loss caused by freezing while the building was unoccupied unless the insured exercised due diligence. The jury found that the insured did exercise due diligence by instructing his employee to take care of the unoccupied house during a freeze but that the employee failed to exercise due diligence. The court of civil appeals upheld the insured's argument that a strict construction of the policy required due diligence only of the insured. If it had been the intention to require due diligence of both the insured and his agent or employee, the contract of insurance should have so stated.

Insurer Has No Duty To Defend Lawsuit Against Insured in Absence of Express Contract Obligation To Defend. A case of first impression held that the Westchester Fire Insurance Company had no obligation to defend its insured because its policy contained no express provision giving the company the right or making it the company's duty to defend the insured in any suit brought for damages to property being transported by the insured.

The insured was also covered by an insurance policy issued by Maryland Casualty Company which insured against the legal liability of the insured as a common carrier. Maryland's policy contained a provision casting upon Maryland the obligation to defend suits brought against the insured. Maryland did in fact defend the insured and obtained a take nothing judgment. The suit against Westchester was for attorney's fees and costs paid by Maryland for exemplary damages.

Westchester prevailed on the theory that its obligation to defend and its

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44 International Ins. Co. v. Reid, 400 S.W.2d 939 (Tex. Civ. App. 1966) error ref. n.r.e.
obligation to pay a loss are several. The obligation to defend is personal to
the insurer in the absence of a contract obligation to defend. While West-
chester is bound to perform its contract to pay any loss for which its in-
sured suffered, it was entirely up to Westchester whether it would permit a
judgment to be entered against the insured without its defense.

Lessor Had Insurable Interest in Lease Building Destroyed by Fire Even
Though Lessee Replaced Building After Fire. Insurer Has Burden To Prove
Lack of Insurable Interest. An insured lessor was held to have an insurable
interest in the leased building even though the original building had been
replaced by the lessee. The lease contained an option clause which gave the
lessee the right to tear down and remove the building and to replace the
same with equal or better structures, provided he submitted to the lessor
for approval written plans and specifications for the new structures thirty
days prior to the removal of the existent structures.

At the time the insured building was completely destroyed by fire, a
partial demolition of the building had taken place, but the lessee had not
exercised the option in the manner provided for in the lease. After the fire
occurred, the lessee did replace the building with other building of equal or
greater value.

The court looked to the date of the fire to determine whether the insured
at that time had an insurable interest. It held that he did, using a supreme
court definition of insurable interest: "... that anyone has an insurable
interest in property who derives a benefit from its existence or would suffer
loss from its destruction." The jury had answered the special issues favor-
ably to the insured, but judgment for the insurer was granted notwith-
standing the verdict. This judgment was reversed and rendered. The court
held it was without dispute that at the time the policy was issued the in-
sured had an insurable interest. If the facts and circumstances had changed
in the meantime, the insurance company had the burden to prove facts
showing a lack of insurable interest. The insurance company had failed to
carry this burden because it did not request submission of issues inquiring
of the status of the fact situation created by the insured and his lessee at
the time of the fire. Submissions of such issues were waived under rule
279, Texas Rules of Civil Procedure.

State Board of Insurance Cannot Prohibit Insurers To Charge Less Than
Six Per Cent on Deferred Insurance Premium Payments. Attempted regula-
tion to prevent some competition between insurers based on cost differ-
ences failed in the only case of the year reaching the appellate level. All-
state challenged rules and regulations promulgated by the State Board of

Insurance prohibiting the charging of less than six per cent per annum simple interest on deferred insurance premium payments on all lines of insurance subject to the provisions of chapter 5 of the Texas Insurance Code as amended.

The Board presented an abundance of evidence before the trial court that the credit rating or standing of the insured was not a factor considered by companies or agents in reducing interest rates on deferred premiums; that the only factors considered were the competition for the business, the size of the premium or risk and the value of the agency making the request for a reduced interest rate. The Board argued that there can be no "bona fide extension of credit" when the credit standing of the persons receiving such credit is not considered by any of the parties to the contract. The court rejected this argument because it failed to find any authority of the Board to pass regulations requiring appraisement of the credit standing of the policy holder to give assurance that the extension of credit is "bona fide."

The majority and the concurring opinion reversing and rendering the trial court's judgment relied principally upon a holding that the Board did not have the authority to fix the amount of commission which fire insurance companies might pay to their local agents even though the Board had exclusive powers to fix premium rates. Although the Board has the power to fix maximum premium rates there is no express authority given it by statute to regulate or control any of the items, elements or charges entering into or going to make up the aggregate premium rate. The supreme court ruled in Commercial Stand. that the Board can exercise only the authority conferred upon it by law "in clear and unmistakable terms, and will not be deemed to be given by implication, nor can it be extended by inference, but must be strictly construed."

Both opinions emphasized article 5.42 of the Insurance Code which expressly provides that "no bona fide extension of credit shall be construed as a discrimination or in violation of the provisions of this sub-chapter."

III. AUTOMOBILE INSURANCE

Supreme Court Holds a "Hot Rod" To Be "A Farm Type Tractor or Other Equipment for Use Principally Off Public Roads." Spectators killed or injured by careening "hot rods" (modified stock car racers) while watching the races cannot recover medical, hospital or funeral expenses for which they are promised payment when struck by an "automobile" under the automobile medical payment provisions of their policies. In Williams v.

Cimarron Ins. Co.\textsuperscript{28} the Texas Supreme Court conceded that the stock car racer which struck the Williams family, seriously injuring Mr. and Mrs. Williams and killing their son, was an "automobile", within the meaning of the term. But the court held that the stock car racer came within the exclusions of the policy because it was "a farm type tractor or other equipment designed for use principally off public roads..."

The racer was so stripped down and modified that it could not be licensed nor lawfully used upon public roads. Williams argued that the racer did not fall within the policy's exclusion language because it was a racer designed for use on a racetrack and was not designed for use on public roads at all. The racer certainly was not farm equipment or intended for farm use.

The supreme court, however, saw no ambiguity in this provision, relying principally on an opinion written by an Ohio court of common pleas.\textsuperscript{29} This is somewhat surprising because this Ohio court is the equivalent of a Texas district court. The court seemed to interpret the provision as follows: no medical payment coverage if you are hit by: (1) "a farm type tractor," (2) "or any other equipment (including an automobile) designed for use principally off public roads." The court stated "the phrase 'designed for use principally off public roads' does not convey the notion that something similar to a farm type tractor was intended by the contracting parties." (Emphasis supplied.) Finding the "intention" of the contracting parties should not be the basis of decision where the insured must accept the printed standard automobile insurance policy as it is written. Under the rule of \textit{ejusdem generis}, the court could have construed the words "other equipment" as meaning something similar to a "farm type tractor." The automobile race spectator as well as the "man in the street" would reasonably believe that the ordinary meaning of this language promised Williams medical payments under these facts.

\textit{Supreme Court Finds "No Evidence" To Support Jury's Finding That Employee Was Driving Insured's Automobile With Implied Consent.} In \textit{Royal Indem. Co. v. Abbott & Sons, Inc.},\textsuperscript{30} the jury found that an automobile which damaged plaintiff's building was being operated by an employee of the insured with the insured's implied consent. The court of civil appeals affirmed judgment for the plaintiff under the omnibus clause of the liability policy, extending coverage to anyone using the automobile with permission of the insured. The supreme court reversed and rendered judgment in behalf of the insurer. The court could find no evidence to support the jury's findings or the court of civil appeals' conclusion that the evidence was sufficient to raise the issue of implied permission. Some of this

\begin{footnotesize}
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\item \textsuperscript{28} 406 S.W.2d 173 (Tex. 1966).
\item \textsuperscript{29} Beagle v. Automobile Club Ins. Co., 176 N.E.2d 542 (Ohio Ct. C. P. 1960).
\item \textsuperscript{30} 399 S.W.2d 343 (Tex. 1966).
\end{itemize}
\end{footnotesize}
evidence was that the employee took his meals with the employer's family; 
he could use the 1961 pickup truck with which the accident occurred if 
the 1955 pickup which he regularly used for ranch work was out for re-
pair; keys to both vehicles were customarily left in them; he had picked up 
his employer's children at the school bus stop four or six miles from the 
home; and had driven the vehicles off the premises on three or four occa-
sions.

The definition of "implied permission" used in the jury charge was 
quoted and apparently accepted as correct. The opinion rejected prior Texas 
cases as not persuasive because, unlike the prior cases, the court found nei-
ther a relationship nor a prior source of conduct from which implied 
permission might be fairly inferred.

_Supreme Court Holds Word "Theft" in Indemnity Insurance Policy Has 
Same Meaning as Theft in Penal Code._ In _Hudiburg Chevrolet, Inc. v. 
Globe Indem. Co._" the supreme court held that the word "theft" used in 
an indemnity insurance policy has the same meaning it has under the 
criminal law. The supreme court approved the definition of "theft" in 
article 1410 of the Penal Code. GMAC repossessed an auto. Hudiburg, the 
insured, held it as bailee. The original purchaser took the car from Hud-
iburg without its consent.

In addition to arguing that the taking was not a theft, the insurer also 
argued that the policy covered only the owner of the truck, that Hudib-
burg was not the owner but only a bailee, and that a bailee was covered 
only upon proof that it was legally liable for the loss. The supreme court, 
quoting two policy endorsements, found language of the insurer agreeing to 
be obligated for loss of "automobiles which are the property of others 
and in the custody of the insured for storage, repair, safe keeping ... 
regardless of the legal liability of the insured."

_The Worst Insurance Procedure Decision of the Year: Insured Has 
Burden To Negative by Proof Thirty-Four (34) Policy Exclusions and 
Limitations Pled by Insurer as "Specific Pleadings."_ The decision that easily 
qualified for the designation of the worst insurance procedure decision of 
the year was _Sherman v. Provident Am. Ins. Co._"88

Provident pleaded all of the provisions and limitations in its policy as 
defenses, together with specific pleading of all of the exclusions and limita-
tions contained in its policy. Provident's pleadings included but were not

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86 Employers Mut. Cas. Co. v. Mosqueda, 317 F.2d 609 (5th Cir. 1963) (prior source of dealing established implied permission).

87 394 S.W.2d 792 (Tex. 1965).

limited to "part 9" quoted in the opinion.\textsuperscript{8} The four quoted paragraphs contain approximately thirty-four exclusions and limitations. Sherman believed the trial court erred in granting an instructed verdict for Provident and believed that he did not have the burden to negate Provident's wholesale pleadings of exceptions and limitations. The court of civil appeals held that he did have such a burden under TRCP rule 94. No analysis of the words of rule 94 was stated. An insured is saddled now with a much greater burden than before. Prior to the enactment of rule 94, the insured needed merely to negative all of the exceptions and limitations in the policy by his pleadings. Under Sherman the insured must now negative by proof every wholesale specific pleading by the insurer. This decision permits insurance companies to make a farce of rule 94 which states that: "Nor shall the insurer be allowed to raise such issue unless it shall specifically allege that the loss was due to a risk or cause coming within a particular exception to the general liability. . . ." The decision is contrary to both the letter and spirit of rule 94. As stated in "Interpretation of Rules" by the subcommittee: "This rule supersedes the line of decisions holding that the plaintiff suing on an insurance policy is required to negative in his pleadings the existence of any exceptions to general liability contained in the policy. Under this rule, the defendant must now plead the presence of such exceptions, if he wishes to rely upon such exceptions, as issues in the case to defeat liability."\textsuperscript{60} (Emphasis supplied.)

\textsuperscript{8} Part 9 as quoted in the opinion pp. 340-41, is as follows:

1. This policy does not cover any loss or disability resulting wholly or partly, in or from (1) any attempt at suicide, while sane or insane; (2) rest cures, nervous or mental disorders, dental treatment; (3) participating in aeronautics, except as a fare-paying passenger in a licensed aircraft provided by a common carrier traveling on an established passenger route; (4) military or naval service or war; (5) venereal disease; (6) injury or sickness while confined to any institution wherein the Insured is entitled to services without cost to himself; (7) hospitalization for which the principal purpose is diagnosis.

2. Any loss or disability resulting wholly or partly in or from sickness or disease involving a kidney or kidneys, cancer, hernia, gall bladder, ulcers, tuberculosis, diabetes, arthritis, rheumatism, asthma, sinusitis, enteritis, gastritis, tonsillitis, bronchitis, apoplexy, loss or disability resulting wholly or partly from treatment, removal or repair of any of the generative organs, or any disease of the heart or circulatory system shall be covered only if the cause thereof originates after this policy has been in force for the preceding six months; (2) any loss or disability resulting wholly or partly in or from any sickness or disease which results in a surgical operation shall be covered only if the cause originates after this policy has been in force for the preceding six months; (3) loss or disability due to childbirth, pregnancy, or any complication resulting therefrom shall not be covered unless provided by supplement.

3. If any member is unmarried and under eighteen (18) years of age when this policy is issued, such member shall receive full benefits of this policy until such member marries or attains age eighteen (18) at which time all benefits of this policy shall be reduced 50%; however the premiums may be increased, if authorized by the Insured to provide full benefits.

4. This policy does not provide benefits for confinement or treatment in any facility contracted for or operated by the United States or State Government for the treatment of members or ex-members of the armed forces.

The rule was enacted as a reform to require the insurer to plead specifically only those defenses by way of exceptions that it actually relied upon as a defense. This decision, upholding Provident’s wholesale “specific pleadings” of each and every exclusion and limitation in the policy, is directly against the meaning of the words of rule 94.

Three Cases on Whether Two-Automobile Owner Is Entitled to Medical Expenses for Injuries Received in Owned Automobile Not Described in Policy. One impact of our affluent society was seen in the number of cases in which an insured owned two or more automobiles. Complications arise with variations of insurance coverage in the multiple ownership situation.

The section of the automobile insurance policy that received the most judicial attention was the “Expenses For Medical Services” section. By coincidence, three cases construing provisions of this section were decided in December 1965 in three different courts of civil appeals. In each case the insured owned two automobiles. Each of the opinions received an “error refused, n.r.e.” from the supreme court.

*Vaughn v. Atlanta Ins. Co.* involved an insured who owned a Ford and a Chevrolet, each covered by different policies issued by Atlantic providing for medical and hospital expense coverage. The plaintiff suffered a head-on collision while driving his Ford; his wife was killed; and the plaintiff and his daughter were seriously injured. Atlantic admitted liability on the medical coverage provision of the Ford policy but denied liability for medical coverage under the Chevrolet policy. The court affirmed summary judgment for Atlantic, finding no ambiguity in the policy. It said the Chevrolet policy expressly excluded any recovery under its medical payments provision for bodily injury sustained by the named insured or a relative (1) while occupying an automobile owned by or furnished for the regular use of either the named insured or any relative, other than an automobile defined as an ‘owned automobile.’ ” The Chevrolet policy defined the term “owned automobile” as being a “private passenger, farm or utility automobile described in the policy.” (Emphasis added.) The Ford

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2. Id. at 876. Specifically the court stated:

   The exclusionary clause here under consideration simply excludes any medical coverage to the insured or members of his family which were sustained while occupying another owned automobile other than the automobile described within the policy. . . . The language used in the exclusion must be taken in its ordinary and usual sense, and must be given such interpretation as was probably in the contemplation of the parties when the policy was issued. As we construe the exclusion it seems to be clearly and definitely stated that the insured would have no protection against loss for medical payments if the injury occurred while appellant or other members of his family were occupying another automobile owned by the insured, irrespective of whether the loss was occasioned by a 'one-car wreck' or was a result of being struck by another automobile.

   . . . It is the duty of the court to construe that which is definite and certain in the contract provision; and there is no room for interpretation here. We think the
was not described in the Chevrolet policy; therefore it was not an "owned automobile." This must have been a great surprise to the plaintiff two-car owner. Although the plaintiff paid two premiums to Atlantic for medical coverage in two policies, he received medical coverage in only one policy.

_American Indemnity Co. v. Garcia_ involved a subsequently-acquired vehicle. The insured owned a Mercury automobile on which American issued a policy providing for medical payments coverage. Subsequently he purchased a Chevrolet pickup truck and insured it with a different insurer under a policy that did not provide for medical payments coverage. Garcia and his wife suffered a collision which necessitated medical expenses for Mrs. Garcia while driving the Chevrolet. Garcia's claim for medical expenses for Mrs. Garcia was denied by American. The medical expense coverage in the policy issued by American was subject to an exclusion providing in part that the policy did not apply to bodily injury "(b) sustained by the named insured or a relative (1) while occupying an automobile owned by or furnished for the regular use of either the named insured or any relative, other than an automobile defined herein as 'owned automobile'; . . ." (Emphasis supplied.)

"Owned automobile" was defined in the policy as "'Owned automobile' means a private passenger, farm or utility automobile or trailer owned by the named insured and includes a temporary substitute automobile." The Mercury was described in the blank provided in the policy for describing the owned automobile. The Chevrolet was not described in American's policy since it was covered by a different policy.

The court said: "In our case, under the plain and unambiguous language of the policy, appellant agreed to pay the reasonable and necessary medical expenses incurred by appellees as a result of bodily injuries while occupying an automobile owned by them. There is no basis for construing this language to exclude this coverage." (Emphasis added.)

_Garcia_ and _Vaughn_ are distinguishable because of the difference in the language of the policies. The court in _Garcia_ states: "Appellant [American] seeks to change the wording of the exclusion from other than an automobile defined herein as an 'owned automobile,' to 'other than an automobile described herein as an "owned automobile"'." _Garcia_ is also noteworthy because it is a case of first impression holding that the claim for medical payment coverage under an automobile policy is a claim in the nature of accident or health and accident claim within the meaning of article 3.62 of the Insurance Code which provides for imposition of pen-

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Language of the policy covering the Chevrolet is clearly subject to the construction that there is no liability for a loss sustained by the insured or any member of his family while occupying another automobile owned by the insured.

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63 196 S.W.2d 146 (Tex. Civ. App. 1965) error ref. n.r.e.
64 Id. at 147.
65 Ibid.
alty and attorneys' fees in case of wrongful failure to pay the claim. Reliance for this holding was upon the supreme court's approval in *Bybee v. Fireman's Fund Ins. Co.*

The third case, *Gonzales v. Farmers Ins. Exchange* involved an insured who owned a Dart and a Pontiac on which Farmers issued one policy describing both automobiles. Gonzales paid a premium for medical payment coverage for the Dart but not for the Pontiac. During the policy period the Pontiac was exchanged for an Oldsmobile. Gonzales' son and his friend were injured while driving the Oldsmobile and filed suit when Farmers denied their claim. The court of civil appeals affirmed the trial court's judgment for the defendant.

The court's construction of the policy was that under the "two or more automobiles" provision, it was compelled to view the policy as a separate policy on the Oldsmobile. Gonzales could not recover under the Dart policy because the Oldsmobile in which they were injured was not described in the Dart policy. Any claim under the policy on the Oldsmobile would find no coverage for medical payments. The words used in the medical coverage provisions appear to be identical or very much like those that were used in *Vaughn*.

**Insurer Held To Have Right To Pay Medical Payments to Assignor After Insurer Has Notice the Payments Have Been Assigned to Assignee.** When the proceeds of a policy become liquidated debt, due and payable to the insured under the terms of an insurance contract, there is no good reason why such debt cannot be assigned freely as are debts that arise under non-insurance contracts or obligations. However, a court of civil appeals held the insured could not assign such a debt without indorsement of consent by the insurer. The court did not make any distinction be-

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64 160 Tex. 429, 331 S.W.2d 910 (Tex. 1960).
66 399 S.W.2d 888 (Tex. Civ. App. 1966) error ref. n.r.e.
67 Gonzales' main argument was that Farmers filed only a general denial, not pleading any exclusions in the policy, therefore they were entitled to judgment because of failure to comply with Tex. R. Civ. P. 94, requiring an insurer to specifically allege that the loss was one coming within a particular exception or exclusion. Farmers' position was that Gonzales waived any issue of pleading by agreeing to submit the case to the court on an agreed statement of facts and also that the issues were tried by implied consent under Tex. R. Civ. P. 67. The court agreed with Farmers, relying upon two non-insurance cases to the effect that when a case is submitted to the trial court for decision on certain issues without objection by the plaintiff with regard to the defendant's pleading all issues with regard to pleadings become immaterial and the plaintiff cannot raise the issue of insufficiency or lack of defendant's pleadings for the first time on appeal. Bednarz v. State, 142 Tex. 138, 176 S.W.2d 162 (1944); Patton v. Wilson, 220 S.W.2d 184 (Tex. Civ. App. 1949) error ref. n.r.e.
between an assignment of the right to receive payments due under an insurance contract and an assignment of the insurance contract itself.

The insured assigned to the Dallas County Hospital District her rights to receive the medical payments that were payable under the "expenses for medical services" provisions of her automobile policy. At the time the assignment instrument was served on Pioneer, the insurer, the amount owed by the insured to the hospital district was greater than the $1,000 maximum liability for medical and hospital expenses. Pioneer, instead of honoring the assignment instrument, paid the $1,000 directly to the insured who departed for places unknown. The court noted with interest that the name of the insured was "Swindler" and then proceeded to determine whether Pioneer or the hospital district should bear the loss of Swindler's keeping the $1,000. The court held that Pioneer had discharged its obligation when it paid the $1,000 to Swindler, even though Pioneer had notice that Swindler had assigned all of her rights to the hospital district. The basis of the court's decision was the clause in the standard form policy which reads in part as follows: "Assignment of interest under this policy shall not bind the company until its consent is endorsed hereon." However, it should be pointed out that this limitation of assignment refers to the assignment of the insurance interests in the policy, not to the debts due or arising under the policy. The fact that this debt arose under an insurance contract should not make any difference to the right to assign the debt. It has long been the law in Texas and elsewhere that a debtor's consent to an assignment of sums due is not necessary. When Pioneer was notified that the hospital district owned the right to the $1,000, it no longer had the right to pay the money to the insured so as to deprive the assignee hospital district of its rights. The decision violates the language of the policy and is contrary to the basic principles of contract law of assignment. It also presents either the possibility of costly, burdensome red tape to have consent indorsements attached to policies. Also, hospitals and doctors may refuse to accept such assignments.

Driver's License Suspension Cases Under Financial Responsibility Act. There were two court of civil appeals cases dealing with some of the problems of motor vehicles liability insurance in conjunction with driver's license suspension.

1. Department of Public Safety May Require Policy Certifying That Department Will Receive Five Days Notice of Cancellation. One case held that a motor vehicle liability insurance policy which could be cancelled by the insurer without giving five days notice to the Department of Pub-

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72 Chapman v. Tyler Bank & Trust Co., 396 S.W.2d 143 (Tex. Civ. App. 1965) error ref. n.r.e.
lic Safety did not meet the requirements of the Motor Vehicle Safety Responsibility Act. The court, reversing the judgment of the trial court staying the Department's order, interpreted the act as requiring a "certificate of insurance." The certificate must "certify that the policy shall not be cancelled until at least five days after notice of cancellation or termination shall have been received by the Department of Public Safety. Such notice permits the Department to take immediate action to require maintenance of financial responsibility when the owner or operator's policy is about to be cancelled by the insurer.

2. Deletion of Exclusion Endorsement Is Automatic Upon Insurer's Receipt of Information That License Suspension Is Lifted. In the other case, Claunch, an automobile owner under driver's license suspension, was required to purchase a motor vehicle liability policy with an endorsement attached providing that the policy did not apply to any claim arising from accidents occurring while any automobile was being operated by Claunch. Pan American, the insurer, agreed to delete the policy exclusion created by the endorsement on receipt of information that Claunch's driver's license had been restored. The Department of Public Safety lifted the driver's license suspension and restored the license to Claunch. This information was passed on to the insurer on August 26, 1963. Claunch was involved in a collision on October 3, 1963, but the endorsement had not been physically deleted. The court of civil appeals affirmed the instructed verdict against Pan American, holding that it was obvious that deletion of the endorsement was considered by the parties to be automatic when Pan American was furnished with the information that Claunch's driver's license had been restored.

Notice of Accident by Attorney of Plaintiff Injured by Insured is Not Notice to Insurer "On Behalf of Insured." Although an insurer received notice that its insured had been in an accident, it had no obligation to defend a suit brought against its insured because the written notice was not deemed given by "or on behalf of the insured" within the meaning of these words in the policy. A letter written by an attorney representing a party injured in a collision with the insured's truck was not notice within the terms of the public liability policy providing that notice shall be given on behalf of the insured to the insurer as soon as practical after the accident. The court relied on two supreme court cases for the rule that although the insurer has notice that its insured has been in an accident, there must be timely notice given by or on behalf of the insured. The

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76 Klein v. Century Lloyds, 114 Tex. 160, 275 S.W.2d 95 (1955); New Amsterdam Cas. Co. v. Hamblen, 144 Tex. 306, 190 S.W.2d 56 (1945).
theory requiring strict compliance with the policy terms is that such timely notice is a condition precedent to liability. Notice by the injured party’s attorney was not on behalf of the insured because it was not notice by one who was authorized by the insured to act for him.

It is submitted that this narrow, strict construction is contrary to the basic purpose of our Motor Vehicle Safety Responsibility Act. It is of vital interest to the injured plaintiff whether the defendant insured meets requirements necessary to keep his liability policy in force, and this is of vital interest to the insured also. This vital interest in effective liability coverage is one of the reasons for our Financial Responsibility Act, and it seems that policy reasons should dictate that one as vitally interested as an injured party could give effective notice “on behalf of the insured.”

_A Truck Used To Haul One’s Own Products Is Not a “Public or Livery Conveyance.”_ The Canal Insurance Co. accepted premiums and issued a policy providing primary coverage with Gensco, a truck lessee, named as the insured. After the truck was in an accident, Canal took the position that as a matter of law the policy did not apply to the truck being used by the lessee because it was being used as a “public or livery conveyance” and that such use was within an exclusion of the policy.” Rejecting this argument, the court of civil appeals said the meaning of “public or livery conveyance” is a conveyance which is held out to the general public for carrying passengers or one held out to the general public for carrying freight. The insured truck was leased exclusively to the lessee and was used by the lessee to haul only its own products. Thus, the loss did not occur while the truck was being used as a “public or livery conveyance.” Although it accepted the premiums for primary coverage, the insurer took the position that it assumed no risk, or at the least that it should be only jointly liable with the excess insurance carrier. The court also rejected this position of Canal.

_Dragline Bucket Falling Upon Truck Is “Collision” Within Terms of Collision Insurance Policy._ One of the more interesting cases found the majority and dissenting opinions each claiming its interpretation of the meaning of the term “collision” represented the common, usual, ordinary, popular, everyday use of the term." Lane suffered damage to his truck caused by a dragline bucket falling upon the truck while it was being loaded with dirt. Lane had purchased collision coverage but not comprehensive coverage, although it was available. The court of civil appeals by majority opinion affirmed a summary judgment for Lane, holding that the impact between Lane’s truck and the falling dragline bucket constituted a “collision” within the meaning of the collision coverage of the policy.

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78 Great Am. Ins. Co. v. Lane, 398 S.W.2d 592 (Tex. Civ. App. 1965) error ref. n.r.e.
The majority opinion relied principally upon Providence Wash. Ins. Co. v. Proffitt which held that loss caused by flood water striking an automobile was a collision within the terms of a similar policy. The basis of the majority opinion was that Proffitt construed the language in a comprehensive coverage provision, "Breakage of glass and loss caused by ... falling objects ... shall not be deemed loss by collision or upset" to enlarge the liability of the insurer under the comprehensive coverage and not to restrict the liability of the insurer under the collision coverage. In any event, if the effect of the language in the comprehensive coverage is to include falling objects, that does not mean that loss from falling objects is excluded from the collision coverage.

Whether Pickup Truck Was "Furnished for the Regular Use" of Non-Owner and Whether Truck Was a "Passenger Automobile" Held Material Questions of Fact. In a civil appeals case the insurer argued successfully on summary judgment that a pickup truck being driven by Johnson which struck and killed two-year old Mary Bledsoe was "not a private passenger automobile" and thus was within a specific exclusion of the policy. The insurer also argued that the motor vehicle was not covered because it was not a "non-owned" vehicle since it was "furnished for the regular use" of the driver, Johnson. The court of civil appeals reversed and remanded, holding there was a genuine issue of material fact whether the pickup owned by Hamilton was "furnished for the regular use" of Johnson. Johnson's affidavit stated that he only used the pickup occasionally. There being no Texas cases on this point, the court looked to decisions in other jurisdictions and cited many cases holding whether an automobile is "furnished for the regular use" of another creates an issue of fact. The court held that the question of whether the pickup truck was a "private passenger automobile" also created an issue of fact. No Texas cases directly in point were found by the court, but reference was made to the court of civil appeals decision which held that a one-half ton pickup truck used for transporting passengers and goods was a "passenger automobile" within

70 150 Tex. 207, 239 S.W.2d 379 (1951).
80 The majority also quoted Glen Falls Ins. Co. v. McCown, 149 Tex. 587, 236 S.W.2d 108 (1951), followed in Proffitt for the rule that though the insured had not purchased comprehensive coverage, the provisions of that coverage might be examined for the purpose of determining the respective obligations and rights of the parties. However, the Proffitt case held that the provision in the comprehensive coverage that loss caused by a falling object shall not be deemed loss by collision "cannot be used to defeat a recovery under" the provision in the policy specifying coverage for collision.

The strong dissent was based principally upon the view that the words in the comprehensive coverage clause "loss caused by ... falling objects ... shall not be deemed loss caused by collision or upset" have the effect of limiting the meaning of collision in the collision coverage to the extent that loss caused by a falling object is not a collision.

the meaning of the health and accident policy involved in that lawsuit.  

Fast Settlement Made Insurer a "Volunteer." One of the more unusual cases illustrates that sometimes it is not wise to settle claims too fast. Employers Casualty settled a claim so fast that it was held to be a "volunteer" and could not recover the settlement payment from Universal who was apparently the primary carrier for the loss. Employers' insured was driving a car temporarily used as a substitute for the insured automobile, which was at the automobile dealer's for repair. Universal was insurer of the substitute automobile being driven at the time of the accident which occurred July 28, 1964. Employers settled and paid the damages to the third parties on July 31, 1964, without informing Universal of the accident. Summary judgment for Universal was affirmed on the basis that Employers was a volunteer. If Employers by mistake paid the sum, it was a unilateral mistake; and money paid under a unilateral mistake cannot be recovered. Another reason given for the decision was that it would not be proper to make Universal repay Employers without giving Universal the right to have determined whose negligence caused the accident. This would deprive Universal of a valuable right. The decision is sound, as Universal's insured may have had a good defense, or Universal might have made a better settlement.

A Definition of "Overturning" in Floater Policy. The only case involving a "scheduled property floater policy" turned on the meaning of "overturning." The policy insured against "collision . . . or overturning of separate conveyances upon which the insured property is being transported." The insured property was being transported on a swamp buggy which partially overturned on the bank of a canal. Water from the canal got into the vehicle and it finally went to the bottom of the canal. These facts met the definition of "overturning." There need not be a complete overturning. Upon loss by the vehicle of its equilibrium, the overturning process commenced and became beyond the power of those in charge to stop its progress.

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83 Mutual Benefit Health & Acc. Ass'n v. Hudman, 385 S.W.2d 109 (Tex. Civ. App. 1964). The Hudman case was reversed on other provisions of the health and accident policy. No mention was made in the supreme court opinion about the holding of the court of civil appeals that the pickup truck was a "private passenger automobile.
