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I. SELECTION AND CONTROL OF RISKS

A. *Defining the Risk*

1. *Definition of "Temporary Substitute Automobile."*—Defendant issued a public liability policy covering insured's use of a described vehicle (a 1955 Ford) as a taxicab. The policy contained a standard temporary substitute automobile clause, covering a non-owned automobile "while temporarily used as a substitute for the described automobile when withdrawn from normal use because of its breakdown, repair, servicing, loss or destruction."[1] The described vehicle was badly damaged and was not used by insured for thirty days while being repaired. During this time insured obtained the loan of a Studebaker to carry on his cab business. After the Ford was returned from the repairer, insured used it for a few trips, but was bothered by a rattle in one door which disturbed his customers. He called the repairer to complain and was told by the repairer that the rattle would be fixed but that it would be some little while before this could be done. Insured parked the car on the lot from which he conducted his cab business and started using the Studebaker again. The repairer

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1. For a quick survey of interpretations of this and related clauses, see Annot., 34 A.L.R.2d 936 (1954); 7 APPLEMAN, INSURANCE LAW & PRACTICE § 4293.5 (1962) [hereinafter cited as APPLEMAN].

proved to be quite slow in getting around to fix the door. For six weeks the Ford remained untouched; occasionally during this period insured or his wife would drive it on personal business. At the end of the six weeks, insured was involved in an accident while driving the Studebaker. After disagreement over whether the use of the Studebaker was covered, insured brought a declaratory judgment action asking the court for an affirmation of coverage.

The defendant posed two basic arguments to support its claims that the Studebaker was not a temporary substitute automobile within the clause quoted above. The first was that since the Ford had been returned to insured's possession and was driven for personal business it was not "withdrawn from normal use." The court held that "normal" use for the purpose of this policy meant use in the taxicab business; since only the Studebaker was being used for that purpose, it was determined to come within the clause.[2] The second argument was that the use of the Studebaker was of such duration that it could not be regarded as temporary. Noting that the term "temporarily" was not defined in the policy the court applied the familiar liberal interpretation doctrine to hold that the trial judge had not exceeded his proper discretion in finding this use to be temporary.[3]

2. *Application of Automobile Policy Liability Limits.*—A husband and wife (hereinafter *H* and *W*) were injured in an accident caused by the insured. In their actions against the insured *W* was awarded 4,500 dollars and *H* 5,600 dollars. In his action, *H* alleged and proved *W*'s medical bills and loss of consortium as elements of his damages. After levying execution on the insured, which was returned nulla bona, *H* and *W* sought recovery from defendant, insured's liability carrier. When defendant declined to pay *H*, *H* and *W* brought the actions involved here. The defendant insurer argued that the per person limit of its liability was 5,000 dollars, that *W* had been awarded a judgment of 4,500 dollars, that the judgment for *H* had not been apportioned by the jury in the personal injury action to indicate the portion attributable to *W*, and that defendant should not be compelled to pay *H* anything since in doing so it might be paying *W* more than the policy limits.

By a two-to-one vote, the court of appeals upheld defendant's con-

2. Canal Ins. Co. v. Paul, 369 S.W.2d 393, 395 (Tenn. App. E.S. 1963). *Cf.* Little v. Safeguard Ins. Co., 137 So. 2d 415 (La. App. 1962) (substitute automobile used for pleasure rather than for usual business held covered); Lewis v. Bradley, 7 Wis. 2d 586, 97 N.W.2d 408 (1959).

3. Canal Ins. Co. v. Paul, *supra* note 2, at 396. The court cites with approval Fleckenstein v. Citizens Mut. Auto. Ins. Co., 326 Mich. 591, 40 N.W.2d 733 (1950), which indicated that the class of temporary substitute vehicles may include any automobile not intended as a permanent replacement.

tention[4] on the basis of the earlier decision in a similar case, *Yancey v. Utilities Insurance Co.*[5] Judge Avery disagreed with the holding, pointing out: (1) In the *Yancey* case, the judgment accorded *W* alone exceeded the policy limits, while in the instant case *W*'s award was five hundred dollars less than those limits, so that *H* should at the very least be allowed five hundred dollars.[6] (2) In *Yancey* the insurer had attempted to obtain a special verdict indicating what proportion of the loss should be attributed to *W*, but was unsuccessful because of the opposition of *H's* attorney. In the personal injury action preceding the instant case, the attorneys retained to defend the insured made no such effort.[7] (3) The testimony in the instant case was very detailed as to certain amounts attributable only to *H* and not to *W*. Judge Avery felt that it would be permissible to allow *H* recovery for those sums.[8]

In the final analysis, the rule involved here is one of burden of proof.[9] Where policy limit problems are involved it is the duty of the party seeking recovery to show that recovery by him is possible within the terms of the policy, including its liability limits (at least if those limits are raised as a defense). The instant case makes it clear that this burden can be an onerous one; so onerous indeed that there is a strong appeal in Judge Avery's plea that the court should be willing to speculate on the apportionment of damages where there is positive detailed evidence on the basis of which to make calculations. The lesson of the case is obvious: it is a warning to plaintiffs' attorneys to consider special verdicts where conflict over policy limits is likely; or to allege in the actions against the insured only those claims which, within the terms of the policy, are attributable to the particular plaintiff.

3. *Federal Government as an Insured Under its Employees' Liability Policies.*—In 1961, title 28 of the United States Code was amended to provide that if an action is brought against the federal government for injuries due to the improper operation of a vehicle by a government employee in the scope of his employment, the remedy against the government shall be exclusive. Suit against the employee personally is not available.[10] In two actions brought against the United States in Tennessee federal district courts under this statute, the

4. Maryland Cas. Co. v. Gordon, 371 S.W.2d 460 (Tenn. App. E.S. 1963) (Judges Bejach, Carney, and Avery sitting for the Eastern Section).

5. 23 Tenn. App. 663, 137 S.W.2d 318 (W.S. 1939).

6. 371 S.W.2d at 470, column 2, first full paragraph; *id.* at 473.

7. 371 S.W.2d at 472-73.

8. 371 S.W.2d at 474-77.

9. It is so interpreted by one of the leading works on insurance. See 21 APPLEMAN § 12,281.

10. 28 U.S.C. § 2679 (Supp. IV, 1963).

government moved to join an employee's liability carrier as a third-party defendant. In one case, the motion was denied;[11] in the other it was granted.[12] The decisions denying the motion focused on the policy language defining the scope of the insurer's duty: "to pay . . . sums which [the defendant Shelley] shall become legally obligated to pay . . . ." Shelley was a government employee. As the court pointed out, under the new act, he could not possibly become obligated to pay damages, since it was not controverted that the accident occurred within the scope of his employment. The reader should note, however, that the material in brackets in the court's quotation from the policy substitutes for the term "the insured." In the case granting the government's motion, the court centered on the definition of that term in the policy.[13] The language involved is: "any person or organization legally responsible for the use thereof by an insured . . . ." As the opinion states, the United States seems "to come squarely within that language."

If the latter decision be correct—and one would be hard pressed to disagree with it as a matter of strict contract construction—an ironical situation has come to pass. Probably the primary motive behind the introduction of the new legislation was the reaction to complaints by federal vehicle drivers that it was necessary for them to incur a heavy financial burden to obtain adequate liability insurance.[14] The action of the federal government in these two cases is hardly designed to bring about a lowering of rates to these employees.[15] Moreover, the Congress would not appear eager for the defense of these actions to come under the control of the insurance carriers (as is usually called for by liability policies).[16] Finally, if the purpose of the statute is

11. Gipson v. Shelley, 219 F. Supp. 915 (E.D. Tenn. 1963).

12. Vaughn v. United States v. Tennessee Farmers Mut. Ins. Co., 225 F. Supp. 890 (W.D. Tenn. 1964).

13. As the opinion in this case points out, apparently the definition of "insured" in *Gipson v. Shelley* differed, or else it was not called to the attention of the court.

14. Letter From Franklin Floete, Administrator, General Services Administration to Hon. Sam Rayburn, Speaker of the House of Representatives, in S. REP. No. 736, 87th Cong., 1st Sess., reprinted in 1961 U.S. CODE CONG. & AD. NEWS 2784, 2789: "The increasing use of motor transport by the Federal Government as a part of its day-to-day operations, coupled with the augmented costs of public liability and property damage insuranee coverage available to Federal employees to protect themselves . . . has imposed a heavy financial burden on the large number of such employees . . . who, as a matter of prudent self-proteetion purchase insurance . . . ."

15. This argument may be met, of course, by asking: "But if the employee has already paid to protect the government, why not take advantage of it?" The answer would seem to be that by not taking advantage of the policy, the insurer will be encouraged not to penalize the employee by re-classifying him, cancelling, or the like.

16. The Senate report on this legislation commended the "exclusive remedy" approach rather than the purchasing by the government of liability insurance for its drivers largely on the grounds of "simplicity of administration." 1961 U.S. CODE CONG. & AD. NEWS 2786.

"to provide a method for the assumption by the Federal Government of responsibility for claims for damages against its employees arising from the operation by them of vehicles in the scope of their Government employment"[17] this type of action does not seem in keeping with that purpose. Perhaps a beneficial result will be to encourage government employees to search for policies whose definition of "insured" will exclude the government and will thereby get less expensive coverage.

4. *Definition of "Hospital" in Medical Policy.*—The medical policy construed in *Prudential Insurance Co. v. Cline*[18] provided indemnity for hospital room and board charges. The policy defined "hospital" to mean "an institution . . . primarily engaged in providing for compensation from its patients medical, diagnostic, and surgical facilities for the care and treatment of sick and injured persons on an in-patient basis, and which provide such facilities under the supervision of a staff of physicians and with twenty-four hour a day nursing services by registered graduate nurses." Plaintiff sought recovery for charges made for the care of his child by the "Brown School," a Texas institution for treatment of mentally disturbed children. The school was visited by one physician daily on a regular basis, and this care was supplemented by frequent, though irregular, visits of others. The school's staff included one registered nurse, on duty eight to nine hours a day and on call the remainder of the time. The court of appeals affirmed the trial judge's finding that the school did not meet the requirements of the policy definition, and enforced the provision against the plaintiff. The holding reflects the general attitude of American jurisdictions, which will enforce such definitions provided compliance is reasonably possible.[19]

5. *Meaning of "Repairer" and "Breakdown" in Inchmaree Clause.*—The district court decision in *Russell Mining Co. v. Northwestern Fire & Marine Insurance Co.*,[20] discussed in last year's *Survey*,[21] was reversed during 1963 by the Sixth Circuit. Insured owned two barges moved to the banks of a lake. The barges were covered by a time-hull policy issued by defendant. The barges had to be pumped out continuously by electric pumps on board in order to be safe. One of insured's employees was engaged in wiring a coal tester which insured was installing on land (and which would not be connected

17. *Id.* at 2785.

18. 371 S.W.2d 158 (Tenn. App. E.S. 1963).

19. It is difficult to generalize about the enforcement of these provisions since the language employed varies notably in different policies. See Annot., 35 A.L.R.2d 897 (1954); 1 APPLEMAN § 705 (Supp. 1964).

20. 207 F. Supp. 162 (E.D. Tenn. 1962), *rev'd*, 322 F.2d 440 (6th Cir. 1963).

21. Covington, *1962 Tennessee Survey—Insurance*, 16 VAND. L. REV. 773, 776 (1963).

with the barges in any way). To do his work, he cut off the power supply at the barge site and negligently left it off overnight. Since the pumps did not operate, the barge sank. Insured asserted coverage under the Inchmaree clause, which indemnifies the insured against loss caused by "breakdown of . . . electrical machinery [or] . . . negligence of charterers or repairers . . . masters, mariners, engineers or pilots." The reversal is based on interpretation of two terms in this clause, "repairer" and "breakdown."

The district court held that the employee wiring the coal tester was a "repairer." The circuit court disagreed, pointing out that the employee in question made no repairs to the barge, but was concerned only with the coal tester, a land-based machine not connected with the barge. The court also disagreed with the trial judge's alternative basis of decision: a finding that there had been a "breakdown" of the electrical machinery. The appellate court noted that there was no allegation that the pumps were not in good working order; they simply received no current because of the negligent failure of insured's employee to turn the switch back on when he finished for the day. This, said the court, was no "breakdown."

B. *Exclusions and Representations*

1. *Automobile Policy Employee Exclusion.*—The employee exclusion clause of standard automobile liability policies was involved in two federal district court diversity cases during the past year.[22] This exclusion provides that the policy does not cover injury to "any employee of the insured arising out of and in the course of . . . employment by the insured." The exclusion is readily justifiable on two bases. The risks of the master-servant relation are more constant and concentrated than the general risks of automobile operation. Moreover, society has recognized the peculiar nature of the hazards of employment by providing workmen's compensation laws to recompense injured workers. Compensation insurance is available to any employer. Why provide double insurance coverage for injuries to employees hurt in automobile accidents? That this reasoning is the basis of the employee exclusion is indicated by the use of language drawn from compensation law in the exclusion clause ("arising out of and in the course of employment") and by the fact that in the great majority of policies the employee exclusion clause is coupled with a clause excluding coverage for "any obligation for which the insured . . . may be held liable under any workmen's compensation law . . . ." If we think only of the named insured and his workers, the

22. Maryland Cas. Co. v. American Fid. & Cas. Co., 217 F. Supp. 688 (E.D. Tenn. 1963); Humble Oil & Refining Co. v. American Fid. & Cas. Co., 212 F. Supp. 953 (E.D. Tenn. 1962).

pattern of coverage of employee injuries may be regarded as simple and well-balanced: automobile and compensation policies should be regarded as complementary—what the compensation policy of the insured covers, the automobile policy does not.

Yet this clause does create many difficult problems when one other factor is introduced: an omnibus insured. The following situations are typical. *A* is the named insured. (1) *C*, an omnibus insured who is one of *A*'s employees, injures *E*, another of *A*'s employees, by negligent use of the insured vehicle. Is *C*'s liability covered by *A*'s policy? (2) *B* (or one of his employees) by the negligent use of the insured vehicle injures *D*, an employee of *B*. Is *B*'s liability to *D* covered by *A*'s policy? (3) *A* (or one of his employees) injures *D*, *B*'s employee, by negligent use of the insured vehicle. Is *A*'s liability to *D* covered by *A*'s policy? (4) *B*, an omnibus insured who is not an employee of *A*, injures *C*, one of *A*'s employees by the negligent use of the insured vehicle. Is *B*'s liability to *C* covered by *A's* policy?

In the first situation listed, the problem of who is "the insured" for the purpose of the exclusion clause has largely been solved by inserting a special provision excluding coverage of actions between co-employees. Such a clause, for instance, was present in *Vaughn v. Standard Surety & Casualty Co.*,[23] decided by the Tennessee court of appeals in 1944. The provision involved stated that the term insured did not include "any employee of an insured with respect to any action brought against said employee because of bodily injury to or death of another employee of the same insured injured in the course of such employment . . . ." As the court said, having reached the conclusion that the injured party and the omnibus insured were co-employees engaged in the course of their employment, the insurer was patently not liable under this express exclusion. Perhaps unfortunately, however, the court also expressed its opinion that the general employee exclusion would have prevented recovery because the injured party probably had a compensation remedy available.[24]

In the second situation listed, the basic policy underlying the employee exclusion would seem to require no coverage. There is no Tennessee case in point.[25]

In the third situation, there is one decision by a federal district court, *New v. General Casualty Co.*[26] In that case, Judge Davies found

23. 27 Tenn. App. 671, 184 S.W.2d 556 (M.S. 1944).

24. 27 Tenn. App. at 680-82, 184 S.W.2d at 560. The statement was clearly dictum, as pointed out in Judge Wilson's opinion. 217 F. Supp. at 693. The case is cited in Judge Taylor's opinion also, with a notation that it is not precisely in point on the issue at hand. 212 F. Supp. at 959.

25. Cases from other jurisdictions are discussed in Annot., 50 A.L.R.2d 78 at 97-104 (1956) (the discussion includes cases of all four types we have listed).

26. 133 F. Supp. 955 (M.D. Tenn. 1955).

the meaning of "the insured" in this clause ambiguous. Construing it against the insurer, he therefore held "the insured" to mean the insured against whom the action was brought. Since the employee injured was an employee of an omnibus insured and the defendant was the named insured, there was liability under the policy. The propriety of the decision can hardly be doubted, for the named insured not only had not, but indeed could not take out compensation insurance to protect himself. Unless the liability policy be held to cover such a situation, the named insured would be powerless to shift this risk.[27]

It is the fourth situation, injury of an employee of the named insured by an omnibus insured, which confronted the two courts during the past year. In both cases, the courts held that under doctrines set out by circuit courts of appeal there would be no coverage. In one opinion, the court makes the somewhat startling remark that "there is no ambiguity in the exclusion clauses as to which insured or risk is intended."[28] This contrasts with the statement of Judge Wilson in the other opinion that "the only thing that can be said with certainty is that an ambiguity exists with regard to the meaning of the phrase 'the insured' . . . ."[29] One feels inclined to agree with the latter statement if only because of the large number of divergent opinions in these cases.[30] Judge Wilson, having found an ambiguity to be present, goes on to resolve the ambiguity against the insurer and concludes that on the basis of "logic and reason" the term "the insured" means the insured claiming coverage.[31] Having reached this conclusion, he nonetheless holds against coverage because the Sixth Circuit Court of Appeals, when called upon to establish a rule in a diversity case commenced in a Kentucky federal court, found no coverage.[32]

It is submitted that Judge Wilson's original tendency to hold for the plaintiff was correct for three reasons. The first is the usual rule requiring ambiguous language in an insurance contract to be construed against the insurer, already mentioned.[33] The second is the presence in the automobile policy for the last several years of the "severability of interests" clause: "The term 'the insured' is used severally and not collectively, but the inclusion herein of more than one insured shall not operate to increase the limits of the company's

27. That there should be such a gap in coverage is not, of course, impossible. But since the language of the clause is susceptible to an interpretation providing complementary coverage, it would seem preferable to follow this approach.

28. 212 F. Supp. at 957.

29. 217 F. Supp. at 691.

30. See 217 F. Supp. at 690 n.1; Annot., 50 A.L.R.2d 78 (1956).

31. 217 F. Supp. at 692-93.

32. Travelers Ins. Co. v. Ohio Farmers Indem. Co., 262 F.2d 132 (6th Cir. 1958).

33. See generally VANCE, INSURANCE § 41 (3d ed. Anderson 1952).

liability." A few years ago a prominent insurance attorney wrote in this *Review*: "This new condition in the policy has made it clear and certain that the named insured and the omnibus or additional insureds are to be treated separately, and that the exclusions or other coverage tests should apply to the particular insureds seeking coverage."[34] The writer was overly optimistic. Courts and attorneys continue to cite the same divergent authorities that were used before the introduction of the clause.[35] One hopes a less ambiguous phrase will be employed in the future, as suggested in one of the opinions.[36] Nonetheless, the clause at least adds to the force of the argument for applying the ambiguous provision construction rule. Third, the policies which make the general employee exclusion a reasonable provision are not present when the employee injured does not work for the particular insured claiming coverage. So far as that insured is concerned, the injured party is a member of the general public for whom he has no compensation law responsibility and for whom he cannot provide compensation insurance. In the *Kelly* case, to which both courts referred, the Sixth Circuit indulged in the following reasoning: "Certainly [the named insured] . . . having paid for workmen's compensation insurance for the protection of its employees would not ordinarily take out liability insurance at its own expense to protect itself from any claim its employees might have against it or any third person."[37] The trouble with this, of course, is that the court is viewing the protection afforded omnibus insureds from the viewpoint of the named insured's interest. Once the basic question whether a person is an omnibus insured has been answered in the affirmative, he is entitled to the same consideration as the named insured. Whether the named insured has ever thought of who constitutes an omnibus insured beyond making sure his employee's negligence is covered is extremely dubious. To look for the "intent of the parties" in this situation is hardly helpful for the odds are that the named insured had no intent one way or the other when he executed the contract.

2. *Default Exclusion in Bankers Blanket Bond.*—The bankers blanket bond sued on in *First National Bank v. Aetna Casualty & Surety Co.*,[38] excluded from coverage "any loss, the result of the complete or partial nonpayment of or default upon any loan made by or

34. Plummer, *Automobile Policy Exclusions*, 13 VAND. L. REV. 945, 955 (1960).

35. "[T]he Severability of Interests clause . . . has the misfortune of being somewhat ambiguous, if not incomprehensible. The result is that there is equal divergency in the opinions as to the effect, if any, of the 'Severability of Interests' clause upon the problem here presented." 217 F. Supp. at 692 (citing cases).

36. 217 F. Supp. at 691.

37. Kelly v. State Auto. Ins. Ass'n, 288 F.2d 734, 738 (6th Cir. 1961) (quoted in Humble Oil, 212 F. Supp. at 957).

38. 309 F.2d 702 (6th Cir. 1962).

obtained from the Insured, whether procured in good faith or through trick, artifice, fraud or false pretences . . . ."[39] Insured made loans to Butler-Foster Milling Co. of nearly three million dollars, secured by negotiable warehouse receipts representing a sizable quantity of soybeans. Butler-Foster repaid the loan in two installments. The second payment of over two and one-half million dollars was made out of proceeds of a sale by Butler-Foster to Continental Grain of the soybeans represented by the receipts used to secure the loan. Soon after the sale, Continental discovered there were no soybeans to support the receipts. Butler-Foster promptly went bankrupt. Continental then sued the trustee in bankruptcy and the insured to recover the amount it had paid for the soybeans, claiming insured held the proceeds as a resulting trustee. The insured won at the trial level in this action. However, the trustee in bankruptcy also filed a cross-suit against the insured claiming that the second payment by Butler-Foster was a voidable preference. A parallel suit was filed for the earlier payment. Insured by negotiation persuaded the trustee in bankruptcy to dismiss his actions in consideration of a payment of five-hundred-thousand dollars; and persuaded Continental to dismiss its appeal for one-hundred-fifty-thousand dollars. Attorneys' fees and incidental expenses of negotiation amounted to a bit over two-hundred-thousand dollars. Insured sought to recover all these amounts under its blanket bond, and was met by insurer's reliance on the quoted exclusion.

Both the district and the circuit courts held for the insurer, reasoning that the sums paid out by the insured were in essence sums lost by it as a result of failure of a debtor to repay his loan. The insured's contention that the loan was repaid and that its settlement was a separate transaction was rejected, apparently on the theory that if the repayment was voidable, it fell within the exclusion. The broader basis of the decision is that this exclusion makes it clear that the banker's blanket bond is not "intended to provide credit insurance . . . ."

3. *Misrepresentation by Applicant Acquiesced in by Agent.—Mutual*

39. *Id.* at 704. The exclusion does not apply to all coverages under the policy. The insured, in addition to arguing that the exclusion did not apply to these facts, also argued that the loss was caused by forgery or counterfeiting, and was therefore covered by insuring clauses not subject to this exclusion. Since the warehouse receipts involved in this case were genuinely executed, they were not considered by the court to be forged or counterfeited. The Tennessee case on which the court relied was Mallory v. State, 179 Tenn. 617, 168 S.W.2d 787 (1943), a decision reversing a criminal conviction of forgery. It is questionable whether the same definition should be applied in the interpretation of an insurance contract. See the compelling opinion of Judge Goodrich in Fidelity Trust Co. v. American Sur. Co., 268 F.2d 805 (3d Cir. 1959). On the blanket bond generally see Fields, *Bankers Blanket Bonds: What They Cover and What They Do Not*, 27 INS. COUNSEL J. 318 (1960).

Life Insurance Co. v. Templeton[40] involved the question of the effect of misrepresentation of his medical condition by an applicant for life insurance when most of the relevant medical facts were known to the insurer's agent. The applicant was a lawyer who for some time before applying for the policy had suffered from tumors. It was found by the court that on the date of the application, the applicant "knew that he was suffering from cancer which could not be removed by surgery and which had not responded to X-ray . . . ."[41] Nonetheless the applicant stated on the form that he believed himself to be in good health. Ironically, the policy sued on, issued on the basis of that application, was delivered to the applicant in the hospital where he was awaiting an operation to remove a cancerous kidney. He died of cancer a few months later. The insurer declined to pay and this action was brought to cancel and rescind the policy.

With only these facts in mind, the necessary decision would be apparent. However, one additional factor complicates the case slightly: The agent who dealt with the applicant had known him for some time and was aware of his medical problem. The beneficiary's attorney quite naturally urged that this knowledge should be imputed to the insurer, as principal, thereby creating an estoppel situation. The court declined to take this view, on the ground that there was collusion between the applicant and the agent to withhold material information from the insurer.[42] "[T]he doctrine of imputed knowledge does not apply where the one who seeks to charge the principal is acting in collusion with the agent."[43]

4. *Violation of Books and Records Warranty*—In *Sciara v. Fidelity*

40. 362 S.W.2d 938 (Tenn. App. W.S. 1962). A large part of the opinion is devoted to a discussion of Texas law which arguably controlled. However, the court indicated that there was no relevant difference between Texas and Tennessee principles. The discussion of the case in this article is limited to the Tennessee principles.

41. 362 S.W.2d at 941.

42. The evidence supporting this conclusion is not extensively reviewed, but obviously important facts were: there was a standing friendship between the agent and applicant; the applicant had submitted a number of claims under a hospital policy through the agency which employed the agent in question; the applicant was an attorney who may therefore be assumed to realize the implications of his conduct.

43. 362 S.W.2d at 945, citing De Ford v. National Life & Acc. Ins. Co., 182 Tenn. 255, 185 S.W.2d 617 (1945). For cases in accord, see VANCE, INSURANCE § 89 nn.7-10 (3d ed. Anderson 1952). See also RESTATEMENT (SECOND), AGENCY § 282 (1958). An excellent brief statement of the law when the agent fills out the application is found in PATTERSON, ESSENTIALS OF INSURANCE LAW § 100 at 515-16 (2d ed. 1957): "To summarize: In most of the states, the fact that the agent or medical examiner knew, when he filled in the application, of facts that made a statement materially false estops the insurer to assert a misrepresentation or breach of warranty. This rule is limited by another rule that, if the insured knew that the agent was not truly reporting glaringly important facts to his company, the insured himself is guilty of fraud and cannot be aided by the principle of estoppel, which requires an honest reliance. This second rule limits the operation of the first to a greater extent in life insurance than in other branches."

& Casualty Co.,[44] plaintiff insured, a restaurant operator, was covered by a comprehensive dishonesty, disappearance and destruction policy. Among the conditions limiting the insurer's liability was a warranty providing: "The insured shall keep records of all the insured property in such manner that the Company can accurately determine therefrom the amount of loss." On November 17, 1959, plaintiff's place of business was burglarized, the thieves taking two paper sacks containing plaintiff's receipts from his business. Apparently the only record plaintiff had of the amount of money in the sacks was an adding machine tape which unfortunately was also in the stolen sacks. Plaintiff urged that his claim should be paid on two grounds: (1) substantial compliance with the policy by keeping the adding machine tape; (2) waiver of the bookkeeping condition by (a) paying a claim under the policy for damage to the restaurant door sustained during the same burglary; (b) offering plaintiff a $250.00 settlement for "nuisance value"; and (c) requesting proofs of loss after insurer knew of the breach of this condition. Both points are extremely interesting.

The court found no substantial compliance, but did not specify the precise basis of the holding. Three possibilities seem apparent. The first is that the adding machine tape, even if available, would not be a sufficient record to satisfy this condition.[45] This is a distinct possibility, although there are cases from a number of jurisdictions holding very sketchy records adequate.[46] One New Jersey opinion pointed out that record keeping in the restaurant business is customarily extremely informal and allowed a cash register tape to serve as the needed record.[47] Second, it is possible that the insured's negligence in keeping the tape and the money together may preclude a finding of substantial compliance. Certainly the insured is not bound to produce books under some circumstances: if all contents of a building were destroyed by fire, for instance.[48] And it would seem unlikely that had the insured kept detailed records in a safe away from the money yet these were also stolen the court would hold his claim barred. But placing the adding machine tape in a paper sack with the funds may very well not be acting "with the care that prudent men ought to exercise . . . ."[49] One is troubled, however, by

44. 362 S.W.2d 935 (Tenn. App. W.S. 1961).

45. For a discussion of the inadequacy of informal records kept in a notebook, see Mabry v. Hartford Ins. Co., 26 Tenn. App. 463, 173 S.W.2d 169 (W.S. 1941). See generally 5 APPLEMAN § 3026; Annots., 39 A.L.R. 1443 (1925); 125 A.L.R. 350 (1940).

46. See 5 APPLEMAN § 3027.

47. Micbler v. New Amsterdam Cas. Co., 104 N.J.L. 30, 139 Atl. 725, *aff'd*, 104 N.J.L. 663, 141 Atl. 920 (1928).

48. See, *e.g.*, Dickey v. Springfield Fire & Marine Ins. Co., 56 Okla. 616, 156 Pac. 204 (1916).

49. Home Ins. Co. v. Higbtower, 22 F.2d 882, 885 (5th Cir.), *cert. denied*, 276 U.S. 634 (1928).

the fact that the act which resulted in the complete absence of records was the very type of act against which the policy protected the insured.[50] The third and most reasonable explanation is simply that the conduct of the insured taken as a whole did not fall within that range of reasonable permissible deviation which is associated with the concept of substantial compliance. Perhaps neither insured's informality in record-keeping nor his carelessness in protecting the record he did prepare would be enough taken alone to prevent recovery. But this condition of the policy should not be viewed as one whose satisfaction depends upon one act alone; rather it should be thought of as a requirement of conduct by the insured reasonably calculated to make estimate of the loss possible on a basis firmer than his own fallible recollection.

The court's refusal to uphold the plaintiff's claim of waiver is significant because it helps define the type of conduct safely open to an insurer who suspects a breach of condition. First, it now seems clear that if an insured has breached a policy condition directed to one type of loss (theft in the instant case), an insurer may pay the loss covered by other language of the policy (damage to premises here) to which the particular condition is not relevant without waiving the breach of condition, at least if the insurer makes it clear to the insured that it does not intend to waive such defense.[51] Second, it establishes that offering to pay the "nuisance value" of a claim does not waive a breach, provided the insurer makes it clear that it does not intend to abandon the defense. This holding may serve as an indicator of the position Tennessee will take in the troublesome area of the effect of compromise offers.[52] Third, the decision adopts the sounder minority position that requesting proofs of loss does not necessarily waive breaches of policy conditions.[53] Of course if the effect of the request was to mislead an insured to his detriment, waiver based on estoppel rather than on election would be involved. It may

50. If insured's records "are destroyed wholly without his fault, recovery has still been allowed. This is particularly true where such destruction is occasioned by the hazard insured against, when kept in a place where the insured had the right to keep them." 5 APPLEMAN § 3025, at 108. The sacks were doubtless not such a place.

51. For a discussion of divisibility, see PATTERSON, ESSENTIALS OF INSURANCE LAW 342-46 (2d ed. 1957).

52. For a survey of the cases in the area, see Annot., 49 A.L.R.2d 87, 131-50 (1956). Compare Hughes v. Home Ins. Co., 8 Tenn. App. 292 (1928) (clearly distinguishable; the offer is for more than nuisance value; the adjuster did much more to indicate insured had a valid claim).

53. The apparent majority opinion puts the insurer in quite an awkward position. If the insurer asks for proofs of loss, he has waived "all existing defenses then known to him . . . ." On the other hand if the insurer does not ask for proofs of loss but simply denies liability, he may deprive himself of a possible source of information needed to analyze the validity of the claim. See VANCE, INSURANCE § 83, at 491-92 (3d ed. Anderson 1951).

also be possible the court would take a different position if forfeiture of the policy were at stake.[54]

5. *Alleged Waiver of Vacancy Clause.*—In *Triolo v. Treadwell & Harry, Inc.*,[55] plaintiff sought to rely on a recent holding of the Tennessee Supreme Court that: " 'where the policy is issued on vacant and unoccupied property with that knowledge and upon an agreement or with the expectation on the part of the insurer and the insured that the property is to remain vacant, the clause against vacancy is waived.' "[56] Mrs. Triolo, the insured, demonstrated that the insurer's agent knew that the described property was vacant at the time the policy was issued.[57] The court of appeals affirmed the decision of the chancellor that such knowledge was not notice that the property would remain vacant for more than the sixty day grace period of the vacancy clause.

Evaluation of this decision is difficult. On the one hand, the vacancy clause of the standard fire policy is reasonable and entitled to be enforced. On the other hand, the facts of insurance marketing practices cause this writer to feel somewhat discomfited by the holding. Who is more likely to realize the significance of lack of occupancy: the lay purchaser, or the insurance salesman who is told at the time he sells the policy that the property is not occupied?[58]

II. INSURER'S FAILURE TO CANCEL

American Insurance Co. v. Taylor[59] involved the relatively rare problem of the effectiveness of an attempted cancellation by the insured.[60] Homer Taylor, the insured, carried several policies of insurance with the Ray Koger Insurance Agency, among them the fire policy in question. After being involved in a wreck, the collision portion of a policy of automobile insurance carried by Taylor with Koger was cancelled. Taylor, irritated by the cancellation, spoke to Glenn Poore, an employee of the Koger Agency, telling him to "cancel his insurance." When Poore related this to Ray Koger, operator of

54. The court places some emphasis on the non-forfeiture aspect. 362 S.W.2d 935, at 937, col. 2, para. 4.

55. 371 S.W.2d 169 (Tenn. App. W.S. 1963).

56. McCaleb v. American Ins. Co., 205 Tenn. 1, 8, 325 S.W.2d 274, 277 (1959).

57. Plaintiff also contended that the agent knew of the continued vacancy a year later when the face value of the policy was raised after a conversation between the agent and the insured. The court does not dwell on this contention; it probably regards it as disbelieved for cause by the trial judge. For a fuller discussion, see Beasley, *Agency—1963 Tennessee Survey*, 17 VAND. L. REV. 917, 920 (1964).

58. The perplexing nature of the problem is indicated by the division of American jurisdictions. See PATTERSON, ESSENTIALS OF INSURANCE LAW § 97, at 505 (2d ed. 1957); Annot., 96 A.L.R. 1259 (1935).

59. 367 S.W.2d 300 (Tenn. App. M.S. 1962).

60. "Very little litigation has arisen over the insured's power of cancellation." PATTERSON, *op. cit. supra* note 58, at 197.

the agency, Koger did not act on the request. Koger testified that he had felt Taylor was simply temporarily angry and would "cool off and not cancel his policy . . . ." A few weeks later the premises covered by the policy burned. Koger, after talking with an adjuster, told Taylor that the policy was still in force and that defendant company would share the loss with another company (which was incontrovertibly on the risk). Later, however, the defendant company refused to accept Taylor's proof of loss forms and Taylor brought this action to compel payment.

The court held the policy to have been in force at the time of the fire. There are several bases for the decision. *First,* the burden of proving cancellation is on the party asserting it. In order for insured's attempted cancellation to be effective his request would have to be made to an authorized agent. In this case, the court found, there was not a sufficient showing that Poore was such an agent.[61] Since Poore conveyed the request to Koger, who was shown to be an authorized agent, however, this basis is weak.[62] *Second,* the request for cancellation may have been ineffective because it was given under circumstances such that the agent reasonably regarded it as not being a firm, serious cancellation order.[63] *Third,* the company knowing of the attempted cancellation through its agent, nonetheless continued to act as if the policy was in force, both by failing to tender unearned premiums[64] and by indicating through Koger after the loss that it intended to treat the policy as in force. Thus, the company arguably waived its defense.[65]

III. Assessment of Cost of Interpleader

In *Paul Revere Life Insurance Co. v. Riddle,*[66] Judge Neese denied the insurance company who had interpleaded the privilege of charging the costs of the suit against the fund. The refusal was based on the grounds that "more than a cursory examination of the facts" would have revealed to the insurer that it was in no real danger of double liability. Generally, costs of an interpleader suit will be allowed to the

61. 367 S.W.2d at 305.

62. It should be pointed out that proof of agency to solicit business is not presumptive of power to accept notice of cancellation. See 6 Appleman § 4226, at 797.

63. Two factors are involved here: the insured's irritation, and the ambiguity of his request for cancellation. Since insured carried several policies with Koger, it is quite possible his direction meant to cancel some but not all of these contracts. To be effective, a request for cancellation must be unequivocal and absolute. 6 Appleman § 4226, at 793.

64. Failure to tender unearned premiums is not necessarily proof of failure to cancel. Victory Ins. Co. v. Schroeder, 167 Okla. 516, 30 P.2d 894 (1934).

65. The court does not discuss the issue of authority of the particular agents involved to waive, perhaps because of the presence of alternative bases for decision.

66. 222 F. Supp. 867 (E.D. Tenn. 1963).

petitioner,[67] but "the allowance of costs, including attorneys fees, is a matter within the discretion of the trial court . . . ."[68] Where the suit is brought frivolously, or is delayed, such costs are normally denied.[69]

IV. INSURABLE INTEREST-AUTOMOBILE POLICY

In *Maryland Casualty Co. v. Gordon*,[70] a stepfather who held legal title to an automobile in which his stepson had the entire equitable interest was found to have sufficient insurable interest to support an automobile liability policy on the car. The decision is clearly correct in the absence of fraud;[71] here the stepson was named in the policy application as chief driver.[72]

67. 3 MOORE, FEDERAL PRACTICE ¶ 22.16 n.5.
68. Bank of China v. Wells Fargo Bank & Union Trust Co., 209 F.2d 467, 476 (9th Cir. 1953). See also MCCLINTOCK, EQUITY 509 (2d ed. 1948).
69. MOORE, *op. cit. supra* note 67, ¶ 22.16, nn.1, 8, 9.
70. 371 S.W.2d 460 (Tenn. App. E.S. 1963).
71. See 4 APPLEMAN § 2134 (1941).
72. Indeed the court found that such full disclosure had been made that the insurer might be held to have waived the insurable interest defense. 371 S.W.2d at 462-63.