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INSURANCE—1961 TENNESSEE SURVEY

ROBERT N. COVINGTON*

I. WHAT IS INSURANCE?

II. CONTROL OF RISKS

A. *Description of Insured Property*

B. *Exclusion Clauses*

1. *Life Insurance—Double Indemnity—Exclusion for Military Maneuvers*
2. *Group Life Policy—Age Exclusion*
3. *Service Station Liability Policy*
4. *Automobile Liability Policy—Employee Exclusion*

C. *Good Health as a Condition Precedent*

III. SERVICING THE CONTRACT

A. *Change of Beneficiary*

B. *Effect of Statute of Limitations on Liability to Third Parties*

C. *Duty To Settle*

The developments in the Tennessee law of insurance during the past year were important without being surprising. The various courts delivered opinions dealing with a number of the central issues in insurance law, especially in the field of risk control, and by and large followed the line of thinking established by past years. Many of the decisions are of less significance than one might suppose, because of their extreme involvement in particular fact situations.

I. WHAT IS INSURANCE?

In *State ex rel. Long v. Mynatt*¹ the Tennessee Supreme Court ruled on the constitutionality and application of a 1959 amendment to the Code which provides:

It shall be unlawful for any life insurance company . . . to enter into any contract with any citizens of this state, contracting and agreeing to furnish funeral merchandise or services upon the death of any person insured.

It shall further be unlawful for any person, firm or corporation to issue any policy or certificate, or to enter into any contract, conditioned to take effect on the death of any person, wherein such person, or the personal representative, heirs or next of kin of such person, is promised any rebate, discount or reduction in price for or on account of funeral merchandise,

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1. 339 S.W.2d 26 (Tenn. 1960).

expenses or services by virtue of his being issued such policy or certificate²

Defendant Mynatt, who operated the Mynatt Funeral Home, had in the preceding twenty years entered into some 35,000 "discount contracts" which provided that the purchaser of the contract or his personal representative was to receive a fifty per cent discount on funeral services and supplies. In this action, the state insurance commissioner charged that Mynatt was violating the section quoted above and that he was guilty of conducting a life insurance business without complying with the regulations imposed on an insurer.

Mynatt offered two defenses: (1) He urged that the contracts he issued were not insurance contracts but simply contracts for the sale of goods and services since the person paying for the contract could purchase merchandise before his death if he so desired. This would mean that the contract was not one that depended upon the contingency of death. (2) He also argued that the 1959 statute outlawing the issuance of any policy, contract, or certificate calling for discounts on funeral services was unconstitutional because it unreasonably discriminated against a single group.

The supreme court, through Chief Justice Prewitt, held against defendant on both counts. By deciding that these contracts for burial services are essentially insurance contracts to be performed on the death of the party to whom the contract was issued, the court followed its earlier decision in *State ex rel. Attorney General v. Smith Funeral Service*.³ In that case, as in the instant decision, a funeral home had issued a discount contract under which the party holding the contract certificate could call on the funeral home to provide a casket at any time. The court, in *Smith*, said:

The nature of a business pursued by anyone is not determined by the things that may possibly be done in that business or by things that possibly have been done. It is determined rather by the usual course of the particular business.

We may safely assume that the sale of burial outfits to its customers during their lives is not according to defendant's usual course of business.⁴

Surely one must agree that these contracts are in practice insurance contracts, conditioned on the death of the contract holder, no matter what the funeral director may call them.⁵

The more interesting point in controversy is the constitutional issue. Is it not undue discrimination against funeral directors to prohibit the

2. TENN. CODE ANN. § 56-3208 (Supp. 1961).

3. 177 Tenn. 41, 145 S.W.2d 1021 (1940).

4. *Id.* at 44, 145 S.W.2d at 1023.

5. The overwhelming majority of decisions have found such contracts to be contracts of insurance. See VANCE, INSURANCE § 10, at 87 (1951).

issuance of discount contracts such as these? The court held "no" and upheld the legislation, explaining its position by giving an illustration of the potential abuse to which these contracts are subject: The defendant in this action had issued 35,000 of these contracts, each promising a fifty per cent discount on burial supplies and services. If the average contract was for \$500, then the value of all the contracts on their face would be \$17,500,000; half of this, or \$8,750,000 would be the potential liability of the funeral home. Such a potential liability, especially on the part of a non-insurer who is unlikely to have his program funded with the actuarial precision of a professional insurer, presents a picture of prospective financial disaster. For this reason, the court held, it was reasonable and proper for the state legislature to single out this type of transaction for regulation or prohibition.

II. CONTROL OF RISKS

A. Description of Insured Property

In *McKee v. Potomac Insurance Co.*⁶ the state supreme court was called on to construe the clause in a casualty policy which extended coverage to "additions and repairs" to specifically described property. Plaintiff in the case was the owner of a motel in Shelbyville, Tennessee. In 1951, he purchased a fire policy from defendant in which this coverage description appeared: "Approved roof, two story, concrete block and brick Tourist dwelling and office, containing 11 units, situated 211 Madison Street, Shelbyville, Tennessee." In 1953, plaintiff purchased a house on an adjoining lot which he converted into three additional motel units; he apparently did not notify the insurer of this move. In 1956, a renewal policy was issued to plaintiff; the property description was identical with the description in the first policy, no mention being made of the three added units. In 1957, these three new units were destroyed by fire. Plaintiff has brought this action for reimbursement for his losses due to that destruction.

In the court below, the suit was dismissed on the ground that the policy showed on its face that these three units were not covered. Plaintiff has prosecuted this appeal arguing that there was coverage under the "additions and repairs" clause and that the insurer was under a duty to determine the location of the subject matter of the policy and to state this accurately in the contract.

The supreme court held against the insured on both counts. In its opinion these three units were not additions and repairs in the sense of that clause, but new property which was independent of the original covered property. The clause was construed to refer to "some

6. 344 S.W.2d 366 (Tenn. 1961).

small addition or work done on the particular units described and not . . . the building of additional units.”⁷

While the court did not dwell upon it at any length, the opinion gives the impression that the fact that the renewal policy specifically stated “11 units” was of considerable significance. Had the policy said simply that it covered a motel in Shelbyville, Tennessee, the result might possibly have been different.

On the second count, the court held that while the insurer might be under a duty to make sure a property description was accurate when it issued the first policy on such property, it is entitled to rely upon the description in the policy when it receives a request for a renewal policy without any notice of a change in the situation.⁸

This opinion, like that in so many insurance cases, is so centered in its factual context that its legal significance is limited. The coverage of any insurance policy is, of course, a matter of the expressed intent of the parties. To assess that intent many factors must be looked to, including the particular language describing coverage, the use to which the allegedly covered property is put, the extent of change and alteration that has taken place since the policy was issued, and the like. One confronted with this sort of problem must compile his arguments in the most effective possible manner, and should look diligently into the secondary sources for references to cases that approximate his own.⁹

B. Exclusion Clauses

The exclusion clause has become a favorite device by which the insurer attempts to control risks. It is used to remove certain risks from the policy which otherwise would be included under general coverage provisions. The Tennessee cases decided during the past year involved exclusion provisions in both life and liability policies.

1. *Life Insurance—Double Indemnity—Exclusion for Military Maneuvers.*—In *Bennett v. Metropolitan Life Insurance Co.*,¹⁰ an extremely brief opinion written by Mr. Justice Burnett, the Tennessee Supreme Court dealt with the issue whether an exclusion clause was ambiguous so as to require application of the familiar rule that ambiguous clauses in a contract of adhesion are construed strictly against its maker. In this case, insured was covered by a \$2,000 life policy which included a double indemnity clause for death caused by accidental means. Insured was killed in an accident while on a routine

7. *Id.* at 368.

8. *Ibid.*

9. See, e.g., 4 APPLEMAN, *INSURANCE LAW AND PRACTICE* §§ 2323-29 (1941); 1 COUNCH, *CYCLOPEDIA ON INSURANCE* §§ 6:7-:28 (2d ed. 1959); Annot., 19 A.L.R.2d 606 (1951).

10. 337 S.W.2d 9 (Tenn. 1960).

training mission as a rear gunner in the armed forces. The defendant insurer declined to pay double indemnity benefits and this suit was brought to recover them.

The double indemnity provision of the policy included a number of exclusions. Exclusion (d) provided that no double indemnity benefits would be paid if the insured was killed in flight if he had any duties with regard to the flight or if the accident resulting in death occurred while in flight during training or maneuvers of the armed forces. Exclusion (f) excluded coverage "while the Insured is in the military . . . forces of any country at war." Following this list of exclusions in the policy was a paragraph providing for the termination of the policy for non-payment of premiums. Then appeared this paragraph: "This provision shall be suspended during any period while the Insured is in the military . . . forces of any country at war . . ." Plaintiff's theory was that this last quoted paragraph created an ambiguity because it could not be ascertained which clause or clauses the words "this provision" referred to. Had the court agreed, there would have been an ambiguity which would have been resolved in favor of the beneficiary. Instead, however, the court held that these words clearly referred to the double indemnity provision, and not to the exclusions. This being the case, the supreme court upheld the chancellor below who had sustained a demurrer to the bill.¹¹

The decision seems reasonable. One would suspect, however, that insurers would in the future be more cautious in using pronouns in long complex sections, lest they be construed to refer to material which the insurer did not intend. The rash strewing of pronouns without clear referents is one of the worst habits of the writers of "legalese," whether in deeds, wills, or insurance policies. Surely the cost of printing this policy would not have been greatly increased by making the allegedly ambiguous phrase read: "This double indemnity benefits provision."

2. *Group Life Policy—Age Exclusion.—Zarzour v. Southern Life Insurance Co.*¹² involved a group life policy which provided that at age 65 benefits would be cut in half and that at age 70 they would be terminated. The policy was so designed in order that the Tennessee

11. One minor additional point deserves mention. In the closing paragraph of the original opinion, Mr. Justice Burnett inadvertently stated that "the insured . . . having accepted this policy with this provision in it is bound thereby . . ." Actually, exclusion (d) as applicable in this case was an amended version of the clause that appeared in the original policy issued to decedent. On petition to rehear, it was apparently argued that this clause should not be enforced since it was not in the original policy accepted by decedent. The court disposed of this argument by noting that the amendment was more liberal than the original clause, so that petitioner had no ground for complaint on this point.

12. 333 S.W.2d 14 (Tenn. App. E.S. 1959).

Restaurant Association, whose members were covered by it, could obtain a minimum premium rate. Richard Zarzour, a member of the association, had paid premiums for several years on a policy formerly held through the association which contained no age limit; he continued to pay under the instant policy even though over 70 and in spite of the fact that the group certificate which was issued to him stated that persons over that age were ineligible. No application was required for the policy and although the broker who arranged for the contract might have been able to ascertain Zarzour's age by inspecting the association's membership records, he apparently did not do so. Upon Zarzour's death, the insurer learned for the first time of his age; they consequently refused to pay benefits and this suit has been prosecuted against them.

The court held that an age exclusion such as the one involved in this case is valid and does not violate the Tennessee statute forbidding a settlement at maturity of less than the amount insured (adjusted for premium payments). As Judge McAmis stated in the opinion, an age exclusion is just that, an exclusion; it is not a mode of settlement.

The court also held that where no application is submitted to the company by the individual from which the company could be informed about age, the company is not under a duty to search out this data.¹³ This holding should not be thought unreasonable; the insured, after all, was given a certificate which plainly stated that no benefits were to be paid past age 70. Surely the insured as well as the insurer has a duty to be informed about the contents of the policy.

The decision seems on the whole a wise one. It permits the insurer to have sufficient control of risks to justify offering a special premium. The case follows the reasoning of an earlier Tennessee decision¹⁴ and is in accord with holdings in many other states.¹⁵

3. *Service Station Liability Policy*.—The basic coverage provision of the service station liability policy involved in *Hardware Mutual Casualty Co. v. Cox*¹⁶ obligated the insurer to defend against and pay damages awarded in actions against the service station operator for bodily injury and property damage "arising out of the ownership, maintenance or use of the premises for the purpose of an automobile service station, and all operations necessary or incidental thereto; and the use in connection with such operations of customers' automobiles while in charge of the named insured for servicing." There was also an exclusion clause in the policy stating that the policy does not apply

13. If the insurer had such knowledge it should be liable at least for the return of premiums. See VANCE, *INSURANCE* § 93 n.22 (1951).

14. *McLain v. American Glanzstoff Corp.*, 166 Tenn. 1, 57 S.W.2d 554 (1933).

15. See VANCE, *INSURANCE* § 93 n.14 (1951).

16. 340 S.W.2d 263 (Tenn. App. E.S. 1960).

to "the use of the premises for . . . engine or body repair . . . or the use of customers' automobiles in connection with" engine or body repair.

A regular customer of the service station operated by defendant had left her car with the station for installation of a battery and other usual services. While defendant's employees were at work on the vehicle they discovered that its water pump was defective and needed replacement. The customer asked defendant if he would locate a used pump for her. One of the employees of the station thereupon used the customer's car to go to a nearby shop where he thought he might find such an item. While returning to the station, this employee struck and killed a pedestrian. The service station operator is being sued as a result. Insurer brought this declaratory judgment action to determine whether it was obliged to defend; the lower court held for the insured.

The sole issue in the case, therefore, was whether the suit against the service station arose out of its operation as a service station (in which case the insurer would be obliged to defend) or as a repair shop (in which case there would be no duty to defend). This is essentially a factual rather than a purely legal question; the decision of the appellate court is based on a finding that the lower court was reasonable in concluding from the proof that was offered that the defendant's activities were not such that they fell within the exclusion. This proof, according to the court's summary, included testimony to the effect that this was the sort of errand which might customarily be run for customers by a service station. There was no proof that the station had promised to install the pump when located, or that it held itself out to the public as a general repair shop. Since the burden of proof in this action was on the insurer, the court felt that the absence of such a showing was decisive.

While not of great legal import, the case is significant as an illustration of the difficulties that can arise in interpreting and applying exclusion clauses.¹⁷ These difficulties are multiplied when the distinction between covered activities and excepted activities is a fine one—as, for example, the distinction between the activities of a service station and those of a repair shop, both of which are engaged in similar lines of work.

4. *Automobile Liability Policy.—Employee Exclusion.*—In *First National Bank v. South Carolina Insurance Co.*,¹⁸ plaintiff's decedent had been issued a standard automobile liability policy which contained

17. For a discussion of some of the difficulties that can arise with those exclusions which appear in standard automobile policies, see Plummer, *Automobile Policy Exclusions*, 13 VAND. L. REV. 945 (1960).

18. 341 S.W.2d 569 (Tenn. 1960).

the usual exclusion, "This policy does not apply . . . to bodily injury to any employee of the insured arising out of and in the course of . . . employment by the insured" Decedent was killed in an automobile accident which occurred while he was driving. A guest in the car at the time was injured; he sued the decedent's administrator alleging in his declaration that he (the guest) was an employee of decedent. The administrator referred the case to the defendant insurer, telling the company that the allegation that the guest was employed by decedent was untrue. The company nonetheless refused to defend on the ground that the employee exclusion clause applied. The administrator thereupon retained counsel and successfully defended against the guest's action. He now seeks in this suit to have the estate reimbursed for its expenses in this defense.

The supreme court affirmed the decision of the trial court denying relief. The court held that a liability insurer is not obligated to defend in a suit against its insured when the declaration in such suit states facts which would make the case fall within a policy exclusion, even though the insured informs the insurer that the allegation which would forestall coverage is untrue.

A great many other jurisdictions also hold that the declaration in the suit against the insured determines the obligation to defend.¹⁹ The Tenth Circuit Court of Appeals and the courts of Missouri have adopted a variant rule, however. These courts agree that in general the facts alleged in the declaration are controlling, but qualify this rule by adding that the insurer will be obligated to defend whenever actual facts are brought to the attention of the insurer which would require the insurer to defend if alleged.²⁰

One may legitimately ask, it would seem, whether one party's contractual rights should be so absolutely determined by another party's skill in pleading. Complications might well arise, for instance, if an insurer refused to defend on the basis of the allegations of the original declaration, but later would be required to defend when the declaration is amended. Should the insurer then be allowed to replace an attorney whom the insured has retained in the meantime? Should it

19. *E.g.*, *Pennsylvania R.R. v. Travelers Ins. Co.*, 226 F.2d 520 (6th Cir. 1955); *Employers' Liab. Assur. Co. v. Youghioghney & Ohio Coal Co.*, 214 F.2d 418 (8th Cir. 1954); *United States Sanitary Specialties Corp. v. Globe Indem. Co.*, 204 F.2d 774 (7th Cir. 1953); *Hardward Mut. Cas. Co. v. Mason-Moore-Tracy, Inc.*, 194 F.2d 173 (2d Cir. 1952); *Boutwell v. Employers' Liability Assur. Corp.*, 175 F.2d 597 (5th Cir. 1949); *Cametal Corp. v. National Auto. & Cas. Ins. Co.*, 11 Cal. Rptr. 280 (1961); *Bobich v. Oja*, 104 N.W.2d 19 (Minn. 1960); *Hersey v. Maryland Cas. Co.*, 102 N.H. 541, 162 A.2d 160 (1960); *Commercial Ins. Co. v. Papandrea*, 121 Vt. 386, 159 A.2d 333 (1960).

20. See *Albuquerque Gravel Prods. Co. v. American Employers Ins. Co.*, 282 F.2d 18 (10th Cir. 1960); *American Motorists Ins. Co. v. Southwestern Greyhound Lines, Inc.*, 283 F.2d 648 (10th Cir. 1960); *Marshall's U.S. Auto Supply v. Maryland Cas. Co.*, 354 Mo. 455, 189 S.W.2d 529 (1945).

be allowed to dictate a change in trial strategy?

On the other hand, if an insured is allowed to question the truth of the allegations of the declaration on such matters, might not insurers find themselves confronted with the unpleasant task of investigating a large number of cases in which coverage seems questionable?

Because of these and other opposing considerations, it is submitted that only the passage of time will permit a fair assessment of the wisdom of the rule set forth in this decision. One must wonder, however, if this holding has not placed the insured in an unfortunate bargaining position both with the insurer and with the injured party, on whose declaration he must rely when he seeks to persuade the insurer to defend under the policy.

C. Good Health as a Condition Precedent

Closely allied to exclusions are conditions precedent. The language of the two types of clauses is similar; the end effect is likewise similar—if the clause is applicable, there is no coverage in the individual case. In theory, however, the two are quite different. If a given fact situation falls within an exclusion, there is no coverage for the particular case but the policy remains alive. If the facts reveal that a condition precedent has not been met, however, the policy itself is without vitality; no coverage has ever attached.

In *Life & Casualty Insurance Co. v. Jackson*²¹ it was held that the policy never came to life, because a condition precedent was not met; one must read the lengthy opinion in this case with some caution, however, lest he suppose that the holding is based on another finding—that the insured was guilty of fraud in his application.

In April 1957, two industrial life policies were issued to James Jackson without medical examination. The applications contained a number of questions concerning Jackson's medical history. The answers which he gave indicated that he was then in good health. The policies issued to him did not contain suicide clauses, but did state that: "Within two years from the date of issue . . . the liability of the Company . . . shall be limited to the return of premiums if the Insured was not in sound health on the date of issuance . . ." In May 1958, Jackson shot himself. His widow applied for benefits under the policy. The insurer refused to pay and filed this suit for rescission of the policies on two grounds: (1) that in his applications the insured had materially misrepresented the state of his health; (2) that at the time the policy was issued, insured was not in sound health. The beneficiary answered and filed a cross-claim, alleging that insured was in good health at the time of issuance and that even if this were not so,

21. 342 S.W.2d 720 (Tenn. App. W.S. 1960).

the insurer had by its careless conduct waived any right to challenge the policy.

The insurer offered proof showing that insured had consulted a number of doctors for treatment of epilepsy both before and after applying for the policies in dispute. One of these doctors testified that he had first seen the insured on March 19, 1957, approximately a month prior to the issuance of the policies, and that the tests made at that time showed that the insured was probably epileptic. The defense countered with testimony by the widow and close friends that they had no reason to believe that the insured was in bad health at the time.

While this evidence indicates that the court could have rescinded the policies because of fraudulent misrepresentations, neither the chancellor nor the court of appeals for the western section chose to follow this route.²² Instead the courts relied on this rule: "Industrial life insurance policies issued without medical examination, which provide for no obligation other than the return of premiums received, unless the applicant insured thereby is in sound health on date of issue, are enforceable."²³ Applying the rule to this case, the court concluded that the evidence strongly supported the trial court's conclusion that the insured had suffered from epilepsy at the time the policies were issued, and that therefore there was no coverage under them.

The court also held for the insurer on the issue of waiver. The testimony recounted in the opinion indicated that the insurer's agents met with the insured, asked him the questions on the application blank which they filled in for him, had him sign the application which was filled in in this manner, and also had him sign another application in blank, on which they later filled in the same answers. The defense claimed that this procedure—whereby the second application was not filled in by the insured or in his presence—was so slipshod that the insurer should be held to have waived any fraud on the part of the insured and any non-fulfillment of the condition of good health. The court disposed of this contention by pointing out that the proof offered by the defense in no way tended to disprove the insurer's showing that it had no knowledge that the insured was not in good health; this was especially true since the insured had answered the application form questions in such a way as to indicate that he was in the best of health. Without knowledge of insured's poor health, the company could not waive the condition.²⁴

22. "[T]he determination of fraud was pretermitted by the learned Chancellor for the reasons stated in his Opinion as herein shown, and it is likewise pretermitted by this Court." 342 S.W.2d at 729.

23. 342 S.W.2d at 29.

24. 342 S.W.2d at 731.

The decision would seem to be clearly correct. It is in accord with reputable authority²⁵ and with previous Tennessee decisions.²⁶

III. SERVICING THE CONTRACT

A. Change of Beneficiary

*Mutual Savings Life Insurance Co. v. Cowan*²⁷ called for a decision as to who was the beneficiary under a life insurance policy when the insured had attempted to change the beneficiary but had been unable to comply with all technical requirements for change provided for by the policy.

The insured in the case was an army sergeant. Unmarried at the time the policy was issued, he named his mother as beneficiary. Insured subsequently married, and a few months after his wedding was sent to a new post in Germany. On June 7, 1959, he contacted an agent of the insurer in Germany, advising him that the sergeant wished to change his policy so that his bride would be the beneficiary. The policy provided that the insured could make such a change by filing a written request on a form to be provided by the company and then returning the policy to the company for indorsement. The agent of the insurer in Germany did not have the proper forms, so the insured simply gave him the policy to be relayed to the insurer for indorsement and asked the agent to procure the necessary application forms. The agent was slow in making this request, and the company's main office was slow in relaying the forms to him; they did not arrive in Germany until July 10, 1959. In the meantime, insured had been seriously injured in an accident which occurred on June 9; he died as a result of this injury on June 25.

In this case, the insurer has interpleaded the mother, the named beneficiary, and the widow, whom insured apparently intended to make his new beneficiary, asking the court to determine to whom the proceeds of the policy should be paid. The court held for the widow. In its opinion, eight Tennessee cases on the subject of changing beneficiaries are analyzed; from this analysis the court concluded that this state is committed to the view that if an insured has done all that he can to effect a change of beneficiary but does not comply with all formal requirements through no fault of his own, but because of the insurer's dereliction, the change will be considered effective. This

25. See e.g., 12 APPLEMAN, INSURANCE LAW AND PRACTICE § 7352 (1943); PATTERSON, ESSENTIALS OF INSURANCE LAW § 19 (1957).

26. DeFord v. National Life & Acc. Ins. Co., 182 Tenn. 255, 185 S.W.2d 617 (1945); National Life & Acc. Ins. Co. v. Lewis, 19 Tenn. App. 459, 89 S.W.2d 898 (M.S. 1935).

27. 188 F. Supp. 148 (E.D. Tenn. 1960).

"substantial compliance" doctrine follows from applying the equity maxim: "Equity regards as done that which ought to be done."²⁸

In this instance, the court concluded that the insured had done as much to bring about a change of beneficiary as was feasible. It was the failure of the insurer to equip its agents with proper forms coupled with the tardiness of agent and company in supplying the forms that caused the insured not to observe the formalities.²⁹ Insured's intention to change the beneficiary was felt to have been clearly shown, even though there was no writing to this effect signed by him.³⁰ Therefore the wife of the insured was held to be entitled to the benefits.

The holding is clearly right; it is in line with the great majority of recent American cases.³¹

B. Effect of Statute of Limitations on Liability to Third Parties

What is the proper statute of limitations to apply between a liability insurer and an injured party who has obtained judgment against the insured? In the case of *Melloan v. Southern Fire and Casualty Co.*³² plaintiff had obtained a judgment against the defendant's insured in 1952, but did not seek to obtain payment from the insurer until 1959. The insurer refused to pay, relying on the six-year statute of limitations for contracts.³³ Plaintiff has prosecuted this suit on the ground that the ten-year statute of limitations for judgments should be applied.

The Supreme Court of Tennessee affirmed the holding of the chancellor in favor of the insurer, ruling that the contracts statute of limitations was that which should be applied. There would seem to be nothing inherently wrong in this decision; it is in keeping with Tennessee's rather strict third-party beneficiary interpretation of liability insurance.³⁴ However, one must quarrel to some extent with

28. 188 F. Supp. at 150. The court's review of the previous decisions is excellent and should serve as a practical aid to attorneys with problems in this area.

29. 188 F. Supp. at 152.

30. 188 F. Supp. at 153. The doctrine of substantial compliance should not be applied unless there is convincing proof that the intent of the party to change the policy was fixed. A writing would doubtless be the best evidence. A delivery of the policy to an agent of the company, as in this case, would seem sufficient in most cases.

31. See 2 APPLEMAN, *INSURANCE LAW AND PRACTICE* 365 n.48 (1941); PATTERSON, *ESSENTIALS OF INSURANCE LAW* § 50, at 217 (1957); VANCE, *INSURANCE* § 109(c) (1951).

32. 337 S.W.2d 452 (Tenn. 1960).

33. TENN. CODE ANN. § 28-309 (1956): "[A]ctions on contracts not otherwise expressly provided for, shall be commenced within six (6) years after the cause of action accrued." The problem of the precise date at which this cause of action accrued was not discussed.

34. For illustrations of the third-party beneficiary approach, see *Hartford Acc. & Indem. Co. v. Partridge*, 183 Tenn. 310, 192 S.W.2d 701 (1946) (the rights of the injured party held "derivative, rising no higher than those of

the court's use of authority. For instance, the court quotes from volume 53 of *Corpus Juris Secundum* section 44—"as a general rule statutes of limitations applicable to contracts govern actions on insurance policies"—but does not mention that the footnotes to this section list among the exceptions to this general rule "injured person's action on indemnity policy." Similarly the court quotes from Blashfield, *Cyclopedia of Automobile Law* section 4112.65 to the same effect, without noting that in the same section there appears the statement: "It has been held that, for the purpose of determining the applicability of statutes of limitations, an action by the injured person against a liability insurer is basically a tort action." This failure on the part of the court to treat its authority more critically does not mean that it reaches a wrong decision; it is unfortunate more because it may mislead the practitioner who is given an incomplete picture of the status of authority in other states.

C. Duty To Settle

*Tennessee Farmers Mutual Insurance Co. v. Wood*³⁵ was an action by an insured to recover amounts paid by him on a judgment obtained against him in a suit by an injured party. Plaintiff claimed that the defendant insurer acted in bad faith by not settling within policy limits when it could have done so, thereby forcing the case to trial in which a judgment in excess of limits was rendered against plaintiff. The company contended that it acted in good faith and that plaintiff had so misrepresented the facts to the company prior to the trial of the damage suit that the insurer's task of defense was made impossible. The trial court overruled defendant's motion for a directed verdict, and the jury returned a judgment against the insurer. The Court of Appeals for the Sixth Circuit upheld the decision on two grounds: *First*, that the facts presented in the trial court were such that reasonable men could differ on whether or not the insurer acted in good faith; *Second*, that in all events the insurer waived the defense of non-coverage because of breach of the duty to cooperate since it defended the suit and paid up to the policy limit without giving any notice of disclaimer.

Judge Weick dissented, arguing that the conduct of the insured in this case had been so inconsistent and so confusing to the insurer that the company was entitled to a directed verdict, since it could reasonably have felt that on the basis of certain of insured's statements a jury might have found no liability in the damage suit. The dissenting

the named insured"); *Horton v. Employers' Liab. Assur. Corp.*, 179 Tenn. 220, 164 S.W.2d 1016 (1942) (violation by insured of cooperation clause held available as defense to action by third party).

35. 277 F.2d 21 (6th Cir. 1960).

opinion did not reach the waiver point.

On the matter of waiver, the court made two interesting statements:

(1) "If an automobile liability insurer assumes and conducts the defense of an action brought against the insured, with knowledge of facts taking the accident or injury outside the coverage of the policy, without disclaiming liability or giving notice of a reservation of its right to deny coverage, such insurer is thereafter precluded in an action upon the policy from setting up the defense of noncoverage."

(2) "Where an insurer, with knowledge of the breach of a condition, pays the amount of a loss into court on an interpleader, or pays, or partially pays, any loss under the policy, it recognizes the policy as still in existence and must be considered to have waived its defense of a claimed breach."³⁶

While the court cited no Tennessee cases in support of either proposition, there is some precedent for at least the second statement.³⁷ Attorneys in the state should take care to explain this doctrine so that insurers will be aware of the possible consequences of their acts in regard to payment.

³⁶ *Id.* at 37.

³⁷ *Deming v. Merchants' Cotton-Press & Storage Co.*, 90 Tenn. 306, 17 S.W. 89 (1891).