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Insurance -- 1960 Tennessee Survey

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INSURANCE—1960 TENNESSEE SURVEY

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I. INTERESTS PROTECTED

A. Property and Liability Insurance

There were no cases during the survey period involving questions of the nature or measurement of interests protected by property or liability insurance.

B. Life and Disability Insurance

1. *Insurable Interest.*—In *Volunteer State Life Ins. Co. v. Pioneer Bank*[1] the court held that a person who stood in loco parentis to a minor, and who had agreed to take custody of the child and provide it a home pending a decision regarding adoption, had an insurable interest in the child's life. This holding is based on a dictum in an earlier Tennessee case[2] and has support in the few cases which have passed on the question.[3] Although the consent of the person whose life is being insured is usually necessary for a valid contract of insurance procured by another,[4] the court here applied the sensible rule (adopted by statute in some states[5]) that consent is not necessary

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1. 327 S.W.2d 59 (Tenn. App. E.S. 1959).
2. Merriam v. National Life & Acc. Ins. Co., 169 Tenn. 291, 86 S.W.2d 566 (1935). The statement is dictum in the case since the insured himself procured the policy and thus no question of insurable interest existed.
3. See, *e.g.*, Thomas v. National Benefit Asc., 84 N.J.L. 281, 86 Atl. 375 (1913); Carpenter v. United States Life Ins. Co., 161 Pa. 9, 28 Atl. 943 (1894); 29 AM. JUR. *Insurance* § 480 (1960); 44 C.J.S. *Insurance* § 207 (1945); 25 A.L.R. 1547, 1548 (1923).
4. See Bransoni v. National Life & Acc. Ins. Co., 4 Tenn. App. 576 (W.S. 1927); Interstate Life & Acc. Co. v. Cook, 19 Tenn. App. 290, 86 S.W.2d 887 (E.S. 1935).
5. See, *e.g.*, LA. REV. STAT. § 22:616 (1959); N.Y. INS. LAW § 146 3 (b); UTAH CODE ANN. § 31-19-5 (Supp. 1953); VA. CODE ANN. § 38.1-330 (Supp. 1953).

where a parent insures an infant incapable of giving consent.

2. *Interest of the Beneficiary.*—Two aspects of the *Pioneer Bank* case need further comment. The beneficiary was also the owner of the policy, having procured the policy, having paid all the premiums and alone having the right to direct disposition of the proceeds. In addition, the person entitled to the proceeds was an assignee of the beneficiary—an organization which itself had no insurable interest in the infant's life. The court had no difficulty holding that a policy validly issued to one with an insurable interest could be transferred to an assignee without insurable interest so long as the whole transaction was in good faith and not an attempt to avoid the insurable interest rule. This is now the settled rule in a majority of jurisdictions[6] including Tennessee[7] and provides a sound yet flexible basis for resolving these disputes.[8] In a case such as this, allowing the assignee to recover accords to the owner-beneficiary power over the disposition of the proceeds which is consistent with his ownership status.

Not all owner-beneficiaries fare so well. In *Grossman v. Prudential Ins. Co. of America*[9] the insured had provided by several endorsements to the policy that the beneficiary (the insured's wife) was to receive the proceeds in installments for 20 years, remainder in case of her earlier death to go in lump sum to her children. On the day the last endorsement was made, the insured also had a rider attached transferring "all incidents of ownership and control" of the policy, "including any and all benefits, values, rights, options and privileges" to the beneficiary. On the death of the insured husband, the wife requested that the insurer pay her the proceeds in a lump sum. She was joined in her request by all other interested parties and contended that as sole owner of the policy she could decide the mode of payment. On the insurer's refusal to make a lump sum payment, the wife brought suit. The court held that although the transfer of ownership gave the wife the right to change the contract to provide for lump sum payment, such change must necessarily be made before the death of the named insured. On his death, the court reasoned, all rights under the contract became irrevocably vested and were not subject to change.

The application of this well established proposition to the instant

6. See Annot., 30 A.L.R.2d 1313 (1953). *Compare* Grigsby v. Russell, 222 U.S. 149 (1911) *with* Warnock v. Davis, 104 U.S. 775 (1881).
7. Hammers v. Prudential Life Ins. Co. of America, 188 Tenn. 6, 216 S.W.2d 703 (1948); Clement v. Insurance Co., 101 Tenn. 22, 46 S.W.2d 561 (1898).
8. For a discussion of the minority view that there can be no assignment to an assignee without an insurable interest, see PATTERSON, ESSENTIALS OF INSURANCE LAW § 41 (2d ed. 1957).
9. 325 S.W.2d 811 (M.S. Tenn. 1959).

case deserves close attention. Appended in the note[10] are two typical authorities upon which the court relies. In the usual case, finalizing all rights under the contract on the death of the insured is a way of preventing the frustration of the insured's desires by acts of his representatives[11] or by the insurer.[12] It is a device for insuring that the person entitled to direct disposition of the proceeds, usually the insured, is in fact able to exercise that privilege, free from subsequent interference by others. Stated this way, it should be apparent that the insured's rights in this regard derive from his status as "owner" (the person entitled to direct disposition of the proceeds) and not from the fact that it is his life which is insured. It would seem to follow that when the insured has fully terminated his status as "owner," and the new owner requests a modification of the contract, the rule applied is irrelevant. Observe that in both statements of the rule quoted in note 10, *supra,* the author assumes that the insured *has* reserved some right or power over the proceeds and thus retains ownership status. Absent such status, when the insured's death has matured the contract, the company's obligation is a simple agreement with the owner-beneficiary to pay her the proceeds. The terms of the agreement here happen to call for installment payments, but there is no reason to treat this as different from any other contract—alterable by the interested parties when they so choose.

To be sure, if the company had an interest in the mode of payment, it would be entitled to stand on its contract. But in this case the company concedes (in its brief, p. 10) that "so far as the Prudential is concerned, the question presented in this case is academic. . . . The Prudential stands to win or lose nothing, monetarily, however the case is decided, because the settlement under the monthly payment plan is the actuarial equivalent of the lump sum value at date of death."

If neither the company nor the owner-beneficiary were interested in the mode of payment specified by the contract, it must be concluded that the only obstacle to the modification of the contract was the

10. "Whatever may be the variant opinions and different descriptions of the beneficiary's interest during the lifetime of the insured, it is everywhere held that the insured's reserved power to extinguish the beneficiary's interest ceases at his death, and cannot be exercised by his personal representatives or assignees. The beneficiary's rights then become completely fixed." VANCE, INSURANCE 680 (3d ed. 1951).

"And, although an insured has reserved the right to change the beneficiary, if he does not do so, either in fact or in legal effect, such right does not survive; rather, the rights of the named beneficiary vest at the instant of the insured's death, and cannot be affected by any subsequent act of the insurer." 2 COUCH, INSURANCE 828 (1929).

11. This seems the thrust of the rule quoted from VANCE, *op. cit. supra* note 10.

12. This seems the purpose of the rule quoted from COUCH, *op. cit. supra* note 10.

court's solicitude for the intent of the insured—an insured who voluntarily divested himself of all control over the policy. This paradox, toward the end of the opinion, issues in a flat contradiction. On the one hand the court denies "authority to order the company to pay in a lump sum contrary to the specific provisions of the policy"—presumably out of respect for some manner of "vested" rights of the insured. At the same time the court said "the company would be fully justified in acceding to [the beneficiary's] request in making a lump sum settlement rather than insisting as it does upon the strict terms of the beneficiary provision"—a recommendation[13] which necessarily involves the conclusion that the insured has no rights whatsoever. An opinion in this form makes a doubtful precedent.

Nor do the practical consequences of this decision justify the logic of the opinion. In divesting himself of all control over the policy, the insured was no doubt seeking to minimize estate taxes by preventing the inclusion of these proceeds in his gross estate.[14] Should he at the same time have intended to retain "informal control" over the disposition of these proceeds (by any means available for maintaining "informal control" over the beneficiary), this kind of decision would guarantee the continuing efficacy of that control and therefore the success of the entire plan. Thus by refusing to allow a wife to exercise her lawful choice when she is free of the control of her husband (and perhaps learns for the first time that she has a choice[15]) a court may find itself acting as a necessary agent in a duplicitous scheme of tax avoidance.

II. SELECTION AND CONTROL OF RISKS

A. Defining the Insured Event

One of the most delicate problems in insurance underwriting is that of describing the events whose occurrence is the primary con-

13. The company did not accept the court's suggestion and insisted on payment in installments.

14. That this was the tactical problem is conceded in the company's brief on appeal (p. 10).

15. This perhaps not uncommon device for maintaining informal control proved unsuccessful in Tyre v. Aetna Life Ins. Co., 353 P.2d 725 (Cal. 1960) where the court reversed a lower court decision and allowed the wife to receive one half the face amount of the policy in lump sum as her community property election, although the insurance contract had been modified by the insured husband to provide for installment payments. The court was not overly bothered by the contract. "[A]lthough the payment of the insurance proceeds is a matter of contract between the insured and the insurer, the insured's exercise of his unilateral right under the contract to select the beneficiary is testamentary in character . . . . [and] he cannot defeat her interest by making a testamentary gift to her under conditions that restrict her management and control of the property." 353 P.2d at 729. In this case, the husband had made no transfer of ownership of the policy as in the *Grossman* case; the wife's rights were a result of the community property law.

dition of the insurer's obligation to pay. Several interesting cases were decided during the survey period involving disputes over whether or not an insured event had occurred.[16]

In *Britton v. Prudential Ins. Co. of America*[17] the supreme court was faced with the complex problem of determining liability for accidental death under the double indemnity provision of a life insurance policy where the accidental death was in part caused by pre-existing disease. The policy provided for accidental death benefits where the death occurred "as a result, directly and independently of all other causes, of bodily injury, effected solely through . . . accidental means," and further, that no benefits were payable if the death resulted "directly or indirectly from bodily or mental infirmity or disease in any form." The 70-year-old insured suffered a broken hip in a fall and died shortly after undergoing an operation to reduce the fracture. The cause of death was certified as "acute coronary thrombosis." The medical testimony made it clear that (1) but for the fall the insured's arteriosclerosis (normal hardening of the arteries) would not have resulted in his death, and that (2) but for the arteriosclerosis, the fall and resulting operation would not have resulted in death. Did an insured event (death from bodily injury not caused directly or indirectly by disease) occur?

The cases grappling with this difficult problem are numerous.[18] General principles with real meaning are virtually absent, both because policy forms defining this event vary materially and because no two sets of facts present the same degree of relationship between the disease, the injury and the death. Where the accidental injury itself produces a disease (*e.g.*, gangrene following an injury) the settled

16. In addition to the cases discussed in the text, several others involved the determination of whether or not an insured event occurred. In Throneberry v. Resolute Ins. Co., 332 S.W.2d 227 (Tenn. 1960) it was held that where an insured automobile was damaged when an escaping convict forced the insured to drive it to another state, there was a "larceny" with policy coverage for "theft or larceny." The company's odd contention that this was robbery (which necessarily includes larceny) rather than larceny was rejected by the court. For further discussion of this case, see Kendrick, *Criminal Law—1960 Tennessee Survey*, 13 VAND. L. REV. 1065 (1960). In Lowe v. Caledonian-American Ins. Co., 324 S.W.2d 420 (Tenn. App. M.S. 1959) the court held that testimony that a cracked wall had been standing in that condition 16 or 17 years, coupled with evidence of storm and wind conditions in the vicinity at or near the time the wall collapsed, warranted finding by trial court that damage to wall was caused by windstorm and not inherent vice.

In Zarzour v. Southern Life Ins. Co., 333 S.W.2d 14 (Tenn. App. E.S. 1959) it was held that an insurer owes no "affirmative duty to inquire whether an applicant [for group life insurance] falls within an excluded class." The insurer thus was not estopped from denying coverage under policy issued to 73-year-old insured and providing for termination when insured reached seventy years of age.

17. 330 S.W.2d 326 (Tenn. 1959).

18. See the extensive annotation in 131 A.L.R. 240 (1941).

rule appears to allow recovery.[19] It also seems clear that where the accident alone would have produced death, the existence of a disease will not preclude recovery.[20] But when the disease antedates the injury and combines with it in some degree to produce the loss, the authorities are very much divided. An apt summary was made by a federal court of appeals:

> The slight weight of authority holds that as a matter of law where the accident aggravates the disease, or the disease aggravates the consequences of the accident, there can be no recovery. Under this view there could be a recovery, where the disease contributes to the injury or death, only if the accidental means is so violent or far reaching that it would have brought about the same result as a natural consequence, without the aid of the disease, but possibly at a later time. A directly contrary view is expressed by those cases permitting recovery as a matter of law on a showing that the disease alone would not have caused the result at the time it did occur, although the result of death is hastened thereby. Some courts refuse to follow either of these extremes but take a middle position. They borrow from the law of negligence and leave it to the jury to decide whether the disease or the accident is the proximate cause of injury or death. In so doing they sprinkle their opinions freely with such participles and adjectives as producing, predominating, efficient, passive and remote.[21]

A verbal formula often used in the Tennessee cases has been "actively contributed." If the disease "actively contributed" to the death, there can be no recovery.[22] The difficulty comes in determining what constitutes an active contribution. A clear case was *Wheelock v. Provident Life & Accident Ins. Co.*[23] where the insured was suffering from an advanced cancerous condition which so weakened him as to lead the court to presume that it caused his fall. The injury from the fall aggravated the pre-existing condition and resulted in the insured's death. The court affirmed a directed verdict for the insurer. But in *Provident Life & Accident Ins. Co. v. Campbell*,[24] the "disease" was, as in the instant case, only a normal hardening of the arteries. A severe shock caused by the death of another combining with the arteriosclerosis resulted in a cerebral hemorrhage—a consequence

19. See cases cited in 29A AM. JUR. *Insurance* § 1213 (1960); 45 C.J.S. *Insurance* 813-14 (1946); VANCE, INSURANCE § 188 (3d ed. 1951). Conversely, where the disease produces the accident there will probably be no recovery. See Wheelock v. Provident Life & Acc. Ins. Co., *infra* note 22.

20. Provident Life & Acc. Ins. Co. v. Ivy, 18 Tenn. App. 106, 73 S.W.2d 706 (1934).

21. Aetna Life Ins. Co. v. Young, 103 F.2d 839, 841 (3d Cir. 1939). For an excellent statement of the problem and a realistic appraisal of the authorities, see Note, *Pre-existing Disease and Accident Insurance: Pathology and Metaphysics in the Common Speech of Men*, 21 U. CHI. L. REV. 266 (1954).

22. Wheelock v. Provident Life & Acc. Ins. Co., 10 Tenn. App. 184 (E.S. 1929); Provident Life & Acc. Ins. Co. v. Campbell, 18 Tenn. App. 452, 79 S.W.2d 292 (E.S. 1934).

23. Wheelock v. Provident Life & Acc. Ins. Co., *supra* note 22.

24. Provident Life & Acc. Ins. Co. v. Campbell, *supra* note 22.

that would not have followed from the shock alone. Still, the court reversed a jury verdict for the beneficiary and dismissed the complaint on the ground that the arteriosclerosis "actively contributed" to the death. A more lenient view was recently taken in *North American Ins. Co. v. Ellison*[25] where the 72-year-old insured was suffering from "a number of chronic organic diseases including impaired kidney function, hardening of the arteries, an enlarged heart and bronchitis. . . ." A fall resulting in a broken ankle required that the insured remain in bed. She died within two weeks. Summarizing the medical testimony, the court said that "while the chronic conditions and diseases with which insured was suffering did not cause death and were entirely compatible with life, the cumulative effect of the heart, lungs and kidneys being unable to function properly made it impossible for insured to survive confinement in bed." Despite what would appear to be the "active contribution" of these diseases, the court allowed the jury to find that the "disease and age merely furnished a condition causing death to follow from a chain of events set in motion by the accident." The court said that where a physical infirmity merely lowers resistance to the effects of an injury, the death may still be caused "independently of all other causes" by the injury. The court suggested, too, that perhaps these cases could be better decided by the jury, noting that it was "hardly . . . the function of the court to say as a matter of law when old age and not the effects of an accident becomes the predominant cause of disability or death."

The court in the instant case, however, relied on the strict view of the *Campbell* case and directed a verdict for the insurer. Indeed, the court seemed to go beyond *Campbell,* for in its conclusion "active contribution" becomes mere "cooperation." If, "at the time of the accident . . . there was an existing disease which, cooperating with the accident and resulting in . . . death . . . the accident cannot be considered as the sole cause of the death or as a cause independent of all other causes."

Three automobile cases presented difficult construction problems regarding the physical relationship of the insured to the vehicle. In *Bowlin v. State Farm Mutual Automobile Ins. Co.*[26] the court held that an injury sustained by the insured while pushing his stalled vehicle was not an injury incurred while "in or upon" the automobile. Considering the phrase unambiguous and thus construing "upon" in its ordinary literal sense, the court did not think a man pushing a vehicle could be considered "upon" it.

The difficulty with this literal interpretation of the word "upon"

25. North America Ins. Co. v. Ellison, 37 Tenn. App. 546, 267 S.W.2d 115 (E.S. 1954).
26. 327 S.W.2d 66 (Tenn. App. E.S. 1959).

is neatly stated by a New York court:

> An examination of the word "upon" in the particular context in which it is found indicates its meaning is related to the idea of use of the automobile. . . . Can it be said that the insurer attached to the word "upon" a meaning so narrow as to encompass only such cases in which the entire weight of a person's body was resting upon or supported by the vehicle? Considering the usual positions of a person in relation to a car in use and the fact that other enumerated risks include acts of being upon the automobile in the sense of resting upon or being supported by it, it is reasonable to give the term a broader meaning including some acts in which the person is in contact with the car.[27]

Virtually all the decided cases follow this broader use of the term "upon."[28] Thus, an insured has been held to have been "upon" the vehicle when he was grasping the taillight in one hand and the license plate in the other to prevent the car from rolling away;[29] or placing a flat tire in the trunk of the automobile;[30] or kneeling by the vehicle taking off or putting on the wheel;[31] or tying on a bumper which had fallen off;[32] or closing the hood of the vehicle.[33] Indeed, even beyond these cases which interpret "upon" to mean "in contact with" are some decisions not even requiring contact in this sense.[34] The Tennessee decision finds its sole support in a Missouri case decided in 1918, holding that an insured is not "in or on" a vehicle when he is cranking it.[35]

If a man pushing an automobile is not "upon" it, is a man attempting to apply the emergency brake from the running board of a vehicle "driving or riding" in the vehicle? The insurer in *Inter Ocean Ins. Co. v. Norris*[36] contended that he was not, and cited an earlier

27. Lokos v. New Amsterdam Cas. Co., 93 N.Y.S.2d 825, 826 (1959).

28. In Henderson v. Hawkeye Sec. Ins. Co., 103 N.W.2d 89 (Iowa 1960) the court allowed recovery under this clause to an insured who was closing the hood of the vehicle when struck. The court observed that "by the clear weight of authority actual physical contact with the automobile, when shown, is sufficient to entitle one to recover. It is the rule generally recognized that such words as 'while in or upon' in an insurance policy of this nature require a broad and liberal construction." *Id.* at 92.

29. Sherman v. New York Cas. Co., 78 R.I. 393, 82 A.2d 839 (1951).

30. Madden v. Farm Bureau Mut. Auto. Ins. Co., 82 Ohio App. 111, 79 N.E.2d 586 (1948).

31. Christoffer v. Hartford Acc. & Indem. Co., 123 Cal. App. 2d 979, 267 P.2d 887 (1954).

32. Lokos v. New Amsterdam Cas. Co., *supra* note 27.

33. Henderson v. Hawkeye Sec. Ins. Co., 103 N.W.2d 89 (Iowa 1960).

34. Katz v. Ocean Acc. & Guarantee Corp., 112 N.Y.S.2d 737 (1952) (insured alighted from car and ran to rear where she was crushed between her car and one parked behind it); Wolf v. American Cas. Co., 2 Ill. App. 2d 124, 118 N.E.2d 777 (1954) (insured returning to his car and two or three feet from it struck when another car knocked his car into him). *Contra:* Green v. Farm Bureau Mut. Auto. Ins. Co., 139 W. Va. 475, 80 S.E.2d 424 (1954) (car fell on insured when he turned to grasp wooden block).

35. Turner v. Fidelity & Cas. Co., 274 Mo. 260, 202 S.W. 1078 (1918). See Annot., 39 A.L.R.2d 952 (1955).

36. 326 S.W.2d 437 (Tenn. 1959).

Tennessee case[37] to the effect that one riding on a running board was not "actually riding" in the vehicle. While the court thought the policy in the instant case was broader—the word "actually" not appearing—its decision for the insured did not rest on that distinction. The court found that the insured was "driving" the vehicle when, from whatever location, he was attempting to operate the controls.

The third case, *American Casualty Co. v. Cutshall*,[38] raises the question of whether the driver of a motorcycle has been "struck by an automobile" when his machine collides with an automobile throwing him over the hood of the car and onto the pavement. The insurer contended that actual personal contact with the automobile was necessary and established that the motorcycle driver at no time actually touched the automobile.

In support of this position are cases like *Johnson v. Maryland Casualty Co.*[39] (holding that a truck driver is not "struck by an automobile" when his truck collides with a passenger car, absent the driver's personal contact with the passenger vehicle) and *Harley v. Life & Casualty Ins. Co.*[40] (holding that one struck by a nut which had become detached from the wheel of a passing automobile was not "struck by an automobile"). The court, however, followed the Tennessee case of *Maness v. Life & Casualty Ins. Co.*[41] which allowed recovery where the insured was struck by a rock thrown by a passing vehicle. In holding that actual contact with the vehicle was not necessary to constitute being "struck," the court in the instant case said, "it is logical to conclude that what the parties had in mind was insurance against injuries inflicted by a blow in which the automobile participated."[42] The possible breadth of "participation" as a standard will no doubt be diligently explored by plaintiffs' counsel in the future. In can be expected that limits will be gradually developed on a case by case basis.

The issue presented by *Slomovic v. Tennessee Hospital Service Ass'n*,[43] decided in 1958 and discussed in last year's survey,[44] received further attention from the Tennessee courts during the present survey period. In *Slomovic*, the insured sought to recover from a hospital service insurer medical expenses incurred in excess of the amounts received for the same injury from his employer's workmen's compensation carrier. The hospital service contract, however,

37. New Amsterdam Cas. Co. v. Rust, 164 Tenn. 22, 46 S.W.2d 70 (1932).
38. 326 S.W.2d 443 (Tenn. 1959).
39. 22 Wash. 2d 305, 155 P.2d 806 (1945).
40. 40 Ga. App. 171, 149 S.E. 76 (1929).
41. 161 Tenn. 41, 28 S.W.2d 339 (1930).
42. 326 S.W. at 445.
43. 313 S.W.2d 265 (Tenn. 1958).
44. Andersen, *Insurance—1959 Tennessee Survey*, 12 VAND. L. REV. 1213 (1959).

provided no benefits for injuries "for which the subscriber . . . receives any award or any settlement in any proceeding under Workmen's Compensation laws. . . ." Thinking this exclusion clearly barred plaintiff's claim, the insurer demurred to the complaint. The chancellor overruled the demurrer and, on a discretionary appeal, the supreme court affirmed. The high court considered the exclusion ambiguous when coupled with the averment of plaintiff's bill ("admitted" by the demurrer) that the contract provided coverage for expenses in excess of the compensation award. On remand, the chancellor, following the opinion of the supreme court, treated the exclusion as ambiguous, construed it as not preventing recovery for expenses in excess of the compensation payments, and awarded plaintiff $390.94.

On appeal to the court of appeals, however, the decision was reversed and the bill dismissed.[45] Unable to find any ambiguity in the exclusion, the court of appeals flatly observed:

> We think this exclusion clause is not ambiguous. It clearly excludes from the policy's coverage hospital benefits for *injuries* or *diseases* for which the insured is entitled to "*any* hospital care or for which he receives *any* award or settlement in any proceeding under Workmen's Compensation laws." That is, it excludes benefits for *injuries* covered by the Workmen's Compensation Law, even though the benefits claimed are in excess of those provided by that law.[46]

In spite of the attempt to accommodate the supreme court's opinion in the first *Slomovic case*,[47] it seems clear that the dominant implication of that case has been discarded by the court of appeals. The supreme court denied certiorari.

The problem came up in slightly different form in *State Farm Mutual Automobile Ins. Co. v. Rice*,[48] where the supreme court held that a claimant under the medical payments coverage of an automobile liability policy was barred by a workmen's compensation exclusion even though claimant had not in fact received any compensation payments. The policy excluded injuries "if benefits therefor are in whole or in part either payable or required to be provided under any workmen's compensation law." Finding no ambiguity in the exclusion, the court held that it would prevent recovery

45. Slomovic v. Tennessee Hosp. Serv. Ass'n, 333 S.W.2d 564 (Tenn. App. M.S. 1959).
46. *Id.* at 566-67.
47. Judge (now Justice) Felts held that there was no longer ambiguity in the exclusion because the averment in the plaintiff's original bill as to excess coverage "was denied by the answer, and shown by the proof to be untrue. The proof showed that . . . [the policy] contained no such provision as that averred in the bill." Since the original bill did not contain the entire policy (only the exclusion clause) the supreme court, in Judge Felts' view, could quite properly have considered the exclusion ambiguous.
48. 326 S.W.2d 490 (Tenn. 1959).

even though the claimant was unable to collect the workmen's compensation award due to the wrongful act of his employer-insurer. Since under the Tennessee statute compensation payments in this case were "required to be provided," the court said the claim fell "strictly within the language of this exclusionary clause" whatever the actual status of claimant's compensation award.[49]

B. Other Risk Control Techniques

Having defined the insured event, an insurer may wish to still further limit the risk. One possible method is by the use of warranties—provisions making the policy voidable upon the happening of certain conditions considered to be potential causes of the insured event. A modern variation of the warranty is the suspensive condition or "while" clause, which suspends coverage during the existence of the named condition.

In *Foote Mineral Co. v. Maryland Casualty Co.*,[50] the policy covering loss to an industrial generator provided that there was no coverage while the generator was not "in use or connected ready for use." Nor was there coverage while the generator was being "repaired." The generator in question was in position "on the line" and was being turned by a motor at the time the fire occurred. But it was not being used to produce current. Instead, it had been disconnected and its commutator was being ground—a routine facet of generator service sometimes occurring as often as every six months. Since grinding the commutator was a normal operation incident to the use of a generator, plaintiff contended that the generator was "in use." Further, the plaintiff argued that the work being done on the machine was not "repair" but rather "maintenance"—the distinction suggested depending upon the condition of the machine when the work was begun. If the machine was actually broken down the work was "repair." Where, however, as in this case, the machine was in working condition when the work was begun, the work was merely "maintenance."

The court disagreed with both of plaintiff's arguments. Finding both phrases plain and unambiguous, the court considered itself bound by their ordinary meanings. "The usual and ordinarily understood meaning of an object being 'in use' is when said object is being used for the purpose for which it was designed." The generator was designed to produce current and, since it was not performing this function at the time the fire occurred, it was not "in use." Further the court found that the ordinary meaning of "repair" was "to restore to

49. For a discussion of the scant authorities in other jurisdictions see Andersen, *Insurance—1959 Tennessee Survey*, 12 VAND. L. REV. 1213, 1217 (1959); Annot., 50 A.L.R.2d 107 (1956).

50. 173 F. Supp. 925 (E.D. Tenn. 1959).

sound condition" and that "that which was being done . . . on the generator at the time of the accident fits the . . . definition."

The circuit court of appeals affirmed (3-2).[51] The opinion of the dissenting judges accepted both contentions made by the plaintiff at the trial.

The fire insurance policy in *McCaleb v. American Ins. Co.*[52] suspended coverage while the premises were vacant or unoccupied for more than sixty days. The policy and the property insured had been transferred to the plaintiff at a time when the premises were vacant to the knowledge of the insurer. More than sixty days after the transfer, (during which time the property remained vacant) the fire occurred. Over plaintiff's objection that the insurer had waived any breach of the vacancy clause by transferring the policy to him with knowledge of the breach, the trial court directed a verdict for the insurer.

The supreme court began with the settled rule that "knowledge by the insurer's agent that the premises are vacant at the time the policy is issued does not waive a breach arising from vacancy continuing thereafter for a period in excess of that permitted by the policy. . . ."[53] At the same time, the court observed the rule that if the policy is issued with knowledge of the vacancy *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 deemed waived."[54] The court considered the existence of such an agreement (under the somewhat obscure facts of this case[55]) to be a question for the jury and remanded for a new trial.

III. MARKETING AND SERVICING INSURANCE

A. Making the Contract

Ordinarily there is no problem in determining what the terms of an insurance contract are—the dispute is usually about their application and interpretation. Because of the nature of insurance marketing, however, problems of this kind can arise. Under modern as well as ancient practice, many insurance contracts begin as simple oral agreements: the (duly authorized) agent tells the applicant that he is immediately covered, then proceeds to obtain the written policy which is thus issued after the risk has attached. Should a loss occur

51. 277 F.2d 452 (6th Cir. 1960).
52. 325 S.W.2d 274 (Tenn. 1959).
53. Quoting from Annot., 96 A.L.R. 1259, 1266 (1936).
54. Conley v. Queen Ins. Co., 256 Ky. 602, 76 S.W.2d 906, 907 (1934).
55. The court observed: "Due to the very careless and irregular manner employed by the parties in their handling of a transaction very material to the outcome of this controversy, this Court cannot be completely satisfied with whatever decision it makes." 325 S.W.2d at 275.

before the policy is issued, a question may arise as to what the terms of the contract are.

In *Dixon v. Pickle*[56] a student had applied to an agent for an automobile liability policy and was told that he was covered immediately. The student loaned his car to another student who injured plaintiff in a collision. After obtaining a verdict against the student driver, plaintiff proceeded against the insurer. The company resisted liability on the ground that its policy (issued after the accident) contained a "student risk endorsement" which limited the omnibus coverage of the contract to members of the student owner's immediate family. Thus the driver of the vehicle was not an insured under the contract.

The seminal rule is that the terms of an oral contract, absent express agreement to the contrary, are presumed to be the terms of the policy either "ordinarily used by the company"[57] or "usually issued to cover like risks."[58] It has been observed that discrimination between these two alternatives has seldom been necessary but that should it become necessary the former alternative would probably be chosen.[59] The company here proved that it had been in the practice of including the student risk endorsement on all student policies for a period of five years pursuant to a published company directive. Therefore, it contended, the contract *with* the student risk endorsement was the policy "ordinarily issued by the company." The court, however, construed the rule to read "issued by the company *through this agent.*" Finding that the company had never notified the agent of its practice, and that there was no proof that the student risk endorsement had appeared on any prior policy issued by the agent, the court allowed the jury to find for the plaintiff.

A variation of this problem arose in *Henry v. Southern Fire & Casualty Co.*,[60] where the agent had allegedly told the insured that his logging operation was fully protected by liability insurance. The policy issued covered the insured's trucks, but not his trailers. Although this fact was apparent on the face of the policy[61] the court held that if he could establish the representation by the agent, plaintiff was entitled to indemnification for payments made to a third

56. 327 S.W.2d 50 (Tenn. App. E. S. 1959).
57. This phrase was quoted by the court from 44 C.J.S. *Insurance* § 230 (1945).
58. See Annots., 15 A.L.R. 995 (1921); 69 A.L.R. 559 (1930); 92 A.L.R. 232 (1934).
59. PATTERSON, ESSENTIALS OF INSURANCE LAW 89 (2d ed. 1957).
60. 330 S.W.2d 18 (Tenn. App. W.S. 1958).
61. As to which the court said: "[T]he insurer is not entitled to invoke the rule that the negligence of the insured in failing to read and understand the policy, and in retaining it, will preclude relief in equity. . . . [A]n insured has a right to rely on the good faith of the insurer and his agent. . . ." *Id.* at 33.

person who had been injured by one of insured's trailers. This was not a reformation of the contract for mistake, said the court; it was allowing recovery under the general insuring agreements of the policy, the insurer being estopped by the conduct of its agent from relying on the terms of the trailer exclusion.

B. Disposition of Claims

In *Central National Ins. Co. v. Horne*[62] an insurer sought to recover from its insured the amount paid on a collision claim, the insurer contending that by failing to attend the trial of a subrogation suit brought by the company against a third party the insured had breached his obligation to cooperate with the company. The court held that the cooperation clause[63] "has to do with cooperation with the company on the part of the insured at trials of cases brought against the insured. . . . [and] apparently, does not contemplate the situation that has arisen in the case at bar."[64] Nor could the company premise its case on the subrogation clause through which it received its rights against the third party and which obligated the insured to "do whatever else is necessary to secure such rights." The court said simply that the "record showed that the defendant, insured, did comply with this agreement," which apparently means that attending the trial of the subrogation suit was not "necessary."

The court went on to say that even if there was a duty to cooperate in the subrogation suit, there was no breach of the duty (the facts indicated "some excuse" for insured's failure to attend the trial), or the breach had not been proved prejudicial ("record does not show how many, if any, other witnesses to the same facts . . . known by the defendant, were available to plaintiff"), or that even if there was a prejudicial breach of an existing duty, the damages claimed were speculative (in view of third party's counter claim). These last two dicta raise the possibility that the Tennessee court has taken a position on the question of whether or not an insurer must prove prejudice before a breach of cooperation by the insured relieves it of obligation under the policy. Prejudice (or, as it is sometimes phrased, a "material" breach) is required by a majority of the jurisdictions which have passed on the question[65] although there is some persuasive authority to the contrary,[66] including a dictum in a

62. 326 S.W.2d 141 (Tenn. App. M.S. 1959).
63. Requiring that the insured "shall cooperate with the company and . . . shall attend hearings and trials. . . ." (*Id.* at 144).
64. *Id.* at 145.
65. Annot., 60 A.L.R.2d 1146, 1154 (1958).
66. Allstate Ins. Co. v. Keller, 17 Ill. App. 2d 44, 149 N.E.2d 482 (1958); Coleman v. New Amsterdam Cas. Co., 247 N.Y. 271, 160 N.E. 367 (1928) (opinion by Cardozo, J.).

recent Tennessee case.[67] The problem is discussed in detail elsewhere in this issue.[68]

67. Pennsylvania Ins. Co. v. Horner, 198 Tenn. 445, 281 S.W.2d 44 (1955).
68. Keeton, *Ancillary Rights of the Insured Against His Liability Insurer*, 13 VAND. L. REV. 837, 847-51 (1960).