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Insurance -- 1956 Tennessee Survey

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INSURANCE—1956 TENNESSEE SURVEY

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LIABILITY INSURANCE

In *Pennsylvania, etc. Ins. Co. v. Horner*,[1] it appeared that Horner had struck a parked vehicle but failed to stop. His identity was later established and he signed a statement admitting that the accident was his fault and assuming all responsibility in connection therewith, including damage to the vehicle and hospital and medical treatment to any person suffering injuries as a result of the accident. It was not until five months after the collision that Horner's insuror received any notice of the accident. The insuror thereupon filed this action in the chancery court for declaratory judgment to determine its rights and liabilities under the policy issued to Horner. The Supreme Court followed the case of *Phoenix Cotton Oil Co. v. Royal Indemnity Co.*[2] in holding that the giving of notice as soon as practicable as required by the policy was a condition precedent to liability and that the delay of five months constituted a breach of this requirement, regardless of whether the insuror showed any prejudice from the delay.[3] A similar result was reached in a recent federal case involving a delay of eight months.[4]

The case of *Virginia Surety Co. v. Knoxville Transit Lines, Inc.*[5] is rather singular in that it involved a controversy over the proper premium charge on a fleet liability policy. The case involved essentially questions of fact and of interpretation of provisions of the premium endorsements but presented one question of law of interest. The premium endorsements provided for the calculation of premiums on a retrospective or experience basis, and although the endorsements had been attached to the policy, the rates therein set out had not been filed with the Commissioner of Insurance, as required by law. Tennessee statutes provide that insurance rates shall be fair, reasonable, adequate and not unfairly discriminatory, and every insuror is required to file with the Commissioner full information as to its rates or rate plans.[6] It is made unlawful for any insuror to make or issue a contract or policy except in accordance with the rates which have

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1. 198 Tenn. 445, 281 S.W.2d 44 (1955), 24 TENN. L. REV. 607 (1956).
2. 140 Tenn. 438, 205 S.W. 128 (1918).
3. This holding is in accord with Rural Educational Ass'n, Inc. v. American Fire & Cas. Co., 207 F.2d 596 (6th Cir. 1953), discussed in Sturdivant, *Insurance —1954 Tennessee Survey*, 7 VAND. L. REV. 851 (1954).
4. Todd v. National Surety Corp., 226 F.2d 579 (6th Cir. 1955).
5. 135 F. Supp. 606 (E.D. Tenn. 1955).
6. TENN. CODE ANN. §§ 56-601 to -616 (1956).

been filed and approved; and violation of the act subjects the insuror to a penalty in the sum of $500 to be recovered in a civil action brought by the Commissioner.[7] The Commissioner is given the authority to abate such part of the penalty as the facts justify and is also authorized to suspend the license of any insuror failing to comply with his order. It was urged that the failure on the part of the insuror to file and have approved the rates set out in the endorsement invalidated the endorsement so that no premium was owed thereunder. The insured by cross-bill sought a recovery of the premiums that had been paid under the endorsement. The court, noting that there was no Tennessee case on the point, concluded that the violation of this statute does not operate to make the contract between the parties illegal and unenforceable. The court noted the general rule that contracts should be invalidated only when necessary to vindicate a sound policy of law,[8] and observed that if the legislature had intended to make contracts illegal where there had been no compliance with this statute it could have expressly done so. Since it had not done so, the court held that the contention of the insured was unsound.

Omnibus Coverage

The scope of coverage afforded by the omnibus clause of automobile liability insurance policies was considered in a number of cases during the survey period.

In the case of *Kirk v. State Farm Mutual Automobile Ins. Co.*,[9] the policy contained the usual omnibus clause, covering the owner as the named insured and any other person while using the vehicle with the owner's permission. The policy expressly excluded injuries to the insured or to any member of his family residing in his household. The insured loaned the vehicle to a third person, and the insured's wife rode as a passenger in the car while it was being operated by such third party. As a result of negligence by the operator she received injuries. After obtaining a judgment against the operator, she sought to collect the same from the insuror in the present action. Both the trial court and the Supreme Court held that the policy did not cover her.

The wife's theory was that the operator became an additional insured by virtue of the omnibus provisions, and that she was not a member of such operator's household. Accordingly, she contended that she was within the coverage afforded to him. Relying primarily upon a Minnesota decision,[10] however, the Supreme Court held that the

7. *Id.* § 56-615 (1956).
8. Biggs v. Reliance Life Ins. Co., 137 Tenn. 598, 195 S.W. 174 (1917).
9. 289 S.W.2d 538 (Tenn. 1956).
10. Pearson v. Johnson, 215 Minn. 480, 10 N.W.2d 357 (1943).

policy was merely a contract and that the court must look to the intent of the parties in construing it. The parties obviously intended to exclude the named insured and members of his family, and the provisions creating additional insureds should not be permitted to change the basic contract of the primary parties.

In three federal cases exclusions relating to employees of the named insured or of an additional insured were construed. In the first of these, *New v. General Casualty Co.*[11] a liability policy had been purchased by Fowler as the named insured. His employee, Patterson, used the car with Fowler's permission, and while so using it, Patterson negligently injured a passenger in the car. This passenger, New, was an employee of Patterson, but had no relationship of any kind with Fowler. He obtained judgment against both Patterson and Fowler, and brought the present action against the insuror to collect the judgment.

The policy contained the standard omnibus clause but expressly denied coverage for injury to "any employee of the insured." The insuror contended that since plaintiff was an employee of Patterson, and since Patterson was an additional "insured" under the omnibus clause, coverage did not extend to the plaintiff.

Had the named insured, Fowler, not been also a party defendant to plaintiff's original suit, probably the insuror would have been successful. Plaintiff, however, had obtained judgment not only against the operator, Patterson, but against Fowler as well, since the vehicle was being operated on Fowler's business. Accordingly, the district court held that the insuror must protect the interests not only of Patterson, but also those of Fowler. Plaintiff was not an employee of Fowler, and accordingly was held entitled to judgment against the insuror. The court pointed out that the policy was ambiguous in its terms, and if susceptible to a construction permitting coverage, such construction would be made.

In the case of *Patty v. State Farm Mutual Automobile Ins. Co.*,[12] there were similar policy provisions involved. There the named insured, one Knauff, had loaned his truck to one Cunningham for use by the latter in taking up hay. Cunningham had asked several neighbors, including plaintiff, to assist him, and while so doing plaintiff received injuries from Cunningham's negligence in operating the truck. The insurance policy excluded injuries to "any employee of the insured," and contained a standard omnibus clause. The district court directed a verdict for the insuror on the ground that plaintiff was Cunningham's employee. The court of appeals reversed, however, and held that a jury issue was presented on the facts as to this issue. Plaintiff had testified that he and many of his neighbors,

11. 133 F. Supp. 955 (M.D. Tenn. 1955).
12. 228 F.2d 363 (6th Cir. 1955).

including Cunningham, frequently traded services in farm tasks, and that he was in no way under the control of Cunningham.

The decision is not inconsistent with the *New* case, *supra*, since there was no attempt here to hold the named insured, Knauff. The ultimate issue was simply one of fact as to the relationship between the additional insured and the plaintiff; and in view of the testimony summarized in the opinion, this appeared to be properly a jury question.

A similar problem of fact as to the relationship of the parties was presented in *Tanner v. Pennsylvania Threshermen & Farmers' Mut. Cas. Ins. Co.*[13] The policy in this case covered the automobile of one Mike Zarzour, with an omnibus provision. It also provided that a substitute automobile used by the insured would be covered, when the primary vehicle was temporarily out of use for repairs. No business vehicle was covered except private passenger cars driven by the named insured, his wife or servant.

The named insured and his brother each owned restaurants in different parts of a city. Early in the evening of the day of the accident, Mike Zarzour placed his automobile in a garage for repairs. He borrowed the automobile of his brother, Louis, and made several trips on business for his restaurant during the evening. Louis stayed at Mike's restaurant and tended it during Mike's absence. Upon his return, Mike asked Louis to drive to Louis' restaurant and bring back some meat. Louis thereupon drove in his own car to accomplish this errand, and while so driving had the accident out of which the suit arose. The proof showed without contradiction that Louis was at no time an employee or servant of Mike and that he was merely assisting him as a brother; there was testimony that the brothers frequently accommodated each other in this way and that occasionally each loaned his car to the other.

The district court dismissed the suit, and the court of appeals affirmed. The court pointed out that for Louis' car to be covered as a "substitute automobile" at the time of the accident, the named insured would have had to have complete control over it, just as he did the primary vehicle. The proof failed to sustain such a conclusion, and, as stated, there was no proof of agency or employment. Presumably if the accident had occurred while Mike himself was driving the automobile, there would have been coverage.

FIRE INSURANCE

There was one state case and one federal case in this field during the survey period. In *Tucker v. American Aviation and General Ins.*

13. 226 F.2d 498 (6th Cir. 1955).

Co.,[14] the sole question was the effect, if any, of an insurance company's having given statutory[15] notice to the Commissioner of Insurance of the cancellation of a certificate of authority previously issued by it to an agent. The particular agent had written a fire insurance policy on behalf of the defendant company covering plaintiff's property for a period of one year. At about the expiration date, the agent purported to issue a renewal of this policy and was paid a premium therefor. It appeared, however, that shortly after the initial policy had been written the insurance company had cancelled his agency and had complied with the statutory provisions requiring a return of the certificate of authority to the Insurance Commissioner. It was not claimed that actual notice of the revocation of authority had been given the insured but it was argued that he was chargeable with constructive notice by reason of the filing of the revocation with the Commissioner. The court concluded that as a matter of legislative intent, it was not contemplated that proceedings under this statute would be notice to the citizens of the state and accordingly held that there having been neither actual nor constructive notice of the revocation of the agency, defendant was bound on the loss.

In the federal case of *Renner v. Firemans Ins. Co.*,[16] the insured had placed a valued fire policy in the amount of $3,000 on a house. The house had burned and in connection with the proof of loss, the insured first represented to the adjuster that he had paid $5,900 for the property and the sworn proof of loss showed its value at $5,000. Subsequently, the insured admitted to the adjuster that he had only paid $1,650 for the property. The insurance company relied on a policy provision that would void the policy in case of any fraud or false swearing by the insured relative thereto. The court held that there having been no false representations prior to issuance that the defense involved the breach of a condition subsequent. The court found that the proof was insufficient to show actual fraud or misrepresentation and that at the time the statement was made the liability of the insuror was already fixed at the policy amount and accordingly judgment was rendered for the insured.

Workmen's Compensation Insurance

Two important cases, each of them presenting questions of first impression in Tennessee, were reported during the survey period.

In the first of the cases, *Wilson v. Van Buren County*,[17] an employee was found to have sustained a compensable injury as a result of

14. 198 Tenn. 160, 278 S.W.2d 677 (1955).
15. Tenn. Code Ann. § 56-701 (1956).
16. 136 F. Supp. 114 (E.D. Tenn. 1955).
17. 198 Tenn. 179, 278 S.W.2d 685 (1955).

silicosis. He had suffered some disability during the year 1951, but it was not until September 20, 1952, that he first learned the nature of his illness, and on September 29, 1952, he was forced to quit work because of his condition. One insurance company had carried the workmen's compensation insurance for the employer through June 15, 1952, and a second insuror had afforded coverage since that time. The problem in the reported case was to determine which of the carriers was liable to the petitioner for compensation benefits. The trial court held that the carrier covering the employee at the date when he was forced to quit work was liable for the entire amount of compensation. The Supreme Court affirmed, relying upon a recent statute[18] which provides that the employer in whose employment the employee was "last injuriously exposed to the hazards of the disease" is liable and that the employer's insurance carrier at the time of such exposure "shall alone be liable therefor," without right of contribution from any prior employer or carrier.

The court recognized that the statute contemplates a situation where one employee has worked for several employers over a long period of time, and that its intent was to fix the liability for compensation upon the last employer. By analogy, however, the court held that as between a prior and a subsequent insurance carrier covering the same employer, the insurer having a policy in force at the time of the employee's last exposure must bear the full liability.

The court recognized that the foregoing rule might impose some hardship upon insurance carriers but it was influenced by the very practical proposition of not requiring an employee to have to determine which insurance carrier would be liable to him. The court also pointed out that there would be difficult problems of administration if rules of equitable apportionment among various carriers were adopted, since it would be extremely difficult to determine the proportionate amounts which should be contributed by different carriers.

The second of the two cases, *United States Fidelity & Guaranty Co. v. Elam*,[19] involved a determination of the rights of a compensation carrier to recover excess medical payments made by it to an injured employee. The practice of providing for the payment of medical expenses and hospital bills for injured employees above and beyond the rather small limits fixed by the compensation statute[20] has become rather widespread and is, of course, highly desirable. Whether the carrier having paid such benefits would be entitled by subrogation to

18. TENN. CODE ANN. § 50-1106 (1956).
19. 198 Tenn. 194, 278 S.W.2d 693 (1955).
20. TENN. CODE ANN. § 50-1004 (1956).

collect such excess from a third party tortfeasor, however, remained undecided in Tennessee prior to this case. In a very thorough and well-reasoned opinion, the Supreme Court held that the carrier would be entitled to collect such excess payments from a third party, where its policy of insurance gave it such right and where the employee accepted the excess benefits pursuant to the policy.

In the instant case, the policy provided for payment of medical and hospital expenses to an injured employee up to $10,000, an amount substantially in excess of the statutory liability of a compensation carrier. The carrier had paid to the injured employee approximately $6,300 at the time when the employee executed a compromise settlement of his tort action against a third party,[21] whose negligence had allegedly caused his injuries. Immediately the carrier filed an intervening petition in the tort action, setting out the amount which it had paid, estimating the amount which it would thereafter be required to pay, and seeking reimbursement therefor from the third party. The trial court held the carrier entitled to recover only the actual compensation benefits which it had paid, together with the statutory medical benefits.

The policy issued by the carrier to the employer, under which the excess benefits had been paid, provided that the insuror should be subrogated "to the extent of such payment, to all rights of recovery therefor, vested by law either in this Employer, or in any employee. . . ."[22] It was stipulated that the employee had accepted the benefits under this policy, although he had entered into no specific contractual relationship with the insuror.

Recognizing that there is some division of authority upon the subject,[23] the Supreme Court held that sound public policy required that the carrier be allowed to recover. The court stated that the employer who furnishes a policy providing for such excess benefits is satisfying a moral obligation, and that the provision of such excess protection is in accord with the liberal spirit of the Workmen's Compensation Act as well as with sound public policy. The court pointed out that to deny the carrier reimbursement for its excess payments would result in permitting the injured employee to receive such benefits and at the same time to receive compensation for his medical and hospital bills from the third party, resulting in double recovery for the same injury. The court made clear that the recovery permitted in this case was not a result of the "legal" subrogation rights afforded

21. The employee under present statutes may receive compensation benefits without waiving his right to sue a third party, but the employer or his insuror is given a lien for reimbursement upon any recovery from such third party. TENN. CODE ANN. § 50-914 (1956).

22. 198 Tenn. at 213, 278 S.W.2d at 701.

23. *E.g.*, De Roode v. Jahncke Service, Inc., 52 So. 2d 736 (La. App. 1951).

the carrier under the compensation statutes,[24] but resulted from the contractual rights contained in the policy of insurance. Since the employee was a third party beneficiary of the policy, he was bound by the subrogation provisions contained in the contract.

HEALTH, ACCIDENT AND DISABILITY INSURANCE

In *Life & Casualty Ins. Co. v. Ayers*,[25] the insuror had issued to the plaintiff an accident and health policy which provided, among other benefits, a benefit of $500.00 for the complete and permanent loss of use of one foot. Plaintiff alleged the permanent paralysis of her right foot from traumatic arthritis which ensued from an injury sustained after the policy was issued. The defendant pleaded fraud based on the plaintiff's statements in the application for the insurance that she had not had certain diseases, including paralysis, and had not been confined in a hospital for treatment. Defendant introduced proof of three hospital confinements prior to the application for a psychoneurotic condition manifested by a temporary paralysis of the right leg and other symptoms. The plaintiff, a woman of limited education, testified that she had not read the application and had not been asked the questions with respect to paralysis or prior hospital treatment. Her testimony was not contradicted by defendant's agent. Plaintiff also testified that she had suffered a fall which resulted in the paralysis. The court concluded that the jury could reasonably find, as it did, that the plaintiff did not willfully and fraudulently mislead the defendant, and that the loss had resulted from the fall she suffered. The defendant also contended on appeal that it should have had a directed verdict in that the application contained material misrepresentations. The court held that there was no proof of such misrepresentations in the record, since the application had not been attached to or made a part of the policy and had been admitted in evidence, upon plaintiff's objection, only for the purpose of showing fraud in the procurement of the policy. The trial judge's ruling on admitting the application for this limited purpose only was approved in view of a policy provision that "no statement made by applicant for insurance not included herein shall avoid the policy or be used in any legal proceeding hereunder." Since the application was not made part of the policy, statements contained therein could not be relied upon to avoid liability on the policy.

24. TENN. CODE ANN. § 50-914 (1956).
25. 281 S.W.2d 75 (Tenn. App. W.S. 1954).