Vanderbilt Law Review

Volume 12
Issue 4 *Issue 4 - October 1959*

Article 16

10-1959

Insurance--1959 Tennessee Survey

William R. Andersen
Vanderbilt School of Law

INSURANCE—1959 TENNESSEE SURVEY

WILLIAM R. ANDERSEN*

* * *

I. INTERESTS PROTECTED

A. Property and Liability Insurance—Measure of Damages

What is the meaning of the term "actual cash value" in the standard fire policy? The middle section of the court of appeals, following a prior Tennessee case[1] and the weight of authority,[2] held that the phrase is synonomous with "market value" only where the goods are readily replaceable in a current market. Where there is no market, or where the market value is inadequate to properly indemnify the insured, "actual cash value" means the "'value to the owner' or the loss he suffers in being deprived of the goods."[3] Since the goods involved in this case were personal effects, clothing and household goods, the latter standard was considered appropriate. Describing this standard as an "elastic" one, the court noted that value to the owner was to be determined by reference to "evidence of original cost, of the cost of replacement, the condition of the goods, the use to which they were being put, and all other relevant

* Assistant Professor of Law, Vanderbilt University; Faculty Editor, *Vanderbilt Law Review.*

1. Third Nat'l Bank v. American Equitable Ins. Co., 27 Tenn. App. 249, 178 S.W.2d 915 (1943).

2. The authority is reviewed in the *Third Nat'l Bank* case, *supra* note 1; see also McAnarney v. Newark Fire Ins. Co., 247 N.Y. 176, 159 N.E. 902 (1928), 56 A.L.R. 1149 (1928); MCCORMICK, DAMAGES 170-74 (1935); Note, *Valuation and Measure of Recovery Under Fire Insurance Policies,* 49 COLUM. L. REV. 818 (1949).

3. Clift v. Fulton Fire Ins. Co., 315 S.W.2d 9, 11 (Tenn. App. M.S. 1958).

facts . . . ."[4] Though holding the "valued policy law"[5] inapplicable to a policy covering personal property, the court affirmed an award of the face amount of the policy because the sole testimony of the owner sufficiently showed the value of the goods to be in excess of the policy limits.

B. Life and Disability Insurance—Interest of Beneficiaries

1. Murder of Insured by Beneficiary.—In a short per curiam opinion, the Sixth Circuit Court of Appeals affirmed a holding by the district court for the eastern district that the beneficiary of a National Service Life Insurance policy who had intentionally killed the insured was not entitled to recover on the policy.[6] Sustaining a trial court finding that the killing had not been done in self defense, the court concluded that public policy as expressed in the maxim that no one should profit from his own wrong precluded recovery by the beneficiary.[7] The United States having interpleaded the claimants, the proceeds were awarded to the parents of the insured.

2. Change of Beneficiary.—Life & Casualty Ins. Co. v. Cornish[8] presented a routine holding on the effectiveness of an inchoate change of beneficiary. The insured had completed the required forms and delivered them with the policies to the agent who was in turn to forward them for necessary endorsement by the home office. The agent apparently forgot the matter and a few months later the insured was killed. The company, faced with claims from the original beneficiary and the new beneficiary, interpleaded both claimants and paid the proceeds into court. In affirming the chancellor's finding that the change had been effected, the court pointed out that while a mere unexecuted intent to change would not suffice,[9] where, as in this case, the insured had done substantially all that was required of him and what remained were mere ministerial acts of the insurer, equity will treat the change as effective.

While this general proposition is accepted by most courts[10] a certain

4. 315 S.W.2d at 12. Compare the discussion of the breadth of this standard in the *Third Nat'l Bank* case, *supra* note 1.

5. TENN. CODE ANN. §§ 56-1137 to -1139 (1956), while not a valued policy law, in practical effect makes the face amount of the policy the measure of recovery in event of a total loss. See Riddick v. Yorkshire Ins. Co., 165 Tenn. 105, 52 S.W.2d 166 (1932).

6. Shoemaker v. Shoemaker, 263 F.2d 931 (6th Cir. 1959).

7. See to the same effect Jamison v. Metropolitan Life Ins. Co., 24 Tenn. App. 398, 145 S.W.2d 553 (1940) and Houser v. Haven, 32 Tenn. App. 670, 225 S.W.2d 559 (1949).

8. 315 S.W.2d 6 (Tenn. App. M.S. 1958).

9. See, *e.g.*, National Life & Acc. Ins. Co., v. Bryant, 27 Tenn. App. 294, 179 S.W.2d 937 (1943).

10. VANCE, INSURANCE 685 (3d ed. Anderson 1951); Annot., 19 A.L.R.2d 5, 15 (1951).

diversity in holdings remains. Much would appear to hinge on the judgment of the court as to the "substantiality" of the insured's acts directed at effecting a change, and the "ministerial" quality of the acts remaining to be done by the insurer. These evaluations are affected by numerous factors including (1) the degree to which the company is itself responsible for the failure to complete the change,[11] (2) the desirability of protecting the original beneficiary, usually the insured's wife, from temporary whims of the insured,[12] and (3) the possibility that the insurer, which has paid out the proceeds relying on the beneficiary designation as originally written, may be prejudiced by considering the inchoate change effective.[13] In the instant case, since the company was apparently responsible for the failure to effect the change, since the original beneficiary had no special claim to protection[14] and since, by interpleading the claimants, the company demonstrated that it had not changed its position in reliance on the original designation, the holding of the court seems clearly justifiable.

II. Selection and Control of Risks—Defining the Insured Event

Central National Ins. Co. v. Adams[15] was a suit on a collision policy in which it appeared that the insured's husband had damaged the insured's car by deliberately ramming it with both his car and his truck. His intent was to demolish the car; in the language of the court, "He just about accomplished his purpose." The insurer resisted payment on the ground that the insured event (collision) had not occurred. Referring to the "comprehensive" insuring agreement which was a part of the policy form but not part of this contract, the insurer noted that in excepting "collision or upset" from that clause, the policy said that loss by malicious mischief was not to be deemed loss by collision. From this premise the insurer reasoned that since the cause of loss in the instant case was "malicious mischief" it could not be considered "collision or upset." The court properly refused to allow its interpretation of the collision insuring agreement to be

11. See Page v. Detroit Life Ins. Co., 11 Tenn. App. 417 (1929). But *cf.* National Life & Acc. Ins. Co. v. Bryant, *supra* note 9. See Annot. 19 A.L.R.2d 5, 120 (1951).

12. See the discussion in Patterson, Essentials of Insurance Law 214-18 (2d ed. 1957).

13. Vance, Insurance 690 (3d ed. Anderson 1951). Compare the similar statements of the Tennessee courts in the *Bryant* case, *supra* note 9, the *Page* case, *supra* note 11, and Barnes v. Prudential Ins. Co., 28 Tenn. App. 109, 186 S.W.2d 918 (1944).

14. The person entitled to the proceeds had the change not been effective was the thirteen-year-old wife of the seventeen-year-old insured; the marriage had lasted only a few days and annulment proceedings had been instituted. The new beneficiary was the insured's father who had paid for the policy and had kept it in force.

15. 319 S.W.2d 486 (Tenn. App. M.S. 1958).

affected by a clause not a part of the contract. The defendant further contended that since the loss was caused by the intentional act of a third party, it was not an "accidental loss" within the contract. The court followed the general rule[16] that in this context intentional acts of third parties are "accidental" as to the insured.[17]

Since any ambiguity found in the policy is usually construed against the insurer, courts have sometimes displayed a remarkable capacity for discovering ambiguity. In *Slomvic v. Tennessee Hospital Service Ass'n*,[18] the insured filed an action against a hospital service insurer to recover hospital and medical expenses incurred in excess of the $1500 he had received from his employer's workmen's compensation carrier. The group hospital policy under which he claimed provided no coverage for injury or disease "for which [the insured] is entitled to any hospital care or for which he has received any award or settlement in any proceedings under Workmen's Compensation laws . . . ." With this apparently clear policy exclusion, the defendant insurer filed a demurrer which was overruled by the chancellor. The supreme court affirmed, considering the exclusion ambiguous. The court could "conceive of no reason why [the insured's] employer should carry a policy with the defendant covering expense of hospitalization and medical care unless it be to take care of additional expenses over and above that which he is required to carry by the Workmen's Compensation Statute . . . ." "If the policy sued on is not carried for that purpose," the court continued, "it should so state without equivocation."

The policy seems to express this intent and to do so without equivocation. While the court apparently read the contract as excluding *pro tanto* benefits for injuries for which workmen's compensation has to some extent been paid, the policy, in its terms, excludes benefits for those injuries for which *any* workmen's compensation benefits have been paid. And the not inconceivable reason for such a provision may be that in the absence of such specific exclusions, many courts have refused to consider workmen's compensation "other insurance" as that phrase is used in many private accident and health policies and have thus allowed the insured double recovery.[19] Is it really inconceivable that a nonprofit hospital service corporation should seek every opportunity to reduce its expense by contracting for the advantage of other insurance on

16. The court cited 45 C.J.S. *Insurance* § 772 (1946).
17. *Accord,* Insurance Co. v. Bennett, 90 Tenn. 256, 16 S.W. 723 (1891); Mutual Benefit Health & Acc. Ass'n v. Houston, 22 Tenn. App. 570, 124 S.W.2d 772 (1938).
18. 313 S.W.2d 265 (Tenn. 1958).
19. See Shealey v. American Health Ins. Corp., 220 S.C. 79, 66 S.E.2d 461, (1951) and cases collected in Annot., 27 A.L.R.2d 946 (1953).

the risk?[20] Or is it inconceivable that an employer might wish hospital benefits for his employees for injuries not covered by workmen's compensation? While it is true that there was no danger of double recovery here, that the insured was only seeking full indemnity for his just claim (which indemnity was denied him by the inadequate workmen's compensation recovery), does this prove that the plain words of a policy should be found ambiguous or merely that the workmen's compensation schedule needs revision? While other courts have not found similar exclusions ambiguous, in none of them was the issue the same as that presented in *Slomvic*. Where the insured has been fully compensated by the workmen's compensation award, a similar exclusion was held to preclude recovery.[21] Similarly, where the insured has not applied for workmen's compensation benefits the exclusion will be given effect,[22] presumably on the theory that since the insurer has contracted for the advantage of workmen's compensation coverage, the insured should be required to first pursue his claim against the compensation carrier.[23] The problem presented by the instant case of *partial* payment of the loss by the compensation carrier is thus sui generis.

The court rests its finding of ambiguity partially on the "factual" admissions of the defendant's demurrer. Considering as a statement of fact the allegation in the complaint that the policy covered expenses in excess of workmen's compensation benefits, the court held that defendant's demurrer admitted the truth of this "fact" and thus the policy was rendered ambiguous. This leaves the question of whether or not a statement of the legal effect of the instrument is a statement of fact admitted by the demurrer[24] and in any

20. And should contracts written by nonprofit hospital service insurers be construed against their makers as strongly as other insurance contracts? For a statement favoring the nonprofit hospital insurer see Moeller v. Associated Hosp. Service, 304 N.Y. 73, 106 N.E.2d 16, 17 (1952) (three judges dissenting).

21. Kosick v. Hosp. Service Corp., 12 Ill. App. 2d 291, 139 N.E.2d 619 (1956). Moeller v. Associated Hosp. Service, 304 N.Y. 73, 106 N.E.2d 16 (1952).

22. See Bonney v. Citizens' Mut. Auto. Ins. Co., 333 Mich. 435, 53 N.W.2d 321 (1952) (holding exclusion unambiguous and denying recovery).

23. But see State Farm Mut. Auto. Ins. Co., v. Rice, 326 S.W.2d 490 (Tenn. 1959) decided since the survey period and holding that third party claimant under medical payments coverage of liability policy was unable to recover by reason of a similar exclusion even if his failure to receive workmen's compensation benefits was due to refusal of workmen's compensation carrier to provide them.

24. Compare Mr. Justice Brandeis speaking for the Supreme Court: "The allegations in the petition as to the meaning, application and effect of the [contract sued upon] . . . being conclusions of law, are not admitted by the demurrer . . . . The legal effect of the instrument remains that which its language imports." St. Louis, Kennet & Southeastern R.R. v. United States, 267 U.S. 346, 349 (1925).

event, how a factual averment can render ambiguous the terms of the otherwise clear instrument.[25]

The ambiguity device, of course, is not always successful. In *Standard Life Ins. Co. v. Hughes*,[26] the plaintiff was insured under a limited accident policy covering injuries on a "public highway." While traveling at a moderate rate of speed on the old Elizabethton-Johnson City highway, the insured's car unexplainably veered off the road and onto a graveled area in front of a nearby grocery store-filling station where it struck the rear corner of a building. The insured died almost immediately. The chancellor and the court of appeals considered the term "public highway" ambiguous. Relying on several railroad station cases[27] which made "public highway" of private property used by the public generally though not formally dedicated to such use, the court of appeals held that the graveled area on which the accident occurred was a "public highway" since it was used both by customers of the owner and by members of the public generally for parking and turning around.

The supreme court reversed and dismissed the bill. Observing that "the rule of ambiguity and construction against the insurer does not permit a court to create an ambiguity where none exists" and that "contracts of insurance, like other contracts, must be construed according to the terms which the parties have used in their plain and ordinary sense,"[28] the court concluded that "there can be no doubt that the common understanding of a public highway is such a passageway as any and all members of the public have an absolute right to use as distinguished from a permissive privilege of using same." The court found no evidence of the creation of such a public right by act of public authorities, express or implied dedication by the owner, or by adverse user.

It is unfortunate that the fate of the beneficiaries of such a policy should depend on what happens to a rapidly moving automobile after the insured has lost control of it. Had it struck another vehicle on the highway there would clearly have been coverage. It is likewise unfortunate that, as the court indicated, the policy does not provide coverage in many areas in which today's automobile finds its way: the court of appeals' opinion mentions "parking lots, driveways used by the public, parking lots used for supermarkets, entrances to drive-in theaters, motels, filling stations, hot dog stands, etc. . . . ."[29] But

25. The case was remanded for trial; the chancellor's judgment for the insured is now on appeal to the court of appeals.
26. 315 S.W.2d 239 (Tenn. 1958).
27. Rudd v. Indemnity Co., 114 Minn. 512, 131 N.W. 633 (1911); Gatewood v. Insurance Co., 23 F.2d 211 (E.D. Va. 1927).
28. Compare the court's attitude toward ambiguity in the last discussed case.
29. 315 S.W.2d at 242.

an inapt definition of an insured event is not necessarily an ambiguous one and where it is not misleading to the insured should be given effect according to its terms. It is believed that this feeling lies behind the rule mentioned above that the terms of insurance contracts should be construed according to their plain and ordinary sense.

III. Marketing and Servicing of Insurance

A. Making the Contract

The life insurance binding receipt is the peculiar instrument by which the company gives its selling agents power to grant what appears to be "immediate" coverage while at the same time reserving for itself some power to pass on the risk before liability attaches. The receipt provides for a contract of interim insurance to cover the applicant from the date of the application (or some other specified date) until the date the policy is delivered, provided certain conditions are met. While there are a great variety of forms, the common problem has resulted in certain common characteristics. Each receipt specifies a *condition precedent*[30] which must occur before the contract of interim insurance exists and an *effective date* upon which the contract will be considered in force.

The feature of this instrument which makes it potentially misleading arises from the problem the receipt was framed to meet. A close reading indicates that the condition, which is in legal effect *precedent* to the existence of the contract, in point of fact almost always occurs *after* the date on which the contract is to become effective. Thus, in a common form of receipt, final "approval" of the company may be specified as the condition of the contract, yet the date of the initial application may be the effective date. There is no contract if approval has not been given, but when it is given the contract is considered as being in force retroactively from the date of the application.

Since the extent of the company's control over the occurrence of the condition is seldom specified and arises only by implication from the phrasing of the condition itself,[31] the receipt can easily appear to give more than its literal terms require. Where the applicant dies after the "effective date" of the contract, but before the condition has occurred, the question arises whether the company has sufficient

30. While the term "condition precedent" may be restricted to mean acts or events which must occur before a duty to perform arises under a contract, RESTATEMENT, CONTRACTS § 250 (1932), the term is used here in its broader sense as a fact or event which must precede the *existence* of the contract. See Ferson, *Conditions in the Law of Contracts*, 8 VAND. L. REV. 537, 538 (1955); RESTATEMENT, CONTRACTS § 250, comment *a* (1932).

31. *Compare*, "If the Company approves" *with* "If the applicant is insurable."

control over the happening of the condition to allow it to escape liability. If the condition is truly precedent, and if it is phrased in such a way as to give the insurer absolute control over its occurrence, the company would appear to be free to avoid any liability under the contract on learning of the intervening death of the applicant.[32] Thus while the receipt appears to give coverage from the date of the application, its practical effect is to grant interim coverage only between the date of final approval and the date the policy is delivered. Loathe to enforce such an agreement, a court may (with the help of a thread of ambiguity) treat the receipt as a grant of immediate coverage subject to termination by the later disapproval of the company. This appears to convert what was intended as a condition precedent into a condition subsequent. Under this interpretation, the intervening death of the applicant matures the obligation and the company will be liable.[33] Two recent Tennessee cases demonstrate variations on this "condition subsequent" theme.

In *American Nat'l Ins. Co. v. Thompson*,[34] a policy was issued calling for a slightly higher premium than the policy applied for. The applicant died before the agent was able to deliver the up-rated policy to him. The receipt provided that temporary insurance would be effective *from* the application date *if* a policy conformable to the application was issued. Should a nonconforming policy be issued, the receipt went on to provide in effect that there was to be no temporary insurance, that the insurance applied for would take effect only on actual delivery of the policy during the continued good health of the insured. This is simply a restatement of the common law view that an "acceptance" which materially differs from the terms of the offer is, in reality, a rejection and counteroffer. The court found this part of the receipt in conflict with another provision which was probably added (unhappily as it turned out) to specify in more detail the consequences of the issuance of a nonconforming policy. The provision said in effect that no liability would be created under the receipt if an up-rated policy was issued and rejected by the insured. The court said this provision "can reasonably be construed to mean that interim insurance is to continue until the policy as applied for has been issued . . . or, if uprated in premium, until the applicant has refused to pay the additional premium . . . ."[35] Thus the reasonable implication of this clause is that insurance is *presently* existing, and this is in conflict with the first mentioned provision. Given this

32. See Annot., 2 A.L.R.2d 943, 964 (1948) for collection of cases reaching this result.
33. *Id.* at 967.
34. 316 S.W.2d 52 (Tenn. App. E.S. 1957).
35. *Id.* at 56.

ambiguity, the jury was allowed to construe the receipt as affording present coverage subject to later termination and, since the applicant died before rejecting the policy, the beneficiary's judgment was warranted.

In *Life & Cas. Ins. Co. v. Vertrees*[36] another form of receipt was similarly construed as granting immediate coverage subject to later termination. The application provided that the temporary insurance would be effective *from* the date of the application or, if a medical examination was required, *from* the date the examination was completed, *provided* the company was satisfied that on the relevant date the applicant was a risk acceptable to it under its rules for the plan and amount of insurance applied for. An application for insurance not requiring medical examination was completed and submitted to the company. After reviewing the application the company decided that a medical examination was necessary, but the applicant died before he was notified of this decision. The court quoted with approval from the circuit court opinion that the "receipt gave the applicant coverage from the time of the application subject to the right of the defendant to terminate the agreement if it subsequently concluded that [the applicant] . . . was not acceptable."[37] The court thus adopted plaintiff's argument that the receipt granted immediate coverage subject to a "condition subsequent" and affirmed judgment for the beneficiary.[38]

The condition subsequent theory would appear to completely eliminate the home office control over the selection of the risk that a company seeks in its receipt. Presumably, if the receipt grants immediate coverage, the insurer is bound to the risk upon completion of the application, and if the applicant dies before action is taken on the application, the insurer is liable irrespective of the applicant's insurability. Interestingly, neither opinion went this far in its holding, though the language is certainly broad enough to warrant it.

36. 318 S.W.2d 559 (Tenn. App. W.S. 1958).
37. *Id.* at 561.
38. The case may be interpreted, alternatively, as involving a dispute over the *effective date* of the contract, rather than the question of whether the *condition* was precedent or subsequent. Although the opinion is not clear on this point, the case may be considered as holding that the effective date of the original agreement (the application date) was determinative until it be shown that the applicant was notified to the contrary. Since the applicant died before being notified that another effective date (the examination date) was being substituted, the contract was in force from the application date and was thus in force on the applicant's death. The difficulty with this interpretation is that it neglects the wording of the condition in the receipt. *No* insurance was to be in effect until the company was satisfied that the applicant was a satisfactory risk *under its rules for the plan applied for.* The decision that a medical examination was required seems evidence that the company was not so satisfied with the applicant. Hence no contract dating from the application date ever came into existence.

In *Thompson,* while the jury found that a receipt of that type would have effected temporary insurance until the application was rejected and placed no restrictions on the reason for rejection, the court approved the rule that if the insurer determines in good faith before or after the loss that the applicant was never an insurable risk it is not bound on its receipt. The rule was held inapplicable to the case in suit because "in this case, admittedly, the company found that the applicant was an insurable risk though at an increase in premium." But the court goes on to say that this receipt does not give the insurer the right to determine insurability to its own satisfaction. "The Company wrote the receipt. It could have reserved the right to determine the applicant's insurability . . . [but it] failed to . . . ."[39] Absent such a reservation, the question will apparently be for the jury.

In similarly modifying the condition subsequent theory with the insurability requirement, the court in *Vertrees* quoted from the *Hamilton*[40] case that the condition of insurability could not be ignored, but apparently found the condition satisfied by lay testimony that "the deceased appeared to be in good health" which testimony was not contradicted by the insurer.

Thus, despite the "condition subsequent" language, the net effect of these cases is simply to replace one condition precedent with another. In each case the court substituted "insurability on the date of application—as determined by the trier of fact" for the condition expressed in the receipt. This is also true of the *Hamilton* case, despite even stronger "condition subsequent" language.[41] While this construction gives the insurer what is apparently felt to be the functional equivalent of the home office control it deems necessary, there is no doubt considerable difference between insurability as judged by the insurer's medical experts and insurability decided by a sympathetic trier of fact and proved by lay testimony as to what the applicant's health "appeared to be."

Prejudice to the insurers' interests may be justified where a corresponding benefit to the interests of applicants is thus conferred. But beyond sporadic relief from possible deception it is doubtful that decisions such as these can in the long run satisfactorily protect the interests of applicants for life insurance. In the first place, the decisions leave the insurer free to devise more precise binding

39. 316 S.W.2d 52, 57. (Tenn. App. E.S. 1957).
40. Liberty Nat'l Life Ins. Co. v. Hamilton, 237 F.2d 235 (6th Cir. 1956), discussed in Sturdivant, *Insurance—1957 Tennessee Survey,* 10 VAND. L. REV. 1100, 1102 (1957).
41. "There is respectable authority for the proposition that where a premium has been paid there is insurance coverage, regardless of other stipulations in the application or receipt." Liberty Nat'l Life Ins. Co. v. Hamilton, 237 F.2d 235, 240 (6th Cir. 1956).

receipts which clearly (at least to the courts) state the conditions, clearly make them precedent, and clearly afford the company absolute control over their occurrence. Many courts,[42] perhaps even those of Tennessee,[43] have been ready to enforce such contracts according to their terms where those terms are clear.[44] Secondly, even where a wisp of ambiguity is held sufficient to turn the condition into a "condition subsequent" or, more accurately, to replace it with another condition precedent, the uncertainty of such an outcome, deriving from the plethora of forms in use and the variations and inconsistencies of their judicial interpretation,[45] makes litigation the only sure way of determining the effect of a given receipt.

Applicants thus continue to buy insurance policies on which lawsuits are virtually endorsed, and the judicial process continues to expend great energy in a contest with company drafting departments. Is it perhaps time, in the interests of both parties, for legislative action by way of a standard binding receipt form?

B. Adjusting and Settling the Loss Claim

The *Thompson* case discussed above presents another interesting problem involving the statutory penalty for failure to promptly pay losses. Under the terms of the statute[46] a penalty is assessable against an insurer for refusal to pay a loss within sixty days after proper demand provided (1) the refusal was in bad faith, and (2) the failure to pay inflicted additional expense upon the insured. In *Thompson*, the up-rated policy issued on the application arrived at the local agent's office on May 27 but was not delivered immediately because the selling agent was on vacation. The insured died on May 29. In affirming a jury's award of the statutory penalty, the court said that the defendant could have prevented the law suit entirely had it delivered the policy promptly instead of withholding delivery for reasons of its own.[47] It is of course true that had the policy been

42. See note 32 *supra*.

43. The court in *Thompson* cites Arnold v. Locomotive Eng'rs Ins. Ass'n, 30 Tenn. App. 166, 204 S.W.2d 191 (1946) as falling in this category. The receipt in the *Arnold* case provided temporary insurance from the *date of approval* as distinguished from those receipts making the *application date* the effective date. This is not as deceptive an instrument and perhaps justifies a literal reading of the contract. The position of the Tennessee courts on the effect of a clearly expressed "approval" receipt which dates coverage from the application is thus still uncertain.

44. See the concurring opinion of Clark, J., in Gaunt v. John Hancock Mut. Life Ins. Co., 160 F.2d 599 (2d Cir. 1947).

45. A picture of the judicial process at its creative best and discordant worst may be found in an elaborate and unusually articulate annotation on this problem in 2 A.L.R.2d 943 (1948). The annotation collects the cases and much of the secondary material.

46. TENN. CODE ANN. § 56-1105 (1956).

47. The court suggested that no one else in the local office undertook

delivered during the applicant's lifetime he would have been compelled either to accept or reject it, and either event would have made this suit unnecessary. Prompt delivery thus would have saved the beneficiary the expense of litigation. But does the statute in its terms allow the penalty for neglect *prior to the loss* which raises legitimate legal questions that must be settled by suit, or is it limited to compensating the insured for conduct of the insurer *after the loss* which added to his expense? The terms of the act seem clearly to provide the penalty only in the latter case.

It is difficult to consider the interposing of this defense in itself "bad faith" within the interpretation given that phrase by the Tennessee courts. It has been held that where the company's defense is based on substantial legal grounds,[48] or where the case is one of first impression in the state,[49] the insurer is entitled to a decision on the disputed point and that therefore the penalty is not allowable. These conditions seem to have been amply met in the *Thompson* case.

A more orthodox application of the penalty statute was made in *Agricultural Ins. Co. v. Holter*,[50] where it appeared that for almost two years the company had refused to pay the loss or to cooperate in settling the claim. First the company demanded an arbitration but refused to arbitrate. Then it litigated the appointment of an umpire, and, though unsuccessful in this action,[51] continued thereafter in its refusal to arbitrate. Finally, though the demand for arbitration is considered in Tennessee a confession of liability,[52] the company denied all liability and forced plaintiff to institute this action. The court concluded that the proof "amply supported the charge that defendant had refused in bad faith to pay the loss."

The penalty was not awarded to the insured in the *Clift* case discussed above[53] on the ground that there was no evidence of a bad faith refusal to pay. The insurer had kept the proofs filed by the insured for over a year when the insured finally brought suit.

The somewhat related problem of liability in excess of policy limits for bad faith refusal to settle arose in an interesting Sixth Circuit

---

delivery of the more expensive policy in the selling agent's absence for fear of losing the sale.

48. Columbian Nat'l Life Ins. Co. v. Harrison, 12 F.2d 986 (6th Cir. 1926).

49. Lewis v. Western Assur. Co., 175 Tenn. 37, 130 S.W.2d 982 (1939); Pacific Mut. Life Ins. Co. v. McCrary, 161 Tenn. 389, 32 S.W.2d 1052 (1930); Thompson v. Concordia Fire Ins. Co., 142 Tenn. 408, 215 S.W. 932 (1919).

50. 318 S.W.2d 433 (Tenn. App. M.S. 1958).

51. Agricultural Ins. Co. v. Holter, 299 S.W.2d 15 (Tenn. 1957), noted in Sturdivant, *Insurance—1957 Tennessee Survey*, 10 VAND. L. REV. 1100, 1108 (1957).

52. Gulf Compress Co. v. Insurance Co. of Pennsylvania, 129 Tenn. 586, 167 S.W. 859 (1914).

53. See note 3 *supra*.

case.[54] Helen and Drew, apparently engaged to be married, each owned automobiles and each had liability insurance with the defendant. Helen's policy excluded coverage for liability incurred while she was driving a vehicle furnished by another for her "regular use," and both policies limited liability for a single injury to $10,000. While driving Drew's car, Helen was involved in an accident in Mississippi seriously injuring Jones who instituted suit in a Mississippi court against both Helen and Drew for $70,000. During the trial, it became known that Jones was willing to settle for $17,500. The insurer refused to negotiate a settlement apparently on the ground that the "regular use" exclusion of Helen's policy precluded reliance on that policy and thus its contractual liability was limited to $10,000. After a verdict in favor of Jones for $35,000, Helen brought an action against the insurer to determine her rights under her policy; the insurer admitted liability under the policy and credited the $10,000 against the Jones judgment. The company was then in the uncomfortable position of having refused to accept an offer of settlement which turned out to be within the (combined) limits of the policies. Helen and Drew brought this action for the full $35,000 alleging a bad faith refusal to settle. A jury verdict for plaintiff in that amount was affirmed.

The first issue thus presented went to the propriety of defendant's denial of liability under Helen's policy, since the gist of the action is bad faith refusal to settle *within* the policy limits.[55] Circuit Judge (now Mr. Justice) Stewart said there was sufficient evidence to support a finding that the insurer was guilty of bad faith in not acknowledging liability under Helen's policy or, alternatively, that the insurer, in failing to give timely notice of its decision to deny liability, had misled Helen to her detriment and was therefore estopped at the time of the settlement negotiations from asserting the "regular use" exclusion.

The general issue of defendant's "true motive" for refusing to accept the settlement offer thus being posed, the court said the jury was entitled to consider defendant's knowledge of the serious nature of Jones' injuries, and its knowledge that the comparative negligence rule in Mississippi made an adverse jury verdict in Jones' action extremely probable. "Upon the whole case," the court concluded, "the jury could properly have found that the appellant was clearly obligated under both . . . policies, that an opportunity

54. United States Fid. & Guar. Co. v. Canale, 257 F.2d 138 (6th Cir. 1958).

55. Except, of course, where the insured is willing to contribute the excess above the policy limits as his share of the settlement. *Cf.* Southern Fire & Cas. Co. v. Norris, 35 Tenn. App. 657, 250 S.W.2d 785 (1952). See Keeton, *Liability Insurance and Responsibility for Settlement*, 67 HARV. L. REV. 1136, 1148 (1954).

for settlement within the combined limits had been made known to its agents, and that its failure to make the settlement was a bad faith disregard of the appellees' interests."[56]

In accord with prior Tennessee decisions,[57] the court appears to state the "bad faith" rule[58] and to define "bad faith" broadly as the insurer's failure to make a "reasonable business judgment . . . after weighing the [insured's] . . . interests as its own."[59]

Mazikowski v. Central Mutual Ins. Co.[60] concerned another aspect of the adjusting and settling process. After a full investigation of a collision claim, the insurer negotiated a settlement with its insured and issued its check to cover the loss. The check was endorsed by the insured and deposited in his account, but before it was paid the insurer discovered a restrictive endorsement in the policy which would have precluded recovery[61] and stopped payment on the check. The insured brought an action on the settlement contract in the general sessions court and recovered the amount of the loss. The circuit court reversed and the insured appealed. In reversing the circuit court, the court of appeals granted that there could be no action on the policy contract because of the restrictive endorsement but held that an action was maintainable on the settlement agreement—a valid enforceable contract entered into by the company through its adjuster and approved and ratified by the company when it issued its check payable to the insured. Its effort to avoid liability by stopping payment on the check, in the opinion of the court, came too late. The insurer's request for rescission of the settlement contract was denied on the ground that the company was unable to return the consideration given for the contract,[62] and its further claim for restitution of money paid under mistake of fact[63] was denied for lack of equitable jurisdiction in both the general sessions court

56. 257 F.2d at 140.

57. Vanderbilt Univ. v. Hartford Acc. & Indem. Co., 109 F. Supp. 565 (M.D. Tenn. 1952); Roberts v. Amer. Fire & Cas. Co., 89 F. Supp. 827 (M.D. Tenn. 1950); Farmer's Mut. Ins. Co. v. Hammond, 306 S.W.2d 13 (Tenn. App. W.S. 1957); Southern Fire & Cas. Co. v. Norris, 35 Tenn. App. 657, 250 S.W.2d 785 (1952).

58. Usually distinguished from the "negligence" rule. For a more careful analysis of the cases, see Keeton, *supra* note 55. The cases are collected in Annot., 40 A.L.R.2d 168 (1955).

59. 257 F.2d at 140.

60. 312 S.W.2d 867 (Tenn. App. M.S. 1958).

61. The policy provided no coverage while the automobile was being operated by any person other than the named insured or members of his immediate household. The company had failed to notice that when the accident occurred the vehicle was being operated by a friend of the named insured.

62. The company's tender of salvage money received from the sale of the insured vehicle pursuant to the settlement contract was considered an inadequate substitute for the damaged vehicle.

63. See cases collected in Annot., 167 A.L.R. 470 (1947).

where the action was originated and the circuit court to which it was appealed.

IV. Legislation

The major legislative action in the field of insurance produced amendments to the Financial Responsibility Law. The Legislative Council's comparative study[64] of Tennessee's financial responsibility statutes showed that while the percentage of uninsured drivers in Tennessee was about average for this section of the country, there remained over 350,000 uninsured drivers in the state. Since under the Tennessee statutes there is no requirement of proof of financial responsibility *prior* to the occurrence of an accident, victims of the uninsured motorist's first accident may well go uncompensated. It was also determined that the financial responsibility laws of all states but Tennessee and Utah included some provision requiring future proof of financial responsibility following serious or frequent motor vehicle violations, and that only Georgia, Connecticut and Tennessee did not require future proof of financial responsibility after a judgment has been obtained against a financially irresponsible motorist. On the basis of these studies, the Council recommended certain changes to the 81st General Assembly.

The problem of future proof of financial responsibility was met by a series of amendments which, under certain conditions, require such proof for a period of five consecutive years. Thus the owner or operator involved in an accident who is not exempt from filing security by reason of the existence of a valid automobile policy is now required (a) to file such security, *and* (b) to give and maintain proof of financial responsibility for five years in the future.[65] Also, licenses or registrations revoked for failure to provide the required security following an accident cannot be reinstated until the security is filed (or until judgment has mooted the issue) *and* until proof of financial responsibility has been given and maintained as a condition of such reinstatement (Secs. 1207, 1212).

In broadening the class of persons required to prove financial responsibility, the act provides that any conviction under the vehicle code which requires the revocation of the driver's license is now grounds for revocation of the vehicle registration unless the owner gives and maintains proof of financial responsibility for five years (Sec. 1214 a). Similarly, such conviction of a *driver* is grounds for revocation of the *owner's* registration if the car was being used with the owner's permission, and provided the owner was not insured at the time of the violation. To preserve his registration, the unin-

64. Tennessee Legislative Council Comm. Final Report 146 (1958).
65. Tenn. Code Ann. § 59-1204 (Supp. 1959). All further references in the

sured owner must therefore give and maintain proof of financial responsibility for five years (Sec. 1214 b). Still further, the act provides that any conviction of an uninsured motorist for a moving traffic violation is grounds for revocation of his registration and license until the motorist becomes insured or otherwise responsible (Sec. 1215 a). Should the owner satisfy this condition with short term insurance which is not in force at the time (within 12 months) of another conviction, the motorist can recover his license and registration only by giving proof of financial responsibility for five years (Sec. 1215 b). Finally, upon failure within 60 days to pay a judgment arising out of an automobile accident (payment to the minimum limits of $5,000/$10,000/$5,000 sufficing) the motorist's license and registration will be revoked. Such revocation will continue until the judgment is satisfied, and until the motorist as a condition of reinstatement gives and maintains proof of financial responsibility for five years (Sec. 1219).

The proof of financial responsibility thus required may be made by filing a certificate of insurance, or a certificate of self-insurance, by posting the required bond, or by depositing $15,000 cash (Sec. 1220). From the standpoint of the rights of third party claimants under liability policies, this first alternative (the certificate of insurance) needs further comment. Ordinarily, the standing of the claimant under an automobile liability policy is much the same as that of the insured. Policy defenses arising from breaches by the insured are available to the insurer in actions by claimants.[66] If the public interest is served by full compensation of the injured person, this situation leaves much to be desired; the legitimate claims of third parties can be destroyed by acts or neglects of the insured over which the claimant has little or no control. Tennessee has now joined that group of states which have attempted to alleviate this situation by legislation enlarging the rights of the third party claimant. Where proof of financial responsibility for the future is made by filing a certificate of insurance, what is certified is the existence of a valid "motor vehicle liability policy" (Sec. 1221). The statute defines the "motor vehicle liability policy" in section 1223 and states the provisions with which it must conform. The most important of these are the conditions that the insurer's liability will become absolute when the liability-producing accident occurs, that the policy cannot be cancelled as to such liability after the accident, and that no statement made by the insured or on his behalf and no violation of the policy shall defeat or avoid the contract. (Sec. 1223 (f) 1). This enlarged

text will be to the 1959 Supplement to this chapter.

66. Hynding v. Home Acc. Ins. Co., 214 Cal. 743, 7 P.2d 999, 85 A.L.R. 13 (1932).

protection of claimants, however, extends only as far as the policy may be deemed compulsory. Thus where the policy has been breached and is therefore void as to the named insured, the third party may still recover, but only up to the minimum limits ($5,000/$10,000/$5,000) required for proof of financial responsibility (Sec. 1223 g). This is true no matter what the size of the claimant's judgment, and no matter how large the policy limits. Further, the statute (Sec. 1223 h) permits a reimbursement provision which allows the insurer to recover from the insured any payment it may be required to make under a policy void but for the statute.[67]

Strength has been added to the statutory scheme by the enactment of an impoundment law. Any vehicle is subject to impoundment when involved in an accident for which the Commissioner is empowered to revoke the driver's license and from which death or serious personal injuries result. The statute provides that the owner shall place the vehicle in storage at his own expense within 48 hours after the accident (with certain exceptions for repair work and for out of state cars). The vehicle will remain so impounded until proper security has been filed under section 1204, *supra,* until judgment has been rendered in the owner's favor, or until a judgment against him has been satisfied (Sec. 1239).

There is little doubt but that these amendments will increase the percentage of insured drivers in the state. At the same time the problem of the uninsured motorist's first accident will be somewhat alleviated by requiring future proof of financial responsibility from those drivers who are presumably most dangerous. There remain gaps, however, in the protection afforded by the statute and their extent is difficult to determine. Another proposal of the Legislative Council aimed at closing these gaps was not adopted. The Council had concluded that unsatisfied judgment funds, compulsory insurance and other methods of meeting these problems were not in the best interests of the people of Tennessee. Alternatively, a plan was proposed modeled on the Virginia statute[68] which would have required an uninsured motorist's endorsement on all automobile policies written in Tennessee, thus giving all insured drivers protection should they be involved in an accident with an uninsured motorist. Insurers would be compensated for this extended coverage not by sub-

67. For a discussion of the effect of these mandatory provisions on automobile liability policies *not* filed as proof of financial responsibility for the future, and a consideration of the recent revision of the financial responsibility condition of the standard automobile policy, see Risjord & Austin, *The Financial Responsibility Condition of the Automobile Liability Policy,* 25 U. KAN. CITY L. REV. 83 (1957).

68. See VA. CODE ANN. §§ 12-65 to -67, 38.1-381 (Supp. 1958), § 46.1-167.1 (1958).

stantial rate increases but by a pro rata sharing in an Uninsured Motorists Fund. The fund would be made up of the $20 fees charged the one-third of a million uninsured motorists who annually register their cars in Tennessee.

Despite criticism[69] the plan seems a fair adjustment of the interests at play. The Council had received a favorable opinion of the Attorney General on the constitutionality of the plan and the practical problems seem well provided for. The proposal would virtually eliminate the problem of the uninsured motorist's first accident, and would clearly increase the number of insured motorists; both objectives would be accomplished without the political complications of a compulsory insurance plan and the delays involved in recovery from an unsatisfied judgment fund. The ultimate cost would be borne by the uninsured motorists who, after all, created the problem. Only further experience under the present act can demonstrate whether or not the legislature stopped short of a full solution.

69. "The Virginia plan has been criticized as: being conceived in the heat of legislative battle without prior careful study and consideration; creating a conflict-of-interest situation on the part of insurance companies; eliminating desirable arbitration provisions; requiring too much paper work and administrative expense; creating another state-administered fund, which funds are bad in principle; posing a serious constitutionality problem on the question of class legislation; being likely to cause some inequities in automobile insurance rates; creating a difficult problem in working out a plan of administration and enforcement; being likely to result in public demand for compulsory liability insurance; being likely not to prove to be in the best interest of the public; and being likely to ultimately result in the state's taking over the insurance business, to the elimination of private enterprise." TENNESSEE LEGISLATIVE COUNCIL COMM. FINAL REPORT 152 (1958).